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Trans-migrations: border-crossing and the politics of body modification among Puerto Rican transgender women

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Since the 1990s in the United States, there has been an historical shift in public health toward understanding lesbian, gay, bisexual, and transgender (LGBT) populations as an emerging ‘special population’ in need of a systematic state response (Epstein, 2003). At the same time, dramatic health disparities continue to exist that affect the health of LGBT populations, as evidenced by numerous studies focusing on a wide range of health outcomes (Gay & Lesbian Medical Association [GLMA], 2010; McKay, 2011; Sanchez, Sanchez, & Danoff, 2009). Nevertheless, the clustering of highly diverse populations under the LGBT umbrella has tended to depict their health needs as homogeneous. Consequently, transgender persons have been widely overlooked in health research and interventions, particularly among ethnic minority populations (Garofalo, Deleon, Osmer, Doll, & Harper, 2006).

This situation is concerning given the epidemiological evidence regarding transgender persons. In the area of HIV/AIDS, the topic on which the greatest amount of research has been conducted, it has been established that a significant proportion of transgender persons is HIV-infected, engages in high rates of sexual risk behaviors, and is not reached by existing interventions and health services for ‘LGB’ populations (Clements-Nolle, Marx, Guzman, & Katz, 2001; Rodríguez-Madera & Toro-Alfonso, 2005; Sykes, 1999). Herbst et al. (2008) developed a systematic review of 29 peer reviewed studies published between 1990 and 2003 and found an average HIV prevalence of 27.7% among male-to-female transgender persons in the United States and Puerto Rico. Unfortunately, the impact of the HIV/AIDS epidemic on the transgender community and the specific social characteristics of this

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population have been masked by the fact that epidemiologically, they have been frequently included within the statistics of 'Men who have Sex with Men' or MSM (Bockting & Coleman, 1992).

Beyond HIV/AIDS, several studies in the United States have recently shown a cluster of negative health outcomes in transgender populations, including high rates of substance abuse (Ann, Colón, Robles & Soto, 2008), violence-related injuries and homicide (Bradford, Reisner, Honnold, & Xavier, 2013; Nemoto, Bödeker, & Iwamoto, 2010; Testa et al., 2012), mental health conditions (Bockting, Miner, Swinburne, Hamilton, & Coleman, 2013; Blosnich et al., 2013; Kidd et al., 2011), suicidality (Duncan & Hatzenbuehler, 2014; Moody & Grabt, 2013), and chronic diseases.

The lack of research on the social contexts that contribute to these health disparities among transgender populations limits our ability to design policies and programs that would be effective in addressing their overall health and well-being. In this regard, a unique dimension of transgender health not shared by other sexual minorities, and on which little ethnographic research has been conducted, involves the set of deeply meaningful cultural beliefs and practices that motivate personal quests for gender transformation and bodily self-realization, including a wide array of biomedical and lay medical procedures. Many transgender persons dedicate enormous time, money, and emotional energy in the pursuit of biomedical and informal procedures in order to modify bodily features to be more consistent with their internal sense of gender identity. When these procedures are not available locally, are too costly, are of questionable quality, or result in highly stigmatizing interactions with medical providers unfamiliar with transgender needs, transgender persons often embark on journeys in search of a wide range of technologies and procedures in distant cities or countries. Autobiographical, ethnographic, and artistic accounts often include descriptions of the quests for physical transformation that occupy the imaginations, resources, and sub-cultural knowledge of transgender persons (Cotten, 2012; Kulick, 1998). Anthropologist Don Kulick (1998), for example, documented the voyages of transgender sex workers in Brazil, who spent considerable sums of money earned through commercial sex work to fund trips to Italy and elsewhere to access gender transitioning surgeries and procedures not available in Brazil. Nevertheless, migration and travel for transgender body modification practices, the motives behind them, and their interactions with medical and non-medical practitioners are poorly understood, particularly in ethnic minority communities. In particular, we know very little about the health consequences of trans-migration, that is, migration motivated in part by the desire to access transitioning technologies and procedures (Jeanty & Tobin, 2013).

This gap in knowledge is particularly true for transgender women in Puerto Rico, with whom we conducted a two-year ethnographic and survey study in metropolitan San Juan. In our usage, the term *transgender/transsexual woman* refers to an individual born with male genitalia who exhibits a gender identity that is non-normative in the local cultural setting, meaning it does not coincide with the social gender assigned at birth. This definition includes individuals who have conducted the full sex reassignment surgery as well as those who have not. This is an intentionally broad definition, intended to be inclusive of individuals who express their identity using numerous local expressions as illustrated by the diversity of terms used in Puerto Rico to refer to transgender/transsexual women, including

transgénero, transexual, travesti, and mujer trans. In this article, we also use the terms *transgender* and *transsexual* inclusively because the population we studied does not express a consistent definition of these terms, and we have found much overlap in their social usage. In addition, our project aimed to understand the social and health profile of the diverse community of transgender/transsexual women, as this was the first large scale mixed methods study of this population in San Juan.

Our goal is to work in partnership with trans women to understand the constraints they face in charting their own transitioning journeys, and finding systemic ways of ensuring that safer options are available to them in the future. The research reported here focuses particular attention on the use of body modification procedures and practices, such as lay silicone injection and hormone injection, both of which had been reported anecdotally prior to our research, but had not been systematically documented in social or health research prior to our project. These practices are intimately connected to gender and social identities in this population, and therefore reveal numerous perspectives on social life. Our analysis in this paper focuses on the ethnographic and qualitative interview findings of our study with transgender/transsexual women in San Juan, Puerto Rico.

In Puerto Rico, as in much of Latin America and the Caribbean, transgender/transsexual women are at much higher risk for HIV than other populations (UNAIDS, 2014). A persistent problem in the entire region is the lack of data available on HIV prevalence levels among transgender persons (AmFar, 2008). There is no separate epidemiological category for transgender/transsexual individuals in Puerto Rico, where officially men represent 74% of the reported AIDS cases and women, 26% (Health Department of Puerto Rico, 2013). It is quite probable that a number of transgender women are misclassified in epidemiological categories as “men.” The primary means of HIV infection in Puerto Rico include intravenous drug use (IDU) (51%), heterosexual transmission (24%), and transmission between MSM (17%). In an epidemic driven mainly by IDU, it is concerning that gender-transitioning practices such as lay silicone and hormone injection have been overlooked by HIV prevention research in Puerto Rico. As described in this article, lay hormone and silicone injection are widely practiced among Puerto Rican transgender/transsexual women. Although no systematic national or local surveillance data are currently available on the incidence and prevalence of HIV/AIDS among transgender people, preliminary data collected in different states and Puerto Rico suggest disproportionately high rates of HIV infection among this population (Herbst et al., 2008; Rodríguez Madera & Toro-Alfonso, 2003).

In this article, we aim to understand the ways that trans-migrations interact with other social and economic factors to heighten health vulnerabilities in the transgender/transsexual population. While this is not an epidemiological study, we provide qualitative and ethnographic data on interviews and observations with transgender women that strongly suggest that these social factors combine to create conditions that are linked to numerous health outcomes, such as HIV, drug abuse, mental health outcomes, and violence, among others. These more fundamental causes would need to be addressed through legal, political, and social mobilization to significantly impact health vulnerabilities among transgender/transsexual persons.

Transgender Experience in Puerto Rico

Puerto Rico has often been described in the Social Sciences literature as possessing conservative cultural norms and beliefs regarding gender and sexuality (Acosta-Belen, 1986). Terms such as “machismo” and “marianismo” have often been used to describe a marked contrast between gender ideologies guiding behavior for men and women in Puerto Rico (Stevens, 1973), and reflect quite distinct and restricted sets of social expectations based on gender (Wilson, 1969). In this context, transgender persons represent a symbolic violation of expectations of heteronormative gender performance, resulting in intense stigmatization that our team has described in prior research (Rodríguez-Madera, 2009).

Largely due to this stigmatization, many transgender women in Puerto Rico encounter extreme social barriers to resources and social capital. For example, access to formal work is often entirely obstructed for transgender women, as employers refuse to hire transgender individuals due to hiring policies requiring normatively gendered bodies or because of a deep fear of backlash from coworkers, supervisors, or the public. This contributes to the high observed rates of participation in informal sex work among transgender women, which has been documented in a number of studies cross-culturally (Kulick, 1998; Padilla, Vásquez del Aguila, & Parker, 2007; Prieur, 1998). Similar processes of exclusion and discrimination occur in multiple domains of life, including access to health and social services, education, social support, and housing.

Further, systematic societal stigmatization is linked to a cultural logic in which discrimination, and even hatred, of transgender persons is self-perpetuating, as beliefs about these individuals serve as ideological justifications for their exclusion and unequal treatment. In strongly Judeo-Christian settings such as Puerto Rico, notions of “sin” and “perversion” that are often associated with non-normative gender and sexuality further inform assessments of transgender persons, leading to the inability to view these individuals in their full humanity. These processes contribute to the incredibly high rates of anti-transgender violence and hate crimes that have been identified across a wide range of societies (Padilla, Vásquez del Aguila, & Parker, 2007). These patterns of anti-transgender violence have been dramatically evidenced in Puerto Rico, where there has been international attention to the assassinations of transgender women, totaling dozens of hate-related killings in recent years (Miami Herald, 2011).

Method

We implemented a mixed-methods design to document injection practices and HIV risk among adult (18 years of age and older) transgender/transsexual women in Puerto Rico’s San Juan metropolitan area. In this methodological approach we included ethnographic observations (approximately 85 hours of targeted field observations over 8 months), qualitative interviews ($n = 39$), and quantitative surveys ($n = 59$) conducted in 2012 with a total sample of 98 transgender/transsexual persons. The study was approved by Institutional Review Boards at the University of Michigan and the University of Puerto Rico. In this article, we focus on data from our ethnographic observations and in-depth interviews,

including sociodemographic data collected with each in-depth interview participant using a structured questionnaire.

Ethnographic Observations

We conducted ethnographic observations in the San Juan metropolitan area in which transgender/transsexual women live and work. We undertook the study in large part due to our belief that understanding the social context of transgender/transsexual women was a critical first step in order to assess the community's health needs, determine gaps in social and healthcare services, and identify feasible intervention approaches, since the social organization of this population was largely unknown. We also suspected from our prior research and conversations with community leaders that body modification practices would be an important place to focus ethnographic observations and interviews, since these gender-transitioning practices are central to transgender/transsexual identity formation, community cohesion, and healthcare needs. We targeted our ethnographic observations on two types of social contexts: (1) those related to transgender/transsexual drug/hormone/silicone injection practices and (2) those related to sex work and HIV-risk practices, especially sex work areas, other work settings, socialization and "hook-up" areas (i.e. bars, restaurants serving the transgender community), and transgender shows and events.

As is typical of anthropological fieldwork, ethnographic data collection included a continuous cycle that incorporated: (1) participant observation sessions, (2) the development of provisional hypotheses or interpretations based on those observations, (3) the writing of ethnographic field notes and analytic memos, and (4) recurring visits to previous sites for continued participant observation.

Participants

We employed a sampling technique that aimed to diversify recruitment along the lines of four key factors which we believed would foster variability in the experiences and health-related conditions in this population. These factors are: (a) history of body modification practices; (b) history of gender reassignment surgery; (c) history of commercial sex work; and (d) history of drug use. Theoretical sampling emerges from qualitative techniques, including ethnography, that emphasize achieving the greatest diversity of perspectives on the issues at hand from which to draw comparisons and develop interpretations (Corbin & Strauss, 2008). Our theoretical sampling approach worked in conjunction with participant observation, such that individuals who were encountered in the course of ethnographic observations were briefly screened using operational criteria for theoretical sampling (e.g., "Have you ever used hormones or silicone for body modification?", "Have you undergone gender reassignment surgery?", etc.), and then individuals fulfilling particular criteria were intentionally recruited to obtain a maximally diverse sample along our four primary factors of interest. Two transgender/transsexual community gatekeepers, who worked as consultants in our research team, collaborated as key informants and referred participants possessing relevant characteristics to the research team to complete our sampling framework.

All participants in the study were persons born with male genitalia and who currently self-identified as *transgender* or *transsexual*, or one of the local terms used to describe an

individual with cross-gender dress and demeanor. While the most common local term to describe such individuals was *mujeres trans* (trans women), this category was used very broadly in practice, subsuming an array of local identity terms such as *transgénero* (transgender), *transsexual* (transsexual), *transformista* (cross dresser), *travesti* (transvestite), *draga* (drag queen) and *ponka* (punk). While there were continuous debates within the community about what precisely constituted a *mujer trans* and who should be included in this category, a large proportion (albeit not all) of those who self-identified with the category *mujer trans* had engaged in some form of feminizing body modification. These practices ranged from liquid silicone injection obtained through the illegal market, on the one hand, to full sex reassignment surgery, on the other. Nevertheless, full genital reassignment surgery was quite rare in our sample, due in part to the difficulties of accessing this surgery, which is not available in Puerto Rico, as well as its high cost.

Sociodemographic data for the participants in the in-depth interviews are shown in Tables 1 and 2. Participants had an average age of 29 years. One-third lived alone, and the rest with either family or friends. Most resided primarily in the San Juan metropolitan area, including the towns of Bayamón and Carolina. All participants showed high levels of mobility throughout the island.

Three participants reported having children, and several more discussed having deep intimate relationships with women, including marriage. Many participants had completed high school, and one-third had some post-secondary education. The average monthly income from all sources was just over \$1,000, and ranged from \$20 to \$5,000. This range is a testament to the intentional diversity of our sample, and represents a unique spectrum of socioeconomic status in transgender samples globally, which generally tend to be of lower socioeconomic status (SES).

Instruments and procedures

We developed a semi-structured interview guide that included open-ended questions on diverse subjects, including: experiences of body modification (e.g., motives, practices, and knowledge of hormones and silicone use, and social activities surrounding them); the social contexts and environments of transgender/transsexual related spaces (e.g., descriptions of geographies, site-specific activities, and migratory routes or mobility patterns); sexual risk practices; drug use practices; commercial sex work histories; narratives of gender transitioning procedures and experiences; and exploration of cultural and structural vulnerabilities that may contribute to sexual risk-taking and injection practices, such as the stigma of non-normative gender/sexuality, *machismo*, religion, and institutionalized discrimination.

This demographic questionnaire included questions regarding participant's economic status, historical and current gender identification, area of residence, education level, and sexual orientation, among other demographic variables. It was composed of 12 items measured through multiple-choice answers and had been previously piloted among members of the transgender/transsexual community in Puerto Rico (Rodríguez Madera, 2002).

Study procedures and all interviews were conducted at the research team field office, which is centrally located in the Santurce sector of San Juan. This office was located a 5-minute walking distance from where many members of transgender/transsexual community work and socialize, and is well-known as a primary area for socializing among the LGBT community in San Juan. After obtaining informed consent, the Demographic Data Questionnaire was administered and qualitative, in-depth interviews were conducted. Interviews took approximately 1.5 hours. Participants received \$50.00 for their collaboration in the study. Interviews were audio-recorded and transcribed in Spanish. As all team members are bilingual Spanish-English, and to preserve conceptual integrity of participant narratives, all data was coded and analyzed in Spanish. Segments of interviews have been translated into English by the authors in the preparation of this article.

All textual data (field notes and interview transcripts) were formally coded and analyzed using NVIVO qualitative analysis software. Coding occurred in two stages. Stage 1 involved “in vivo” coding grounded in the language and perceptions used by participants on themes of central interest to our project. This stage included: (1) open coding using brief summary statements of emerging themes in a sub-set of interviews ($n = 8$); (2) writing analytic memos to describe behavioral and thematic patterns in the data; and (3) the development of a code hierarchy including main themes and sub-themes. This process allowed us to create a formal codebook of clearly defined central themes and sub-themes. The application of the codebook marked the beginning of Stage 2 focused coding. Two procedures ensured consistency in the assignment of codes in NVIVO across the four coders and helped us to clarify ambiguities in the codebook. First, all transcripts were double-coded, with two coders working independently on each transcript, and subsequently discussing their coding decisions in a meeting for this purpose. If differences were encountered they were discussed and consensus reached between coders. Consensus was reached in all cases. Second, the co-investigators themselves were involved in coding and spot-checking each coder’s work throughout the coding process, ensuring conceptual linkage to study aims and analytic continuity throughout the project.

Once textual data was fully coded in NVIVO, we examined codes across the sample, detected general tendencies, and determined marginal or exceptional cases. This kind of “vertical” analysis facilitated the examination of code-specific responses across the entire sample by decontextualizing the data from the larger narrative. We analyzed variations in the data by exploring how specific instances of codes were related to the context of meaning and experience for specific individuals. This “horizontal” analysis allowed us to look systematically at how factors of interest were linked to other aspects of an individual’s narrative or characteristics. The results obtained from this process are presented in the following section.

Results

The following ethnographic field note from an observation conducted by the first author on March 2, 2012, describes an evening following a transgender key informant, “Sandra”², a well-known leader in the transgender and sex worker communities. This vignette is helpful in situating our analysis, as it synthesizes several of the core themes of this article, including

the intersections of informal body modification practices, the travel and border crossing of transgender women in their search for transitioning technologies and procedures, and the potential health consequences of these processes. We therefore begin by quoting this field note at length:

After the show in Santurce, we ran into a number of familiar characters, including Joaquin. He's the injection specialist whose name is mentioned by nearly all the trans women I run into, even those from other parts of the island. As we stand in front of Club X, surrounded by the girls on the stroll who use that area to traverse between two key points of client contact on the adjacent streets north and south of here, Sandra was in her element, noisily chatting and gossiping with many different friends, including Joaquin. Joaquin – a darker-skinned, almost Dominican-looking gay man who typically sports a five-o'clock shadow – was in his usual spot, propped on the back bumper of his dented hatchback, which is always parked at what Sandra calls “*el centro del universo*” (the center of the universe) – a term she favors because it refers to a place where “*todo puede pasar*” – where anything can happen. It seems an apt phrase to characterize this area, since it is a crossroads where the nighttime informal activities of the residents of Santurce all converge.

Sandra was aware that I was intent on learning more about Joaquin's experiences as a silicone injection specialist. Many of the *chicas* had mentioned him as the most well-known and reputable silicone injector – or *inyeccionista* – in the area, and seemed to almost universally qualify him as very professional, cautious, almost maternal in his work (and, in fact, many trans women refer to “Joaquin” as “*mi mamá*” – my mother). “*Hace un buen trabajo*,” he does great work, many of them had commented, and talked about his principles and precautions. No other injection specialists seem to have earned the solid reputation enjoyed by Joaquin, and certainly none were mentioned as often. In fact, this was now the third or fourth time I had seen “*la mamá*” in this very spot, around the corner from one of the bars known as a trans-friendly bar. Here, he holds court amongst the trans women, all of whom know him and invariably swing by his hatchback to give him the obligatory greeting and kiss, often accompanied by an exchange about one's dress, shoes, or general fabulousness.

We walked over to the back of the hatchback and stood there around “Joaquin” for several minutes making small talk... Suddenly, I got the sense that we were in the midst of Joaquin's social circle. Several trans women sauntered over, including the drag queens featured in the evening's show. One of them is “*la flaquita*” that I had seen in shows before, an incredibly talented dancer and entertainer whom -- I had been informed by other trans women -- was first cultivated by Joaquin for the shows at the age of 15, “*cuando ella era una bebe*” (when she was a baby girl), in the words of one of the drag queens accompanying her.

²All participants were assigned pseudonyms to protect their identities. Heretofore, quotation marks will be omitted around pseudonyms.

After some drinks, Joaquin opened up and began telling us about his recent injection experiences. Shaking his head, he commented, “*Se hacen mujeres de repente y eso causa problemas emocionales*” (they become women all of the sudden and this causes emotional problems). He told us he knows a number of trans girls who had asked him to help them become women through silicone injections or other procedures, and had later – after undergoing the procedures – regretted having done them... Joaquin believes that as a result, many of them who rush to engage in the procedure, are traumatized and psychologically damaged. He told us a story about one young trans woman who had planned to go to Mexico to have her “*cirugía de corrección genital*” (genital correction surgery), but in order to save money, went to Ecuador instead. But after she came back to Puerto Rico, Joaquin lamented, the poor girl was a wreck. “*La vagina fue un desastre por la falta de experiencia de los que hicieron la cirugía*” (The vagina was a disaster due to the lack of experience of those who did the surgery). Later Joaquin saw the young woman walking around the streets of Santurce in a catatonic state.

This field note illustrates several dimensions of the trajectories into gender transitioning for Puerto Rican transgender women in our sample, a process that incorporates travel and movement to access body modification technologies and practices provided both locally and transnationally. Liquid silicone injection is one of the techniques we primarily studied in this project, and one which is of significant public health concern because of the known risks of injectable silicone for long-term chronic diseases, such as cancer, and – in the context of the Puerto Rico’s sizable population of injection drug users – because of its potential to magnify other health risks, such as HIV and Hepatitis C infection. As suggested in the field note, these practices are embedded in social networks of well-known specialists who possess sub-cultural knowledge and, indeed, engage in lay medical practices that are rooted in their own moral economies. Joaquin, the most well-known and respected *inyeccionista* in San Juan’s transgender community, uses language that demonstrates his concern for the transgender women he cares for and with whom he socializes daily. As our subsequent analysis aims to demonstrate, such informal medical practices are best understood as sub-cultural responses to the intense barriers to accessing trans-sensitive health care combined with the resilient responses of the transgender community, which has created complementary medical systems to reshape bodies and identities, despite systematic exclusion and discrimination in the broader society and healthcare system. Their global quests for the realization of these procedures are shaped by a complex interplay among local informal service providers such as Joaquin; transnational circuits of information shared within transgender networks on available services and practitioners in other nations; and the extreme global unevenness of access, cost, and quality of transitioning technologies and services that these individuals must navigate. The social and health consequences of this navigation process are scarcely understood.

The range of body modification technologies we observed ethnographically include injectable silicone, injectable and oral hormones (obtained both on the street and in certain neighborhood pharmacies), surgical procedures such as breast implants, electrolysis, facial feminization surgeries, and – in rare cases – genital correction surgery. Some of these services are illicit, while others operate legally in Puerto Rico or other nations, and still

others exist in a gray area between legal and illicit. While silicone injection is the most common of the informal feminization procedures in Puerto Rico's transgender community, this clandestine practice has not received widespread media attention or provoked public health campaigns on the island. Formally trained medical practitioners in Puerto Rico receive no specific training in transgender care, and they are largely unaware of the practice of silicone injection with injection specialists among transgender women or other informal procedures, as demonstrated below in our discussion of specific cases. This creates an additional barrier to formal healthcare access in this population, since transgender/transsexual women may be justifiably concerned about the quality of their care in hospitals or clinics where their specific needs are misunderstood or delegitimized.

Social Factors and Puerto Rican Trans-migrations

In this section, we examine three social and structural factors that are highly salient social determinants of health among transgender women in Puerto Rico based on our analysis, and consider how these factors intersect with processes of movement, travel, and migration. These factors are intersecting phenomena that collectively contribute to structured vulnerabilities, ultimately compromising the health and well-being of transgender/transsexual women. They are: (1) institutionalized stigma and discrimination in social, legal, and healthcare services; (2) barriers to work and resulting poverty; and (3) involvement in sex work or sexual-economic exchanges as a survival strategy. While these factors are difficult to separate in practice – for example, poverty is the direct result of stigma and discrimination, which limits work opportunities and contributes to the need to engage in survival sex work – we separate them into sub-sections below to focus on the most vivid expressions of each among Puerto Rican transgender/transsexual women. Our analysis is focused on elucidating the linkages between these key structural factors and the migration and travel of transgender women in their quests for body modification.

Institutionalized stigma and discrimination in social, legal, and healthcare services—In the context of Puerto Rican transgender women, the intense stigmatization of non-normative gender identity and bodily feminization creates highly constrained opportunities for access to basic resources and social capital to live and thrive in society. Using other language, we might say that they experience highly constrained *opportunity structures* as a result of pervasive and institutionalized stigmatization. In structuralist sociology, opportunity structures are exogenous factors that limit or empower a group or population to take collective action on its own behalf (McAdam, McCarthy, & Zaid, 1999). The concept has been applied to ethnographic research on HIV/AIDS among vulnerable populations in Latin America and the United States (Hirsch et al., 2007). In the context of our analysis, we found that there are multiple constraints on the opportunity structures of Puerto Rican transgender/transsexual women that are direct consequences of stigmatization and discrimination. Key among means by which opportunities are constrained is through discrimination in social, legal, and healthcare services, that is, in access to the “public goods” that are presumably accessible to all citizens, but which are often denied to transgender/transsexual persons.

Yesenia was one of several participants who described constant problems receiving governmental aid or social services due to discrimination. She shared with us her experience when applying for service from a government agency:

When anyone in a government office or in public service identified me [as a transgender woman] they discriminated against me telling me that some governmental aid was not available. They made my life difficult... when I was seeking a formal job they asked lots of questions to justify not giving me the service. They ranged from mentioning things that do not appear in the [form] to finding arguments and using terminology to discriminate and reject me, and not consider my application.

Public assistance programs often rejected participants in our study, not because they did not meet formal requirements, but rather because of discrimination by bureaucrats who were charged with processing clients. Marta gave the following description when she told her story of applying for housing assistance:

I have to go to the streets to make money because money was not made for us. Transsexuals only find discrimination. For everything, for everything there is discrimination; discrimination will never leave you because... because I applied for housing and they denied it to me. There are always a lot of 'buts'. I went to look for work and they did not give it to me because of what I am.

Many of our participants described the use of administrative justifications for discrimination based on problems with appropriate "documentation." This was particularly evident in reactions from bureaucrats when a client's gender representation did not match one's legal documents. Puerto Rican law does not permit a legal change of sex, leading to apparent inconsistencies that often stalled or nullified applications for public services. Carmen described the struggles that she and other trans women faced with the legal documentation due to discrimination:

Here in Puerto Rico I have struggled because there are three trans women who have changed their sex but the Supreme Court has not granted the change of sex [in their birth certificate]. They leave the issue to the politicians because they [legislators] would have to create a bill that provides for that. There is one [transgender woman] who is studying medicine in Santo Domingo... I think she is done and she said to me: "Look, I changed the name... my name is [name] but the sex appears as 'M' (male)"... So that poor woman went to Santo Domingo to study medicine and completed her degree, but she is trapped in this legal limbo. You change it [sex], but it doesn't appear in the papers. Politicians here have a bad habit, they rely heavily on the votes of the churches and society, but when they have to act... they do nothing.

In discussing healthcare services, a number of participants compared the reality in Puerto Rico with other contexts in the Caribbean and Latin America. Caterina mentioned that her favorite places for her own surgeries were Santo Domingo and Ecuador. She explained the rationale for this as follows:

...[in these places] surgical and aesthetics procedures are less expensive and the treatment is much better. There, breast augmentation with silicone is \$2,000 and they really have an adequate experience providing care to transsexuals. They treated me better... Here [in Puerto Rico] they [health care providers] treat us badly. At the moment you say that you are a [biological] male the way they treat you changes completely. There the doctor... the services are better and the outcomes are good. At least there are a lot of guys [transgender women] that had the procedures there and the results were good enough.

Similarly, another participant, Olga, explained that in Puerto Rico there is a lack of progress in access to quality transgender care:

Socio-culturally we are behind. I don't know, I love myself and I want the best for me and there are other countries that are more advanced in medical services which are provided to transsexual persons, and, well, evidently, I want if something happens to me, that someone knows how to deal with the situation, how it is, and that I don't need to be educating the doctor about what is happening.

Narratives such as those by Caterina and Olga not only stress the substandard quality of healthcare for transgender/transsexual persons in Puerto Rico, but also contrast this with the quality and availability of these services abroad. In Puerto Rico, Olga felt she needed to orient doctors about her reality, which made her feel much more vulnerable and concerned about her clinical outcomes "in case of an emergency."

Participants were remarkably worldly and "globalized" in their knowledge of medical practices and transgender care in other societies, and they expected certain standards of treatment that they believed were more widely available in other countries. These conceptual contrasts between services in Puerto Rico and those elsewhere were one of the primary ways in which institutionalized discrimination connected with motivations for travel. Samantha, an older transgender woman who had achieved a legal change of sex in 1973 through a court decision before transgenderism was widely known or understood, provides a prime example of how Puerto Rican healthcare services were often contrasted with those available elsewhere, and how these contrasts relate to decisions to travel abroad for procedures:

I was going to the doctors [in Puerto Rico] and saying that I wanted hormone treatment because I wanted to be a woman. But what did the doctors say? ... I encountered health professionals that told me, "I don't deal with people like you." And I told them, "I thought medicine had no borders! But I see that there are demarcations. But don't worry, because to deal with me you have to be brilliant and visionary." ... And in New York things were progressing and the girls were getting silicone boobs, and getting their noses done and things, and then I said, "Well the path is New York!" And that's why I went following this doctor, who I can call, without a doubt, the father of modern transsexualism. Because to his clinic will come doctors from around the world, to see how he did those changes...

The difficulties Samantha encountered in accessing care in Puerto Rico eventually led her to migrate to New York in search of a doctor who was at the cutting-edge of genital reassignment surgeries. Inherent in many such narratives was an awareness of the relatively

lower quality of health services available in Puerto Rico, which were often based on direct experiences of discrimination in healthcare settings, as well as their contrasts with transgender services elsewhere.

In cases of institutionalized discrimination in social, legal, or health services, official policies that do not recognize transgender rights combine with stigmatizing beliefs and stereotypes of transgender/transsexual persons to create scenarios in which social, legal, and health services are experienced as oppressive or dangerous places that serve as reminders of social inequalities. At the same time, many participants knew of services or procedures available elsewhere, either through personal experiences of travel or stories from other trans-migrants that circulated within their social networks. This knowledge, in combination with the poor quality of transgender health care in Puerto Rico, tended to drive decisions to travel or migrate as a means of accessing services or receiving more humane treatment. However, access to social and health services in other nations is strongly stratified, and expensive trips are inconceivable to many transgender women who are struggling with basic survival. Patterns of movement are therefore shaped by the material circumstances of transgender women, which are often quite precarious. As the doors to so-called “safety net” services were denied to them, their access to basic resources and social capital for survival were further compromised, contributing to poverty and vulnerability.

Barriers to work and resulting poverty—The institutionalized stigma and discrimination in access to social and legal services left individuals with few alternatives when they were unable to make ends meet. This was compounded by the fact that transgender/transsexual women in Puerto Rico are very likely to be under- or un- employed. While we intentionally recruited a diverse sample, including some participants who were in college or professional positions, many narratives emphasized extreme difficulties in obtaining work and providing for basic expenses, leading to residential instability and general financial precariousness.

Many of our participants told poignant stories of their inability to obtain formal employment due to their transgender identity or ongoing bodily transformations, which provoked the negative attention of potential employers or coworkers. While those who began transitioning early in life may have never been able to obtain a formal job, some older participants told stories of being harassed or gradually removed from their prior work positions when they decided to begin transitioning. For example, Teresa described how she became marginalized at her prior job as she engaged in more body modification procedures, and the difficulties she experienced in applying for jobs:

[I began having problems] when I started taking my hormones – because then I had a strong manly structure and I didn’t have any electrolysis as required – people saw that contrast and started teasing, rejecting, discriminating, condemning... They started *con la cerradera de puertas* (closing of doors). I had to use my male name and wear neutral clothing or dress in a manly way when job searching. If I went as a woman, I would be rejected or fired.

Teresa had been fired from her factory job after many years of exemplary employment because she began wearing more feminine clothing at work.

Many participants in our sample grew tired of applying for formal jobs, because they were often told – directly or indirectly – that their applications would not be seriously considered before they had even been reviewed. Veronica described this experience when she recalled a time that she had applied for a job at a fast food restaurant:

I went to solicit a job in Montehiedra [shopping center] at a fast food restaurant and I'm filling out the application and the manager goes like this [gestures with finger] and he goes behind and I hear him say, 'As soon as he fills it out I'm going to rip it up because here we don't take homosexuals.' So I didn't fill it out! Pam-pam! And I gave it to the lady, she folded it, and I acted like I left but I was hiding to see what she would do. She grabbed it, tore it in half, and threw it in the garbage can.

Amanda described frustration with applying for jobs, and had resigned herself to continue sex work as her sole source of income and to stop applying for other jobs. Her narrative represents another common theme in our participants' discussions of work-related discrimination, that is, the fatigue that a fruitless search for formal employment can cause, as searching may seem pointless in the context of such pervasive discrimination:

You know that to get a normal job [is impossible] because there aren't any. I tried to get out of prostitution because, I mean, it's horrible also. That job is bad, and it dishonors you, having a man treat you like a sex machine. When I would go to look for a job that would interview me fine, but when they would see my ID and they realized that I was born a man – there it all changed! They would ask me questions about why I dressed as a woman, how was I born, why was I doing it. And later they would say, 'well, ok, if we accept you we'll call you,' and they never called.

The poverty that resulted from lack of access to work meant that most of our participants were attempting to transition and to pay for costly body modification procedures from a position of highly scarce resources. This created a demand for affordable procedures on the illegal market that are more financially accessible to under- or un- employed transgender women, such as injectable silicone. Injecting silicone allows for certain shaping of the body – such as in the hips, breasts, and cheeks – within an economy of deprivation, social exclusion, and mistreatment by biomedical practitioners. In the global context, this deprivation also fostered a market for more affordable procedures in unregulated foreign markets such as those in Ecuador – the most common destination among our sample of transgender/transsexual women seeking procedures abroad.

Involvement in sex work or sexual-economic exchanges as a survival strategy

—Having exhausted all options for formal employment, many of our participants had begun engaging in sex work primarily as a survival strategy. Nearly all of our participants with sex work histories described their involvement in sex work as a strategy for survival. Beatriz's description of her reasons for sex work is typical of such narratives:

Currently there is no work for me... and where do I have to go to pay for all of this? On the street, because there is nothing else. Who will pay my debts? Nobody. If I don't work I have to find the strength to look for things to pay my bills. And I pay a lot, you know? I have to go to the street for cash.

As with most research on transgender women in Latin America (Kulick, 1998; Prieur, 1998), our research found that a history of sex work is very common among transgender/transsexual women in Puerto Rico, even among those with higher levels of education. Partly because sex work is so common in the community, sex work environments are important spaces for the exchange of information and resources for transitioning. Cristal, who has worked as an HIV prevention educator among transgender women, described in her interview how her increasing integration into sex work environments exposed her to information about international services for transitioning, as well as opportunities to earn money for transitioning through sex work. Describing the moment in which she realized how she could obtain surgeries and fund them, Cristal explains:

At that moment came the boom [realization], when I went down to that place [the trans stroll] to hand out condoms and everything, and I saw all of those men [clients] that were asking, “Look, what’s her name? Does she work? Does she go out [do sex work]? Give me the telephone number!” So many things the first week! And I said, “I wonder what would happen?”... What happened? I began with that game [sex work], and once you enter that world it is harder to get out. When I entered that world and started to see the flow of money was so big, at that time in my case, who was going to leave that? Nobody... Thanks to that money, in a fraction of the time, in 8 months I had traveled to Ecuador and been operated with the money that I made there in less than nothing. The flow of money was very big.

Cristal subsequently underwent multiple procedures in Ecuador, including breast implants, Adam’s Apple reduction, and facial contouring.

Sex work in the transgender/transsexual community in Puerto Rico is both a survival strategy and a key sub-cultural trait of the community, providing environments for social networking and information sharing. When community members returned from a trip abroad to access services, they were inspected and thoroughly discussed, with particular attention to the visual effect of the procedures. In Cristal’s case, friends from sex work environments provided a name and contact information for a physician in Ecuador who is known to provide transgender body modification “packages,” which include airport pick-ups and hotel reservations booked from abroad. Sex work therefore provides the context and the subcultural knowledge to access global transitioning technologies and providers.

In the following section, we describe in more depth how individual transgender/transsexual women decided to engage in trans-migrations in their quests for body modification by examining specific cases of border crossing.

Case Studies of Trans-migration

In this section we present three stories of transgender/transsexual women who have decided to travel abroad for clinical procedures at different stages of their gender transitioning careers. The term *career* is perhaps particularly appropriate because each of these individuals is pursuing career aspirations: a graduate student with academic aspirations; a nurse and HIV prevention educator; and a cosmetologist working at Puerto Rico’s largest mall. They each represent distinct sets of personal and contextual factors that contribute to the choices they have made about their bodies, two of them seeking transitioning services in Quito,

Ecuador, and one of them in Miami, USA. In general, these cases point us to the interconnections between career trajectories and transitioning decisions, a point to which we will return in the conclusion.

Case 1: Chanty—Chanty, a 21 year-old university student, is an interesting counterpoint to other trans women in the sample, as she was one of a handful of trans women who lived 24/7 as a woman, but who had not engaged in any body modification procedures (other than wearing feminine clothing and long hair) upon our initial interview (more recently she has obtained breast implants in Miami). She regarded herself as “transsexual” – as opposed to transgender – which for her meant that she eventually sought to be “*una mujer completa*” (a complete woman) – a phrase that is often used to indicate a desire for sex reassignment surgery (sometimes called “bottom surgery”). She had had extensive counseling with a psychiatrist who had diagnosed her as having *disforia de género* (Gender Dysphoria), much to the disappointment of her parents, who had sought her this counseling as a means to “correct” what they perceived to be emotional problems. Chanty described a slow, methodical strategy for her planned surgical procedures, and her narrative contrasted with those of many others in our sample who sought to make these changes quickly. When asked about how she had devised her plan for body modification, she said:

From my friend who I mentioned to you previously... She went to do an evaluation in a clinic in Miami. The costs were pretty cheap and later she informed that in Miami the operations are like cheap and its safer than going to Ecuador or Colombia or foreign countries because independent of how cheap they are or not for the operation, you have to risk it, right? With the standards of medicine and health in the United States it is safer because I'm in Miami if something happens to me and so, I was in agreement with that. They asked me for pictures, I sent the pictures, they gave me like an estimate, the informed me that when they are going to operate on me I have to be there like a week before... [It was] by email, but obviously the exams prior to the procedure, well, you have to be there for them to examine you, do the tests and whatever.

Chanty emphasized in her interview that she wanted to have sex reassignment surgery “to make things easier for me” in her professional and personal life. She made this clear when she explained the instrumentality and strategy behind her plans, even though she also insisted that this was not about false consciousness; she really believed she was a woman and did not feel comfortable with her penis:

[I want sex reassignment] to make things easier for me, period. I personally am not very in agreement with the asthetic ideals that are put on women, but nothing, I mean, I see it as not femininity itself – being in high heels and corsettes and the tiny waist – but I see it as something that I have to take charge of to make things easier and to flow, because I can decide to struggle against all that, but things will be a little bit easier.

It was clear in her interview that “Chanty” did not separate her career and personal aspirations from her decision to modify her body, and expressed the expectation that these procedures would make things easier for her in her daily life and in her intimacy with men.

In contrast to the trans women who flew to Ecuador for a package of services occurring in a matter of a few days, Chanty's estimated budget was approximately \$10,000 more expensive, but provided certain guarantees – such as follow-up with the attending surgeon – and the perception of greater safety and security than in Ecuador and Colombia. However, it required more patience and a long-term strategy – cobbling together savings from her meager income as a university employee and, as she said, “eating Doritos instead of a full lunch.” Unlike many other participants, she mapped out a clearer plan for her body modifications, and she emphasized several times that she wasn't in a “rush,” despite occasionally feeling pressure from other trans women to “become a true woman.”

“Chanty” discussed her plans to proceed with her procedures in Miami in phases, beginning with her Adam's apple and breast implants, which she estimated would cost her \$15,000 because of the required pre-operative and post-operative care, which requires a longer-term stay in Florida. Subsequently, she planned to pursue sex reassignment, but expressed some questioning regarding the price that she was quoted for this procedure in Miami, which totaled \$10,000. Rather than emphasizing the considerable savings of this procedure, she questioned the quality:

They've advanced in that, but evidently, for \$10,000 I don't believe they are going to do a good job. What they're going to do is extract it and make some connections so you can urinate and basically you have an orifice. And for me, being a woman, right, doesn't consist in having a penis or not having it, it's something that, period, it's a feeling. That is, I don't see why such urgency in the moment to extract it for me to be a woman, because I already feel like a woman.” She expressed skepticism about the low price of the procedure, and therefore was not prepared to move forward with this decision until she had thoroughly investigated all options.

Case 2: Cristal—Chanty's methodical approach to transitioning in Miami contrasts in many respects with Cristal's. Cristal is a nurse and an HIV prevention activist who has become a fairly well-known public figure in Puerto Rico, and was regularly interviewed by the press about transgender health issues. When she walks along the streets of Santurce, many onlookers are struck by the size of her “*bunda*” – the Portuguese term often used by Puerto Rican transgender women to refer to the silicone-enhanced rear-end that is thought to be the ideal female form. Our team learned in the course of the ethnography that Cristal had injected her *bunda* with two full liters of silicone (a procedure which would cost several thousand dollars and several sessions). With her extremely thin frame, the curves of her *bunda* were a spectacular feature of the nighttime scenery in Santurce's trans stroll, which she often accentuated with skin-tight lycra. Indeed, Cristal's *bunda* was something of an advertisement for Joaquin, the injection specialist, since she dramatically displayed the aesthetic possibilities of silicone for trans women.

Cristal was one of two trans women in our sample who were nurses. However, in Cristal's case, she had not pursued a career in nursing due in part to discrimination. During her nursing internship, she was specifically forbidden to wear her hair long or to put on makeup, since cross-gender behavior was deemed inappropriate and grounds for dismissal. Cristal managed to finish her internship and graduate, and had spent most of her career working as a

community outreach worker for HIV prevention programs, one of them funded by the US government.

In her in-depth interview, the first author commented to her that some people believe that transgender women engage in sex work as a result of discrimination, which limits access to formal work or the training needed to obtain it. She explained emphatically that this was not true in all cases, and that in her case, even as a professional, she too had engaged in sex work as a means of paying for silicone and surgical procedures. For her, it was a matter of time and money: the time it would take to make money for these procedures in a traditional job and the amount of money that can be made in sex work in short bursts, particularly when one has the naturally feminine features that Cristal enjoys. “Not all transgender women – even when they have a traditional job – have the money to pay for hormones, an expensive life, a laser treatment, treatments that you can’t imagine, in order to project.” “Project”, or *proyectar*, in local transgender terminology, is often used to describe the ability to project a feminine presence in the general society – a quality that is directly linked to one’s ability to advance in personal and professional projects. Because transitioning technologies help transwomen to advance in this way, many of our participants – particularly those for whom avenues of work and professional progress had been highly constrained – viewed gender transitioning as something to be pursued with urgency and speed, and anticipated improvements in these aspects if they were just able to “project”.

As with many Puerto Rican transgender women who seek transitioning services abroad, Cristal traveled on two separate occasions to obtain procedures from a doctor in Quito, Ecuador known to treat transgender women. On the first trip, she had breast implants and an Adam’s apple reduction. On the second – having discovered the income potential of sex work, she was able to pay for silicone injections in her waist and bunda, in addition to her castration surgery. Ecuador was the most common destination for surgical body modification practices in this study, and Cristal’s description of the process parallels those of others: She obtained an international phone number for the doctor’s office, called the number, received information on how to pre-pay, was given general instructions about the process, was told she would be retrieved from the airport and taken to her hotel, and the next morning she would begin her procedures. For Cristal, this is indeed how she described the process, and it was an experience she now qualifies as successful. However, she also described her great fear that Puerto Rican doctors might someday “ruin me,” since they are entirely uneducated about silicone-enhanced bodies, and might accidentally cut through her silicone (for example, if she were unconscious due to an accident), resulting in extensive silicone leakage or even an embolism. She developed this fear because of an experience at an ER when the attending physician – who had no idea what a trans woman was – attempted to apply an intramuscular injection in her buttocks, provoking a desperate protest from Cristal. “If I had been unconscious, he would have punctured my silicone!” she said. This can result in silicone traveling in the blood stream, leading to blood clots or pulmonary failure if silicone reaches the lungs. “That’s why I avoid doctors,” Cristal observed.

Case 3: Josephina—Like Cristal, Josephina – a 28 year-old, university-educated transgender woman who is employed as a cosmetics saleswoman at Puerto Rico’s largest mall – also received silicone injections on the street from Joaquin, and later travelled to

Ecuador for breast implant surgery, for which she paid \$2,600. Over a dinner with her, she explained to the first author that she was fortunate to have had early contact in her transitioning with a trans activist and organizational leader in the US, who was able to send her links to online resources on body modification. As one of the relatively few trans women who had established herself in a wage-earning position in a major department store, the stakes for her appearance were high. When the first author visited her at the store one afternoon, it was evident that clients were quite intent on inspecting Josephina, who passed as a woman quite successfully, but perhaps not entirely unperceived. She told me later that she sometimes feels uncomfortable because of her voice, which occasionally gives her away.

Josephina explained that Ecuador provided services at the most affordable price she could find, and incredibly, her \$2,600 payment included the airline ticket, three-day hotel stay, and all services. As suggested by some of the recent ethnographic literature on luxury medical treatments available in Ecuador (Roberts, 2012), the private market for such treatments is increasing in Ecuador, driven by a strong bifurcation of the health sector into public versus private, and the government's traditionally laissez-faire attitude toward medical practices in the private sector.

Josephina generally qualified her treatment in Ecuador as good. Unfortunately, however, part of the doctor's advice was to rest and to not pick up anything heavy for at least two weeks. But since she had to travel back to Puerto Rico two days after her surgery, she had to carry her heavy bags at the airport and at customs, and to manage the long trip all alone. "Eso fue terrible," (that was terrible) she explained. "Nobody at the airport would help me to pick up my luggage on the machine at security, and I was so, so sore." Somewhat ironically, she now views the experience as generally positive, despite the complications and lack of appropriate post-operative care, she did not seem to really criticize the doctors or the experience. Rather, as with a number of trans women with whom the authors spoke, she focused on her sense of gratitude that she was able to have the procedure at a price that was affordable to her, regardless of the pain, stress, and considerable risk that it involved.

Interestingly, Josephina told her personal doctor in Puerto Rico *before* her trip to Ecuador that she was planning to receive implants abroad, and says that she routinely tells her doctor about her clandestine use of hormones and silicone. The doctor, who Josephina describes as "trans-friendly" but as entirely uneducated in the clinical aspects of treating trans patients, does her best to respond to her needs, and provided some post-operative examinations after her return from Ecuador. However, Josephina emphasizes that virtually no physician is skilled or knowledgeable about transgender body modification practices or hormone therapy in Puerto Rico. And they certainly are not familiar with the extent of transnational border crossing that their lack of knowledge provokes.

CONCLUSION

The findings from our project demonstrate that Puerto Rican transgender/transsexual women are integrated into a truly transnational network of body modification practices and technologies. Transitioning stories confirm that access to sensitive, quality transgender health care is simply non-existent on the island, pushing many of them to seek clandestine

silicone injections in Puerto Rico, or, in the case of more invasive procedures or surgeries, travel to a practitioners of unknown repute in a country such as Ecuador. Access to technologies for body modification is a central precursor to the development of an affirming gender identity for transgender/transsexual persons, as demonstrated by research and clinical experience (Bockting & Coleman, 1992). Social and health research should address these practices from a non-pathologizing and structural perspective in order to truly capture their significance and identify appropriate policies and interventions.

Our approach, based on a structural framework focusing on the social, economic, and institutional challenges transgender persons face in pursuing such procedures, conceptualizes these practices as an important aspect of social resiliency in the face of systematic discrimination. Trans-migrations for clandestine or illicit procedures should be understood as highly resilient social responses to discrimination, not “risk behaviors.” That is, the patterns of mobility, travel, and migration that we document are the products of sub-cultural knowledge and agentive practices intended to overcome barriers to transgender healthcare access, work-based discrimination, and poverty, while also pursuing the realization of gendered bodies and selves. Trans-migrations should therefore be viewed as highly courageous quests to obtain deeply meaningful bodily transformations in the context of intense social marginalization. At the same time, these patterns of migration and mobility contribute additional health challenges and vulnerabilities, including lack of social support while receiving procedures in a foreign setting, problems with medical follow-up when returning to their home country, and increased possibilities of extortion and even violence in the face of social isolation while abroad. This tension between the resilient nature of trans-migrations and their ever-present challenges needs to be addressed in social research, community-based interventions, and trans-friendly health policies.

Structural interventions and policy advocacy in Puerto Rico aimed at supporting access to quality transgender care would likely have a great impact on the demand for migration and travel as the only option for transitioning procedures. While quality care and supportive services for transgender populations might be improved over time – for example, through much-needed physician training programs in medical schools or continuing education programs, which should be required for accreditation – more immediate harm reduction interventions should also be developed and piloted to reduce the potential for health risks associated with illicit procedures, such as HIV or Hepatitis infection and the carcinogenic effects of liquid silicone injection. Lay injectionists such as those interviewed in this study might be recruited as community partners to improve hygienic and clinical conditions, provide follow-up care, and perhaps develop referral systems with clinical practitioners trained in transgender care, both in Puerto Rico and potentially abroad. These same community partners, as well as other transgender cultural brokers, might further participate as leaders in the diffusion of information about harm reduction procedures, which could be developed and disseminated through community-based trainings in transgender social networks. Interventions should be developed to reduce the risks associated with international travel, perhaps by formalizing existing networks to streamline referrals to providers meeting particular standards of care, or offering other information aimed to reduce the negative clinical outcomes of pursuing procedures abroad. International transgender advocacy organizations, such as the World Professional Association for Transgender Health

(WPATH), might collaborate with such interventions to disseminate established protocols and inform consumers of what to look for when selecting services both in Puerto Rico and abroad. As we found that transwomen often share information with one another and are well-versed in online sources of information, Spanish-based software applications or websites oriented toward linking clients to services that follow WPATH protocols or provide virtual transitioning tours would be an innovative intervention ripe for adaptation to Puerto Rico.

Finally, legal and political advocacy should focus on communicating to key policy makers the severe consequences of the absence of supportive social, legal, and health services for the transgender/transsexual community, and should mobilize for policy changes that would provide the funding, training, and systems of accountability to ensure safe and high-quality transgender healthcare in Puerto Rico. Collectively, the combination of these approaches might begin to reverse the pattern of health vulnerability associated with clandestine body modification practices in Puerto Rico and globally.

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Table 1

Age, Household Composition, and Residence of Puerto Rican Transgender Women from In-depth Interview Sample ($N = 39$)

	N	%
Age (years; $M = 29$) [*]		
21–29	24	61.5
30–39	8	20.5
40–49	4	10.3
≥50	2	5.1
Household composition		
Alone	13	33.3
With partner	4	10.3
With family	17	43.6
With friend	4	10.3
Residence		
San Juan metro	26	66.7
Mayaguez	8	20.5
Other	5	12.8

^{*} One missing value due to unreported age.

Table 2

Marital Status, Education, and Current Employment of Puerto Rican Transgender Women from In-depth Interview Sample ($N = 39$)

	<i>n</i>	%
Marital Status		
Single	33	84.6
“Unión libre”	5	12.8
Divorced *	1	2.6
Education		
High School Incomplete	5	12.8
High School Diploma	12	30.8
Some University	8	20.5
Associate Degree	3	7.7
Bachelor's or equivalent	10	25.6
Some Graduate School	1	2.6
Current Employment		
Sex work	13	33.3
Cosmetology/hairstyling / “estética”	12	30.8
“Transformista”	6	15.4
Sales / fast food	7	17.9
Other	14	35.9

* Participant achieved legal recognition of change of sex in the 1970s, permitting her to marry legally (and later divorce)