Creating Environments of Care With Transgender Communities

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Partnerships between transgender individuals and community health nurses have been a primary source of monitoring and responding to the impact of the HIV epidemic on transgender communities, specifically transgender women. This article provides two perspectives: first, from a transgender service provider, and second, from a public health nurse, on forming partnerships that brought consumers and providers together to create environments of care in which many transgender persons living with and at high risk of HIV were able to engage with medical providers who believed in their right to self-determination. The process led to an increased understanding of HIV prevention and treatment needs, better individual-level health outcomes, and institutional change, including the creation of a transgender medical clinic serving homeless transgender individuals in greater Boston.

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Transgender individuals have often experienced discrimination and poor treatment within health care settings. Collaborations between transgender service providers and community health nurses have been instrumental in creating individual—and institutional—level change. This article, by a transgender service provider at Cambridge Cares About AIDS (CCA) and a community health nurse at Boston Health Care for the Homeless Program (BHCHP), provides two perspectives on establishing partnerships that brought together consumers, providers, and academia to create environments of care in which transgender persons living with or at high risk of HIV could engage with medical providers who believed in the individual's right to self-determination. The experiences of the authors and their respective organizations in uniting transgender individuals and community health nurses have led to the following outcomes: (a) increased understanding of HIV prevention and treatment needs, (b) better individual-level health outcomes, and (c) institutional change.

Cambridge Cares About AIDS: Establishing Partnerships

CCA is a multiservice HIV prevention and care organization located in Cambridge, Massachusetts; it is one of few area agencies providing specific programming by and for transgender communities. Founded in 1988, CCA's mission has been to respond

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to the HIV epidemic by serving those most affected by social and economic inequality through harm-reduction principles and practices. In 2003, CCA staff began to report an increase in contacts with transgender women during street and bar outreach. These results along with utilization reports from CCA's syringe exchange program and drop-in center for homeless and street-involved youth provided the impetus for a formal assessment of the HIV prevention and education needs of transgender women in the greater Boston and Metrowest health service regions.

On September 1, 2005, CCA was awarded a contract with the Massachusetts Department of Public Health HIV/AIDS Bureau (now the Office of HIV/AIDS in the Bureau of Infectious Disease Prevention, Response, and Services) to design the Transgender Care and Education Needs Diversity (TransCEND) program for transgender women and their sexual and substance-using partners. TransCEND has evolved into a peer-based program using the principles of harm reduction to meet the following goals:

- Create nonjudgmental spaces to speak openly about sex and substance use with the goal of learning new ways to reduce risk and stigma from each other. The areas of concern include (a) HIV status, (b) sexuality, (c) gender identity, (d) drug use, (e) commercial sex work, and (f) homelessness.
- Invest in peers who have the power to teach and pass on practical strategies through their networks to reduce unintended consequences of drug use, including overdose and hepatitis C.
- Strengthen relationships between community members and providers to identify and remove barriers in accessing services and support for (a) living with HIV, (b) physical and emotional health, (c) housing, and (d) legal and economic advocacy.
- Recognize and respond to how health disparities stemming from social and economic inequality affect available options and shape individual decision making in the areas of negotiation, communication, and participation.

TransCEND set these principles into practice through a comprehensive array of prevention services delivered in a low-threshold manner. Primary program components include stationary outreach, mobile health services, and individual- and group-level interventions designed to support transgender women who have difficulty initiating or sustaining practices that reduce the risk of HIV transmission. Program activities provided through stationary outreach respond to some of the physiological and safety needs necessary for transgender women to fully engage in more intensive HIV prevention activities. Services include (a) community dinners, (b) needles and syringes for hormone and silicone injection, (c) education about safer injection methods, (d) safer sex supplies, (e) clothing donations and winter weather gear, (f) access to restrooms, and (g) physical space to relax that is free from stigma and does not impose time restrictions.

HIV Prevention and Treatment Needs—The TransCEND Community Needs Assessment

Meaningful engagement of community members at all stages of program development from assessment to evaluation has been the foundation of all CCA programming. Identifying community needs through participatory research projects was especially important with transgender individuals, given the continued omission of transgender communities in national surveillance data and the conflation of men who have sex with men and transgender behavioral risk categories (Jacobs, 2008).

TransCEND staff first partnered with the Institute for Community Health, the community-based research division of the Cambridge Health Alliance, to design a participatory research project with the goal of identifying HIV prevention needs, priorities, and strengths of local transgender women. The Institute for Community Health provided training for TransCEND staff and peer recruiters about protecting human research subjects, data collection, and analysis.

Transgender women ($N = 100$) participated in the TransCEND community needs assessment (TransCEND, 2006) using an applied formative evaluation process (Scriven, 1991). This formative process was a necessary precondition to CCA's ability to develop an effective HIV-prevention program model to serve community needs in a culturally competent manner. Consistent with a participatory approach toward program development, the TransCEND community needs assessment (TCNA) process enabled the

Table 1. Structural Factors in HIV Prevention

Variable	Respondents ($N = 100$)
Commercial sex work	77
Incarceration	63
Homelessness	55

NOTE: Transgender women who indicated an experience within their lifetimes.

program to be designed through a community-driven process by and for transgender women. The TCNA was conducted in four phases between December 2005 and June 2006: (a) designed and developed data collection instruments, (b) administered survey and focus group implementation, (c) analyzed data, and (d) distributed results back to community stakeholders.

The secondary goal of the TCNA was to contribute to the second generation of HIV prevention research, with transgender individuals seeking to include community concerns related to stigma, structural violence, and the implications of a lack of transgender-specific and culturally competent health care. The TCNA results, discussed in the following paragraphs, indicated that structural factors affecting HIV risk were at play in this community, thus supporting the need to view HIV prevention through syndemic frameworks (Singer, 1994; Stall, Friedman, & Catania, 2008). The structural factors are summarized in Table 1.

Twenty-six percent of transgender women participating in the TCNA self-reported living with HIV infection. The majority were African American and Latina. These results placed Boston on the higher end of national averages reported in community needs assessments, with transgender communities ranging from 4% to 32% (Herbst et al., 2008). Economic marginalization leading to commercial sex work was a significant factor for transgender women in greater Boston, with 77% of TCNA respondents reporting a lifetime experience of engaging in commercial sex work and nearly 60% of TransCEND's membership engaging in commercial sex work. The subsequent challenges of managing health, legal, and financial risks were apparent with the intersections of poverty, sex work, drug use, stigma, and marginalization, with accompanying high arrest rates of 63%. African American transgender women reported slightly higher rates of incarceration, reflecting the disproportionate representation of communities of color in criminal justice systems.

Assistance with housing and professional development and/or employment opportunities was requested by over 70% of TCNA respondents. A total of 55% of survey respondents had been homeless for a period in their lives, with 20% meeting the Department of Housing and Urban Development definition of chronic homelessness. The majority of HIV-infected transgender women had experienced homelessness, reflecting documented direct links between housing and health care for persons living with HIV (Aidala & Sumartojo, 2007).

On completion of the TCNA, TransCEND created strategic partnerships. Decision making regarding these partnerships was shaped by two major themes:

1. TransCEND needed to establish partnerships that would help create nontraditional environments of care in which transgender persons living with or at high risk of HIV would encounter providers who believed in their right to self-determination and dignity. These partners had to have an equal level of cultural competency in working with issues of homelessness, commercial sex work, reentry populations, and active substance use.
2. Community partners needed to recognize the inherent survival skills in transgender women who were most at risk of HIV to engage participants, both as equal partners and as individuals with teaching and leadership abilities.

Collaborating partners such the BHCHP, the Bouvé College of Health Sciences (BCHS) School of Nursing at Northeastern University, HIV Innovations—Project Health MOVES, and the Massachusetts Transgender Political Coalition supported TransCEND staff to create environments of care that recognized and responded to the barriers transgender individuals experience in medical, legal, and academic institutions. Figure 1 illustrates TransCEND's community-based partnerships.

Achieving Better Individual-Level Health Outcomes

The Association of State and Territorial Directors of Nursing described the need for public health

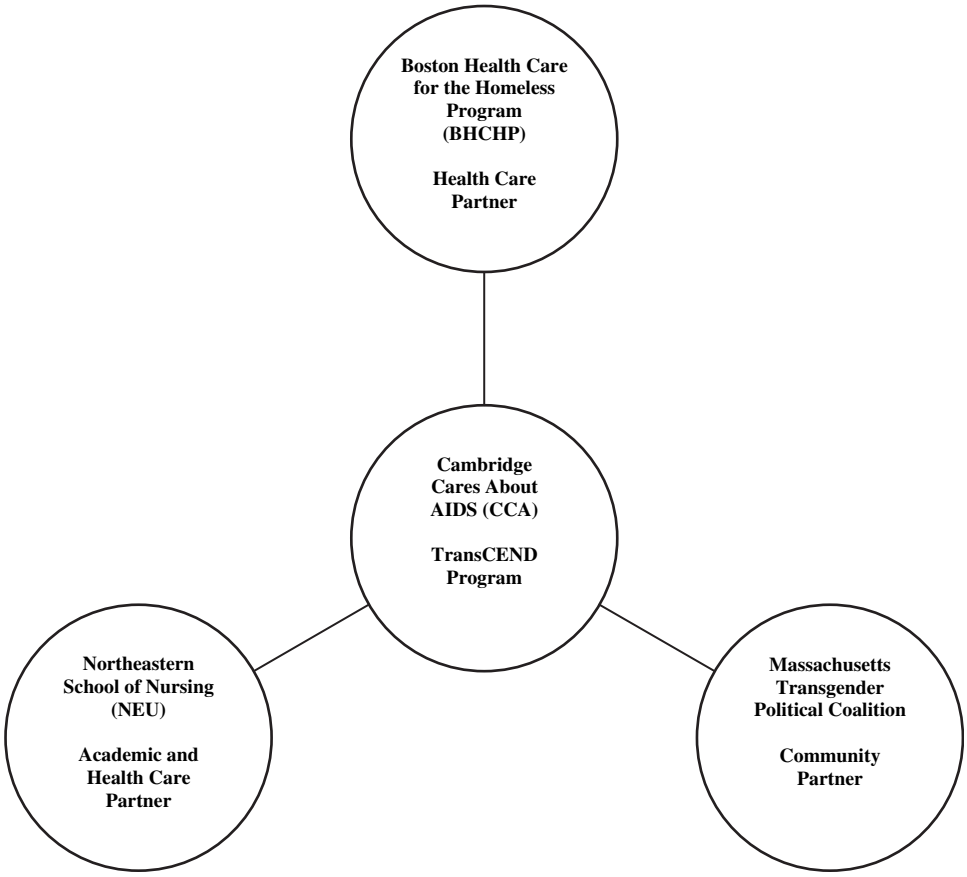

Figure 1. TransCEND's community-based partnerships.

agencies to hold a *construct of caring* as a core value that extends beyond service delivery to examining infrastructures that assure conditions in which people can be healthy (Association of State and Territorial Directors of Nursing, 2006). Examining constructs of care was essential given that 73% of Boston area transgender women participating in the TCNA reported being treated disrespectfully based on gender identity within health care systems, and over 50% reported denial of services during their lives. As one TransCEND survey respondent said, "I overheard the receptionist say to a nurse, 'It is here to see the doctor.'"

A deeper understanding of the trauma many transgender women have experienced on their way to service providers and while waiting for appointments is essential. Verbal or emotional harassment, such as slurs or being pointed at in public (e.g., on the subway, in a restroom, in a waiting room) was a daily occurrence in the lives of 20% of the transgender women in this assessment. Fifty-four percent experience these forms of harassment at least once a week. Harassment and the subsequent avoidance of public transportation and waiting areas was a significant factor in developing the mobile health and house party component of TransCEND as alternative environments of care.

House of TransCEND: Uniting Transgender Individuals and Community Health Nurses

TransCEND house parties had three goals: (a) to expand the social support networks of transgender women to reduce isolation and share health promotion strategies, (b) to bring mobile-health HIV prevention services from trusted service providers

directly to transgender women at highest risk of HIV, and (c) to engage participants in more intense HIV prevention interventions.

HIV Innovations' Project Health MOVES has been TransCEND's primary partner in designing and delivering clinical services in nontraditional venues. These venues have included delivery of care in transgender community members' homes, the TransCEND program drop-in center, and places where the transgender community socializes. Project Health MOVES is a statewide mobile-health outreach van providing early screening and intervention services for underserved populations at risk for HIV, sexually transmitted infections (STIs), and viral hepatitis infection. The program model consists of outreach or recruitment, patient registration, nursing intake and risk assessment, patient education, service provision, phlebotomy, incentives, follow-up for results and supportive referrals, and intensive medical and social case management. TransCEND staff work closely with the clinical director of Project Health MOVES, who is also a faculty member in the School of Nursing at Northeastern University. Project Health MOVES provides a valuable, real-life learning laboratory for community health nursing students under the supervision of a committed and experienced HIV and community health nurse.

For the past 4 years, TransCEND staff has provided classroom education and clinical training to nursing students, thereby helping to ensure the provision of service delivery in a culturally competent manner. The HIV Innovation's Project Health MOVES director has long-established and trusted relationships with transgender community members and has been an advocate for addressing health disparities in this underserved population.

Professional Development: Patients as Teachers

> I honestly wasn't sure how to approach transgender patients—what to say, not to say. TransCEND's workshop made me not only feel more confident but also made me see how much just taking the time to understand and listen to someone's experiences goes a long way in humanizing an issue. (2008 Northeastern University Nursing Student)

Partnership with the BCHS School of Nursing at Northeastern University has also supported TransCEND by providing professional development opportunities for peer workers to empower them as educators and valuable sources of information for the health care community engaged in HIV prevention and treatment. These collaborations, which were initiated by the nurse who is HIV Innovation's Project Health MOVES director and a Northeastern University faculty member have included transgender community members, professors, students, and representatives from BHCHP; Justice Resources Institute (JRI; an agency initially devoted to addressing problems associated with deinstitutionalization that now supports a range of programs and services); and Fenway Health (an organization devoted to meeting the physical and mental health needs of lesbian, gay, bisexual, and transgender communities) working together. For example, partners brought author Cris Beam to Northeastern University to discuss her book *Transparent*, a narrative nonfiction work about young transgender women (Beam, 2007). To date, TransCEND peer workers and staff have spoken to more than 300 current and future community health nurses as a direct result of Northeastern University BCHS School of Nursing's commitment to meaningful community-based partnerships.

Institutional Change: A Community-Based Transgender Health Care Clinic

TransCEND staff and peer workers have also provided their expertise to BHCHP to develop a health care clinic for transgender homeless individuals. BHCHP is a comprehensive health care organization with multidisciplinary teams that work at more than 70 sites including shelters, hospitals, streets, racetracks, and a medical respite facility. Founded in 1985, BHCHP's mission is to provide and ensure access to the highest quality health care for Boston's homeless men, women, and children. In 2004, the second author, a community health nurse, came to BHCHP from California where she had worked for 9 years at the Tom Waddell Health Center (TWHC), a multidisciplinary health care for the homeless primary care clinic within the San Francisco Department of Public Health. TWHC began

offering an evening transgender clinic in a mobile health van in 1994 in response to the large number of transgender individuals engaged in commercial sex work encountered by staff.

On arrival at BHCHP, the second author began asking where the homeless and marginally housed transgender population in Boston received primary care. It became apparent through informal conversations with local outreach workers, nurses, and community-based organization staff that there was a strong possibility of a gap in services for transgender clients who were homeless or marginally housed.

In April 2006, the second author attended a transgender cultural competency training facilitated by the first author, who was then manager of TransCEND. The first author presented a summary of TCNA results, which supported that there was a local need for additional primary care to target transgender homeless communities. CCA and BHCHP began informal collaborations, and the second author began networking with additional health care providers as well as transgender community organizers and activists. At the time, BHCHP agreed to a request for increased work hours for the second author to conduct a needs assessment of the transgender homeless population.

BHCHP Needs Assessment

The second author, with assistance from a BHCHP volunteer and guidance from the Massachusetts Transgender Political Coalition, met with local shelter staff to assess the ability to care for transgender clients in their facilities. This group also assessed the shelters' receptiveness to and perceived need for cultural competency training for their staff. TransCEND used this information to plan trainings, and BHCHP staff found it useful for referring clients appropriately to shelters.

The second author and a graduate nursing student continued to assess the receptiveness of the community to the idea that BHCHP could fill a gap in service for transgender persons who were homeless or marginally-housed. The current director of the Massachusetts Transgender Political Coalition was a key informant during this process and assured the inclusion of the BHCHP in a New England AIDS Education Training Center symposium, "Setting an Agenda for Transgender Capacity-Building in HIV Programs in New England." This forum provided an opportunity to apprise a large number of potential stakeholders of the project and to gauge receptiveness to this plan. Armed with feedback from a wide range of community providers who were overwhelmingly supportive of the plan, the second author prepared a document, *If You Build It, They Will Come: A Proposal for BHCHP to Create a Pilot Primary Care Clinic for Transgender Clients who are Homeless* (Klein, 2007). This document was presented to the BHCHP management team, which concurred that there were sufficient data to support the implementation of a pilot transgender clinic. BHCHP then created a planning team, including management and behavioral health (BH) staff, who met monthly to plan the clinic. The plan was to initiate the clinic some time in late 2008 after the opening of Jean Yawkey Place, a new BHCHP facility across the street from the existing primary care and/or urgent care clinic that would integrate many health care services under one roof.

Client Survey

Subsequently, BHCHP and TransCEND collaborated with the JRI's Sidney Borum Jr. Health Center, a comprehensive health care facility for young people between the ages of 13 and 29, to conduct a client survey with 50 transgender community members regarding service delivery preferences. Half ($n = 25$) of the respondents were living in either a shelter or a program or doubled up. Services and supplies that respondents desired to have on site included (a) a peer support group, (b) one-on-one therapy services, (c) housing support, (d) job training, (e) transportation vouchers, and (f) female hygiene products. The majority of respondents preferred that the clinic would be open on Thursday evenings.

Professional Development

Throughout the needs assessment process and before the creation of a transgender clinic as an entity apart from the general BHCHP primary care and/or urgent care clinic, the second author was receiving referrals for transgender homeless clients in need of primary care and was gathering education and

training resources for BHCHP staff. BHCHP health care providers who expressed interest in transgender health care included a physician, a nurse practitioner, and a physician assistant with HIV expertise; this group became the de facto transgender clinic providers, and new clients were assigned accordingly.

TransCEND staff presented workshops for clinic personnel including front desk, registration, nursing, BH, and medical staff. Clinic staff reported that this was helpful and recommended that the entire BHCHP staff receive training as well, because BHCHP had multiple sites where transgender clients could present for services. The first author, in coordination with the second author and the transgender team physician, presented at a general staff meeting with positive evaluations. Additional trainings were geared toward the BH team through funding from the Kenneth B. Schwartz Center, a Boston-based organization devoted to strengthening relationships between patients and caregivers. BHCHP received a grant to conduct six trainings over the fiscal year and for a subscription to the *International Journal of Transgenderism,* which is published by the World Professional Association for Transgender Health. Another community resource, Fenway Health, has collaborated on two of the trainings.

Protocol Development

Inherent in the clinic plan was a commitment to including hormone replacement therapy as a part of comprehensive primary care, using an informed consent model similar to the model used by TWHC in San Francisco. Informed consent models take into consideration the fact that the majority of clients who present to BHCHP have already been taking nonprescribed hormones, often for years, obtained from friends or bought on the street. This approach, which could include prescribing hormones on the first provider visit, created opportunities for prevention interventions and early treatment of HIV infection and other chronic conditions. Providers were able to address primary care issues while addressing hormone needs. Providers could write hormone prescriptions without refills to help ensure that patients would return for follow-up appointments. Each visit was an opportunity to discuss general risk reduction and assess biopsychosocial issues. Dr. Barry Zevin, founder of TWHC's transgender clinic, led a half-day seminar at BHCHP to address the concerns and questions of providers, with a specific focus on providing hormones through an informed consent model.

Clinic Establishment

On October 30, 2008, BHCHP hosted an open house to officially announce the opening of the transgender clinic. Members of BHCHP management, the second author, and the transgender team physician spoke about the effect that the initiative had on BHCHP and future goals; the first author spoke about the effect that the clinic would have on the transgender community, and a TransCEND client spoke about the effect that the clinic would have on her personally. Representatives from a dozen community organizations attended, including the MTPC, the JRI, Fenway Health, and the Boston Public Health Commission.

The first BHCHP transgender clinic was launched on November 6, 2008, and has since been in weekly operation on Thursday evenings. Services include primary and urgent care, nursing care, BH services, a monthly free legal clinic, phlebotomy, HIV counseling and testing, case management, and a facilitated support group. Clients can access BHCHP's dental, optometry, and pharmacy services during the day.

Individual-Level Health Outcomes

The BHCHP clinic currently cares for 37 transgender women, the majority of whom have not received health care for several years. Nearly 25% of the clients were HIV-infected when they started care, and one client was tested and diagnosed with HIV at BHCHP. Client referrals have come from TransCEND, HIV Innovation's Project Health MOVES, word of mouth, a day treatment program, the local jail, and local shelters. Following are three clinical vignettes that illustrate the clinic's effect on client health. Identifying information has been disguised to protect confidentiality.

Case 1

B.R. is 45 years old; she was born and raised outside of the United States. A TransCEND health

educator escorted her to the clinic for her first visit. B.R. worked in the commercial sex industry and stated she consistently used condoms in her work. She was uninterested in hormone therapy but had a history of multiple silicone injections. She also had undergone facial surgery after a beating by police in her country of origin. She wished to pursue asylum in the United States and was precariously housed alone in an unheated basement apartment. She had not engaged in health care for over 20 years.

B.R. presented with classic signs of diabetes and was found to have a hemoglobin A1C greater than 13%. She began to meet regularly with a BHCHP registered nurse who was also a diabetes educator, and she was motivated to learn how to use a glucometer, modify her diet, and exercise. Five months after her initial visit to the clinic, her hemoglobin A1C had dropped to 5.6% and her symptoms had resolved.

B.R. reported that the recent economic downturn had affected her business and that she had been forced to seek work "out in the streets" with new clients whom she was meeting for the first time. At the time of this writing, B.R. was attending the clinic support group and working with the legal clinic; her hemoglobin A1C remained within normal range. She clearly felt comfortable with the care she was receiving at BHCHP and said she "loved" the fact that the transgender clinic was held in the evening. She also reported that she enjoyed attending the support group.

B.R. initially presented to the clinic with uncontrolled diabetes and was at risk of losing her housing. More recently she was at increased risk for violence and HIV infection as a result of seeing unknown clients outside of the controlled environment of her apartment. BHCHP provided services in an environment where B.R. received health care in a culturally competent manner without fear of being treated disrespectfully based on gender identity. She remained engaged in care, and BHCHP nursing staff were able to help her lower her risk for complications from diabetes. B.R. also exemplified the economic marginalization that the TCNA results reflected. The onsite legal clinic was working to assist her in obtaining safer housing.

Case 2

C.M. is 20 years old; her friend, a clinic client, escorted her to the clinic for her first visit. C.M. was living in a local shelter. She started injecting hormones in her early teens after running away from an abusive family household and living with friends or in shelters. She used estrogen obtained through underground markets, and she had a history of multiple silicone injections. C.M. reported that she engaged in receptive anal intercourse without condoms with a new boyfriend, although she reported that she consistently used condoms when engaged in commercial sex work. She suffered from episodes of severe depression and had a history of multiple inpatient psychiatric hospitalizations. C.M. was receptive to BH services. A chart review indicated she had had a positive tuberculosis test at a shelter clinic, but no follow-up care was done. She requested HIV and STI testing and was found to have a reactive rapid plasma reagin test, which indicated early latent syphilis.

Because of her history of multiple silicone injections, it was impossible to ensure that an intramuscular dorsogluteal or ventrogluteal injection of penicillin would actually reach the muscle, and C.M. self-injected estrogen into her deltoid muscle for this same reason. The clinic nurses were uncomfortable administering a deep intramuscular injection into another site because C.M. was quite thin. Thus, C.M. received second-line syphilis treatment with an oral agent and was awaiting a subsequent rapid plasma reagin to assess reactivity.

C.M. began seeing a BH provider and received prescriptions for an antidepressant and a sleep agent. She missed her follow-up BH appointment and came to clinic one evening after she ran out of these medications 2 weeks early. She disclosed that she took more medication than prescribed when she felt "down." She agreed to start storing her medications at the clinic and only keep a week's supply with her. On experiencing swelling and pain in her arm after an estrogen injection, she decided to keep her estrogen at the clinic as well, and every 2 weeks a nurse injected this hormone into her arm.

C.M. is no longer with her boyfriend, who left her shortly after she informed him of her STI and the need for him to seek treatment. As of this writing, she remained at the shelter and was working to obtain housing with a transgender clinic case manager. C.M. had not followed up with the tuberculosis clinic but ensured the staff that she would keep the next appointment, to which the case manager planned to escort her.

C.M. came into the clinic for estrogen every week, which she was receiving via prescription. She continued to miss many BH appointments but reported that she felt emotionally stable. C.M. continued to be at risk for acquiring HIV infection and other STIs but had lowered her risk by increasing condom use.

Medication storage is beneficial for a number of reasons. C.M. is at decreased risk of overdose on psychiatric medication by virtue of keeping these medications at the clinic and having only a 1-week supply in her possession at a time. Her risk of injection-related complications has been greatly reduced because she no longer self-injects her estrogen. C.M.'s weekly medication visits to the clinic are also regular opportunities for her to receive risk reduction education and staff and peer support. Finally, C.M. used to feel compelled to let friends use her estrogen when she kept her own vials. Now that her medication is at the clinic it lasts longer, so she is spending less for it and therefore may be able to reduce her need to engage in commercial sex work. Storage of C.M.'s medications at the clinic also means that friends who can no longer obtain the medication from C.M. may be more likely to engage in health care and obtain prescriptions for hormones themselves.

Case 3

L.S. is 28 years old; a TransCEND health educator escorted her to BHCHP for her first visit. She has HIV infection and was in HIV care at another institution but did not feel comfortable sharing her gender identity with prior providers. She had an undetectable HIV viral load and a CD4 count in the 400s/mm^3. She lived doubled up with a friend and worked in a restaurant. She had never taken hormone therapy but wished to start. She had a recent history of collagen injections in her buttocks. The collagen had been obtained in another country and was administered by a nonmedical person in the community. A month after initiating care at BHCHP's transgender clinic, she started experiencing severe pain in her hip and was found to have a large abscess as a result of the collagen injections, which required surgical intervention. Although she is listed as a male in the medical records, transgender clinic staff advocated for her with hospital admissions, and she was assigned a private room.

L.S. healed without complication. Her living and working situations remain unchanged. She has started on hormone therapy and was pleased with the results. Her viral load remained undetectable.

The case of L.S. illustrates the harm that can result from the U.S. health care insurance industry's lack of reimbursement for transgender care. The vast majority of commercial health insurance plans in the United States exclude all or most coverage for treatment related to gender transition, including BH counseling, hormone replacement therapy, physician office visits to monitor hormone replacement therapy, and surgeries related to sexual reassignment (Human Rights Campaign, n.d.). L.S.'s situation exemplifies the need for culturally competent transgender health care services, given the particular health risks that this stigmatized and marginalized population may experience.

Future Work

A volunteer recently joined the transgender clinic to assist in recruiting transgender men to the clinic. Clinic staff will obtain appropriate resources and training to meet the needs of this population. Another volunteer will start offering job coaching during clinic hours. She has consulted with TransCEND staff and peer educators to better understand the obstacles to employment faced by many in the transgender community. The second author and a TransCEND health educator recently copresented for the New England AIDS Education and Training Center at a local HIV clinic and plan to continue collaborating in this manner. As the transgender clinic grows and expands, it is hoped it will become a clinical rotation site for nursing students. Finally, the BHCHP Transgender Clinic plans to form a Transgender Community Advisory Board as a subgroup of BHCHP's umbrella Community Advisory Board to ensure that clients' voices continue to inform the shape and direction of the clinic in the future.

Conclusion

This article illustrates how partnerships between transgender individuals and community health nurses

can create environments of care where transgender persons living with or at high risk for HIV infection can engage with medical providers who believe in the right to self-determination. For the transgender client community in the Boston area, especially for those who are homeless or marginally housed, the process of collaboration among TransCEND, HIV Innovation's Project Health MOVES, Northeastern University BCHS School of Nursing, and BHCHP has led to increased skills and confidence in current and future nurses to effectively care for transgender patients. It has also led to institutional change including the creation of a medical clinic serving homeless transgender individuals in Boston, as well as improved individual-level health outcomes.

Best practices would make transgender-specific primary care services less necessary—all primary care providers and health care institutions would be skilled in caring for this population. Toward this end, strategic partnerships with community members are an essential tool in responding to the continued health disparities experienced by transgender individuals.

Clinical Considerations

- Partnerships between transgender individuals, academic institutions, and community-based organizations can help create environments of care for transgender communities.
- Mobile health services in nontraditional settings in partnership with community-based organizations that serve transgender individuals are most effective in reaching patients who have not had access to or have refused health care.
- In addition to accessible and acceptable health care, transgender communities require employment opportunities and stable housing.
- Institutional barriers to obtaining hormones and sex reassignment procedures may result in some transgender female patients using street hormones for secondary sex characteristics, injecting silicone for body modifications, and sharing needles and syringes to inject.

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