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'It's really a hard life': Love, gender and HIV risk among male-to-female transgender persons

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Abstract

Scientific studies demonstrate high rates of HIV infection among male-to-female (MTF) transgender individuals and that stigma and discrimination place MTFs at increased risk for infection. However, there is little research examining how gender roles contribute to HIV risk. This paper reports on in-depth interviews with 20 MTFs attending a community clinic. Data reveal that stigma and discrimination create a heightened need for MTFs to feel safe and loved by a male companion and that in turn places them at a higher risk for acquiring HIV. Male-to-female transgender individuals appear to turn to men to feel loved and affirmed as women; their main HIV risk stems from their willingness to engage with sexual partners who provide a sense of love and acceptance but who also may also request unsafe sexual behaviours. A model illustrating how HIV risk is generated from stigma and discrimination is presented.

Keywords

male-to-female; transgender; HIV risk; relationships; stigma

Introduction

The term transgender refers to individuals whose sexual assignment at birth does not correspond with their current gender identity. Transgender individuals represent a diverse spectrum of gender expressions. The limited data on transgender persons and HIV point to high rates of infection (Kenagy and Hsieh 2005). Reports of HIV rates among MTFs range from 19–47% (Nemoto *et al.* 1999, Simon *et al.* 2000, Clements-Nolle *et al.* 2001, Kenagy and Bostwick 2001, Kenagy 2002, Risser and Shelton 2002, Nemoto *et al.* 2004a). A study conducted in San Francisco on MTFs (n=392) and female-to-male (FTM) individuals (n=123) found that 35% of MTFs in the study were HIV-positive; FTMs had a lower rate of 2% (Clements-Nolle *et al.* 2001).

Researchers have outlined a number of processes relating to stigma and discrimination that may increase the risk of HIV infection (Herek and Capitanio 1999), specifically among MTFs (Green 1994, Nemoto *et al.* 1999). Stigma generally refers to an adverse reaction to individuals who are perceived to be 'different' based on one or more characteristics (Susman 1994). Discrimination is often conceived as a concrete outcome of stigma (Link and Phelan 2001) and prevents stigmatized individuals from engaging in social and economic

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opportunities (Link and Phelan 2001). This paper explores how MTFs experience stigma and discrimination and how those experiences increase their need to feel wanted, loved and accepted by male partners, which may in turn place them at increased risk for HIV.

HIV, stigma and discrimination among MTFs

In a sample of 402 transgender individuals, over half reported some form of harassment or violence at some time in their lives; 25% report experiencing a violent incident (Lombardi *et al.* 2002). Although all MTFs face discrimination, there is evidence suggesting that transgender individuals of colour are at increased risk for HIV infection (Nemoto *et al.* 1999, Clements-Nolle *et al.* 2001). This may indicate that multiple layers of stigma and discrimination increase risk for HIV among MTFs of colour.

Economic discrimination is a common outcome of stigma that may indirectly lead to increased HIV rates for MTFs. A study found that 37% of transgender individuals experienced some form of economic discrimination in their lives (Asthana and Oostvogels 1993). Some MTFs turn to sex work because they lack employment options (Garber 1992, Clements-Nolle *et al.* 2001) and sex work provides an opportunity to earn money to pay for sex reassignment surgery (Pang *et al.* 1994, Bockting *et al.* 1998). The desire to undergo sex reassignment surgery may also lead some MTFs to engage in particularly risky sex work as some clients pay extra for barrier free sex (Boles and Elifson 1995, Nemoto *et al.* 1999, Nemoto *et al.* 2004a). Higher rates of HIV-seropositivity for MTFs compared to other groups of sex workers has been documented in a number of studies (Elifson *et al.* 1993, Clements-Nolle *et al.* 2001, Reback *et al.* 2001).

Studies report that many MTFs turn to substance abuse as a means of dealing with their transgender identity or in easing their ability to reveal their transgender identity to others (Bockting *et al.* 1998). Among the 392 MTF participants in the San Francisco study, 34% had injected drugs in the past six months and drug use was highly predictive of a positive HIV serostaus (Clements-Nolle *et al.* 2001).

Gender roles

Researchers have yet to understand the relationship between stigma and discrimination and gender roles for MTFs. Gender roles refer to the culturally prescribed norms, ways of being and acting particular to men and women (Gagnon and Parker 1995). Gender roles are socially constructed and as transgender individuals demonstrate they can be transgressed, combined or even ignored. Over the years, gender roles have changed for both men and women, but research indicates that traditional gender roles, where women are passive and men active, still prevail in sexual relationships (Williams *et al.* 2001). Men actively seek out sexual relations with women and women await men's actions. Researchers have discussed how female gender roles place (non-transgender) women at risk from HIV (DeBruyn 1992, Felmlee 1994, Amaro 1995, Gomez and Marin 1996, Zierler and Krieger 1997). Men decide whether and if to use protection leaving many women vulnerable. This body of literature describes how social relations and expectations of women and men are played out in interpersonal relations.

Although MTFs face very distinct issues surrounding HIV risk to non-transgender women, many of the same issues are relevant when examining MTFs' HIV risk. Gender roles that interfere with safer sex may be practiced, including roles whereby women are expected to cater to men's sexual pleasure. In focus groups research, Bockting *et al.* (1998) found that many MTFs reported that not using condoms with their partners served as an affirmation of trust in the relationship. Similar to research findings on women (Margillo and Imahori

1998), Bockting and colleagues (1998) found that MTFs also encountered difficulties negotiating condom use with their partners.

Sexual relations are an essential component of gender roles. The desire to be affirmed as a woman may contribute to HIV risk (Kammerer *et al.* 1999, Nemoto *et al.* 2004b). Bockting and colleagues (1998) found that engaging in sex work with men served as gender affirmation for MTFs. Moreover, MTFs were more likely to engage in safer sex with clients as opposed to sex with a relational partner (Nemoto *et al.* 2004b). Other research has revealed that the pursuit of a feminine body and the desire to be affirmed as female contributed to HIV risk when MTFs engaged in sexual activity with relational partners (Kammerer *et al.* 1999). Bockting *et al.* (1998) state that MTFs discussed how their quest for affirmation of their gender identity led to unsafe sex. Rodriguez-Madera and Toro-Alfonso (2005) found that MTFs' construct of feminine gender identity interferes with condom negotiation and is a major factor to consider in HIV prevention for MTFs.

While a number of researchers describe how stigma and discrimination place MTFs at increased risk for HIV, there is less research examining how gender roles and the desire to feel loved contribute to HIV risk for MTFs. This paper examines how stigma and discrimination interact with gender roles to place MTFs in a unique position with regards to HIV risk.

Methods

Qualitative research methods were utilized to engage twenty MTF participants in discussion about their lives, relationships and health-care needs. Data were collected using semi-structured in-depth interviews from clients of a community clinic in a major urban centre. The study was approved by the New York State Psychiatric Institute and Columbia University's Institutional Review Board. Details of the study location and design are described in detail below. Interviews were conducted between November and December 2003.

Study location

The health clinic where the study was conducted is located in a low-income area. The clinic does not cater to lesbian, gay, bisexual or transgender (LGBT) individuals but, rather, sets out to serve the low-income community where it is located, which by and large does not identify as LGBT. Through word-of-mouth, several MTFs came to learn of the clinic where they receive hormone therapy, HIV counselling, testing and treatment and general health-care. The clinic also provides social services to all its clients. Staff have been trained and are accustomed to working with MTFs. The clinic serves mainly Latinos (the majority of which are Puerto Rican) and African Americans; the transgender clientele reflects the ethnic make-up of the non-transgender clinic clients. At last count, there were approximately 80 MTFs who were receiving care at the clinic.

Recruitment

Two medical doctors from the clinic recruited all participants. Transgender individuals were approached by the doctors and asked if they would like to participate in an interview. They were informed that the interview was informal and that they would be asked questions about their lives including HIV health concerns and needs. Patients were told that service access at the clinic would not be affected in any way if they chose not to participate in the study.

Participants

All participants were clients of the clinic and 18 years of age or older. All but four of the 20 participants were Latina. The four non-Latina participants identified as African American, with one African-American participant describing herself as Caribbean. Of the 16 Latina participants, one was from Central America, another from South America and the remaining participants were from Puerto Rico or of Puerto Rican descent. The mean age of the participants was 30.7 years (range=18–53, standard deviation=9.8). Four of the 20 participants identified themselves as HIV-positive. To ensure respondents were comfortable discussing their sexual relationships with male, female and transgender individuals, only gender neutral terms were utilized to inquire about sexual partners; however, all participants expressed desire and sexual activity only with men.

The average monthly income for this sample was US$525, although one participant earned as little as US$136 and another as much as US$1,200. Six participants had completed high school, seven had one or two years of high school, five had finished junior high school and one had a fourth grade education. The majority of respondents (16) lived in apartments or houses, two lived in a shelter for homeless individuals and one lived on the street. Almost half of the sample (nine) lived alone. All others lived with family (six), a partner (four) or friends (one).

None of the MTFs in this sample had undergone genital reconstruction surgery and only a handful had had breast augmentation. However, all were currently taking female hormones (with the exception of two participants who had recently lost the ability to pay for their hormones). To protect the confidentiality of participants, pseudonyms replace actual names in the excerpts presented below. This sample represents a unique opportunity for addressing issues that particularly concern ethnic and racial minority MTFs who may have limited resources. It is not known how representative this sample is of MTFs in urban cities in the US.

Interviews

All interviews were conducted by the first author and were tape-recorded. Since the first author is bi-lingual, participants could select Spanish or English in which to conduct the interview and seven interviews were conducted primarily in Spanish. Occasionally, participants used Spanish words to describe certain feelings or material objects even though the interview was conducted primarily in English, or *vice-versa*. Quotations taken from the Spanish interviews will appear first in Spanish and then in English to preserve the voice of the participant.

Interviews were conducted in the clinic on the day of recruitment. After a participant told the doctor that she wished to participate in the interview, the doctor would introduce the participant to the interviewer. All interviews were conducted in a private doctor's office. On occasion, participants were asked by the medical doctors to wait until an interview was concluded. In these instances, participants introduced themselves to the interviewer.

Most interviews lasted about an hour with three interviews extending to two hours. Before the interview commenced there was a careful consenting process. Participants were instructed that they were under no obligation to participate and that their services at the clinic would in no way be affected if they decided not to participate. Participants were given a consent form to complete, the content of which was explained carefully by the interviewer. At several times during this process participants were asked if they had any questions.

An interview protocol was developed which covered broad areas of life such as discrimination, gender roles, stigma, relationships and health-care including medical

procedures and hormone usage. The interview protocol was not used as a formal interview guideline; participants were never read questions directly from the protocol. The purpose of the interview protocol was to ensure that the same type of question was asked to all participants and that the same themes would be covered among all the participants. The interviews maintained the feeling of a conversation with pointed questions. An example of a typical question asked during the interview is: 'Can you tell me about a past relationship?' Typical follow-up questions include: 'What did you like about this partner?' and 'What did you dislike about this partner?'

Upon commencing the interview, each participant was asked: 'Is there anything on your mind you would like to discuss?' This question allowed some participants to ask questions or to discuss concerns regarding their visit to the clinic. Since the location of the study was a health clinic, there were many possible reasons why participants could have been at the clinic (e.g. receiving results of a medical test or coming in for HIV treatment) and it was important to give participants an opportunity to discuss anything that may be on their minds. On occasion, this question led to a discussion surrounding participants' concerns. For example, one participant described seeking shelter from an abusive relationship, which led to a discussion surrounding her abusive relationship, moved into a discussion of her relationships in general and preceded to other topics such as health-care needs and concerns.

At the end of the interview, each participant was thanked and asked if she would like to receive a list of referrals for HIV services in their area. She was also asked if she would like to receive a safer sex packet containing a number of products including lubricant, male condom, female condom, finger cot and dental dam. Each participant also received $35 cash for their time and transportation costs.

Analysis

Interviews were transcribed verbatim. A modified form of grounded theory (Strauss and Corbin 1990) was used to guide the coding of the interviews. Unlike traditional grounded theory, the approach utilised here does not assume an inexperienced orientation to the data on the part of the investigator. It embraces the idea that the researcher's background, including theoretical orientations, analytic training, skill and experience with the data is necessary and an important part of the analysis (Lincoln and Guba 1985).

Three researchers coded the transcripts. To commence analyses, three interviews were randomly selected. From these three interviews a coding schema was developed that included themes relevant to the aims of the study and the focus on gender roles. After establishing a thematic schema, the remaining interviews were read and coded for themes. If new themes emerged they were added to the thematic schema. To enhance reliability, the authors met to discuss the themes coded and discrepancies with codes. All discrepancies were discussed and agreement was reached. The themes reported here are those relating to gender and HIV risk. These themes are in line with what the authors found to be an overarching story told by participants — that of stigma and discrimination leading to feeling unwanted and desiring to have a partner in order to feel loved, resulting in HIV risk.

Results

Within the public sphere, stigma and discrimination is prevalent in the lives of MTFs; their experiences of stigma and discrimination create a heightened need to feel safe and loved — and they turn to men in an attempt to feel loved, desired and affirmed as women.

'It's really a hard life'

All participants discussed the difficulties they experienced because they were transgender. Several participants used the phrase 'the life' and the 'the hard life' to refer to being transgender. Yolanda a 24-year-old Puerto Rican participant says:

> 'It's really a hard life. It's really hard. See, it's easier for like two guys that are like two thugs and they're tough and gay and they'll be together for years, because nobody can tell and they like to keep it that way, but when it's a transgender, I don't care how pretty you may be, it's always going to be somebody can tell you're a man.'

Respondents discussed how the threat of discovery was stressful to them. Walking down the street could invoke anger and violence if others recognize they are transgender.

Participants reported a tremendous amount of violence in their lives. All described being verbally attacked in the streets and many described being physically attacked by strangers: several had been stabbed, one had been shot and another had had a gun put to her back. Many said they called the police; however, no action was taken on their behalf. Going outside the home was perceived as dangerous by many. Isabel, a 28-year-old Puerto Rican participant, was asked if she went out with friends and she replied, 'No. I'm not going out with people, I don't go out'. She then described being attacked by people on the street: 'See I walk in the street (alone), nobody tells who I am, (that) I'm a transvestite'. Isabel felt that going out with other MTFs makes it easier for people on the street to recognize her as transgender and therefore increases her chances of harassment and violence. When people recognize Isabel as transgender she says, 'they start "Oohh"…and they start calling me "faggot", "you homo" and hit (us) with bottles, brick(s) stuff like that'. Many felt threatened and scared to go out in public and staying home served as a means of dealing with this threat.

Home was the place where they could escape these stresses — a place they could feel safe. In contrast to her description of being in public and having people harass and be violent towards her, Isabel describes coming home at night:

> 'I'm in my house already by 8 tonight at 10 o'clock that's it. Once I lock the doors behind me they are staying locked. Yeah, because I don't like to open, once I'm in my house, cluck cluck and that's it…I'm not going back out and if I did forget something, it's going to stay for tomorrow. I'm just going to stay in my house.'

Isabel took time to describe the locking of the door, insisting that the door stayed locked once she is in her house. Her use of the onomatopoeia 'cluck cluck' corresponds to hand movements where she mimed someone turning a knob in vertical space. Her insistence that she will not leave the house, even if she had forgotten something, represents a sense of protection from danger.

Mirasol, a Puerto Rican respondent, was 53 years old and the oldest person interviewed. She felt vulnerable leaving the house because she feared men in her neighbourhood would realize she was not a biological woman. She was concerned they would hurt her and cause problems for her in her apartment complex by telling others she was transgender. She described leaving the house covering her face and timing her movements to avoid men — only leaving her home to come to the clinic where she was interviewed. She says:

> 'No, no, yo no puedo trabajar porque es que yo le tengo miedo a la calle. No puedo tener un trabajo porque yo tengo terror…yo quiero estar en la casa, como te dije, fue algo increíble que llegue aquí, porque yo tengo terror a la calle.'

> 'No, no, I cannot work because I am scared of the street, I can't have a job because I am terrified…I want to stay in the house (to the clinic), like I said it was incredible that I came here, because I am fearful of the street.'

Many respondents associate the world outside their homes with danger. The inside world of their homes was associated with safety. Home for most respondents took on the significant characteristic of protecting them from harassment they might encounter when going outside and being seen.

Domestic gender roles

Participants clearly described their preferred gender roles in relation to their homes and partners. They described taking on roles equivalent to what people often describe as traditional women's roles as home makers and care takers. Perhaps because public places were seen as dangerous, many respondents spoke eloquently about how they saw themselves inside their homes. Mirasol for example, described herself in relation to her home:

> 'Así, casera, tú sabes, yo quiero, quisiera ser una mujer pero mujer de mi casa…es el 'look' que yo quiero dar, mujer de mi casa…Me da por limpiar, cocinar, ir a lavar cosas, me las paso en la casa y sí, viendo novelas…'

> 'Oh yes, housewife, you know, I want to be a woman but a woman of my house… that is the "look" I want to give, woman of my house…I have an inclination to clean, cook and to wash things, I pass my time in the house and yes I watch soap operas…'

Mirasol's sense of self is tied to her home. The 'look' she chooses is one of a housewife. She also described herself as having an inclination to clean and take care of the house.

Ana, who lived with her partner and is a 33-year-old Puerto Rican, described herself in her relationship and the duties she performs at home:

> 'I cook for him, I do things for him. Everything a wife will do. Stay in the house, cook, clean, wash clothes, you know what I'm saying…I made that yesterday and I have an avocado and I'm going to open it today and I'm going to make him some pork chops. That's food today.'

Ana actively sets out to care for her home and partner. She takes on the traditional female role vis-à-vis her partner. Her demeanour and discussion of her home highlight the importance of the domestic life as a place to be the woman she wants to be and the freedom to do so without worry of harassment or violence.

'They've always got a girl on the side'

Respondents who did not have a partner discussed the importance of finding one. Isabel said, 'It's like, oh my God, I need somebody. C'mon, I'm 28 now and I live my life this way for six years. It's time for me to get someone that's gonna help me'. Isabel denotes a sense that a man can help her with her life.

Although having a male partner was valued, many participants discussed the difficulties of finding a man who wanted to be with them for a long-term relationship. Respondents described living in a world where men want to have sex with them but few wanted committed relationships. Jasmine, a 22-year-old participant, provided her perspective on relationships with men and summed up what many respondents said about men:

> 'You run into a lot of relationships where guys just want you for sex. You know what I'm saying? You have a girl, I'm 22. I have met so many men that promised me the earth, moon and stars and I really thought they was going to give it to me

> and they turned out to be shit. You know what I'm saying? And it's because a lot of men are insecure about their own sexuality, so you will always be the backburner. You will always be the person that if they…they're always…I don't care, any transgender that don't know this by this age is stupid. Every man that deals with a transgender always has a girl on the side. Always. Believe me. I've been in the life a long time; they've always got a girl on the side.'

Among study participants, only four were currently with a partner who they described as their committed partner or husband. Yet, all respondents wanted to have a loving and committed relationship with a man.

Another participant, Maria, who was 35 years old and Puerto Rican, also reported that it was hard to find a man who will accept MTFs as they are. She said:

> 'I mean my whole life I've always been with men that only want you for sex. You know, the majority of men…the reason they like transsexuals is that they resemble females, but, how can I put (it), when it comes to relationships it is very hard for us transsexuals to find a man who's proud of you, who wants you for you and walk down the street with you and don't care who knows you're a transsexual. It's really hard to find a man like that.'

Maria describes a nuance that is not well explored in the research literature. She says men like MTFs because they look like women but also because they are not women. While the intersection between female and male is highly desirable for some men, many MTFs fear that their partners will leave them for a non-transgender male or female person.

Joy, a 32-year-old African-American respondent, shed light on the importance of her partner in her life. She says her partner helped her deal with the difficulties she faced due to being HIV-positive:

> 'My current relationship now is good. He's aware of all my medical problems and he's there for me. He's there for me. He's a wonderful human being. He loves me for me. He helps me with whatever whenever I have…doctor's appointments…he's there. If he has to take off from what he has to do, he always is there. If I'm — if its days that I don't feel good or I don't feel like doing anything he steps in and does whatever has to be done. He's a good support system. He's a very good support system and I wouldn't trade him for nothing in the world.'

Joy's partner keeps her spirits high and this in turn helps her stay hopeful and focussed on taking care of herself. Joy states that her partner 'loves her for her'. The sentiment of being loved and accepted was discussed by other respondents as ideal but few reported currently having a partner who accepted them. Male-to-females who did not have a partner stated that finding someone who accepted them for being transgender was a major hurdle.

Love, gender roles and HIV risk

Although there was a desire to have a committed relationship with a man, respondents discussed the difficulties of having a long-term relationship. Jasmine, a 22-year-old African-American respondent who was HIV-positive, offered her perspectives on the relationship between the need for an intimate relationship and HIV risk. At one point in the interview, she leant into the microphone and said:

> 'We know how hard the life is so when you meet a guy it's like you go through all means to keep this man, because you really want to be with him, you know what I'm saying? So it's really hard. You just want to be loved, that's it. Being ridiculed so much, called this called that, being used…It's just like after a certain point in your life you just…you get needy, I guess…And a lot of people don't want to

> admit it, but a lot of people settle. A lot of us settle…I really think that it's so many of us that are getting this (HIV) because we want to be loved and you know…and a lot of times you meet somebody and you feel as though that this person's going to love you, so you…you risk a lot of things that…you know what I'm saying? To make this person happy, you know, you feel as though if you don't use it (condom) it's going to be closer, it's going to make him love you even more.'

Perhaps because Jasmine was in the midst of dealing with her newly-discovered HIV status, she reflected on how relationships may lead some MTFs to become infected with HIV. For participants who describe the difficulties they face, being put down and made to feel like they are worth less than others, relationships take on added meaning and value. The need to feel loved, to feel 'closer' to someone can trump the knowledge that one needs to be protected against disease.

Jasmine linked her experiences of being discriminated with those of finding a partner and feeling accepted, she said:

> 'You meet a guy and he's attractive and you know, you feel like oh, he really likes me, he walks down the street with me, he knows what I am, he holds my hand and then here you go caught in that ploy, now here it is he wants to have sex with you and the first couple of times you might use a condom, but then he want(s) to stop, because you feel like he really cares about you and I mean part of us being transgender, we feel like we're women, so I guess that woman side of us wants to please our man, so it's a lot of things that we would do to just to please our man.'

This description of wanting to be accepted and loved was common to other respondents in the sample. As with the importance of the home as safety from the outside world, intimate relationships were emotional locations in which participants could be themselves, be accepted for who they were and feel free from the discrimination they faced outside their homes. Jasmine wanted to be accepted as a transgender person. Beyond being accepted as transgender, Jasmine's sense of being a woman could place her at risk. Jasmine discussed the importance of wanting to please a man. She stated that she wants to please her partner — this is her sense of what it means to be a woman.

Another participant, Clara, also discussed the relationship between gender and HIV risk for MTFs. Clara had undergone several operations to enhance both her face and body and reported that she receives much attention from men. However, she also reported that no man is capable of truly loving her. She noted that men want to be with her for sex but stated that as she gets older and presumably less attractive, she will surely be alone. She talks here about the possibility of contracting HIV in the future:

> 'Claro que no me gustaría tener el SIDA ahora porque soy joven pero quizás en unos años…no me asustaría el hecho de contraerlo porque yo creo que no me gustaría vivir una vida en después de los 40 años, es una etapa muy dura para una y es muy triste quedarse sola y el sentir que nadie va a estar contigo por el hecho de no verte bonita o verte joven como ahora lo estoy.'

> 'Of course I would not like to have HIV now because I am young but maybe in a few years…I wouldn't be scared to get infected because I do not think I would like to live a life, after 40, which is a hard stage for you and it is very sad to be alone and to feel that no one wants to be with you because you are not being attractive and young like I am now.'

Clara associated HIV with death and saw an early death as a possible escape from her life. She felt that getting HIV could help prevent a life where no man would want to be with her and where she would feel alone and unloved. Clara's sense of self-worth, interestingly

enough, comes from her sense of beauty and youth. She feels that once these are lost, she will not have men's attention. Although Clara describes having various men in her life and often mentions that some men pay for her hormones and have paid for her surgery, she does not believe that a man could actually love her. Like other respondents, such as Jasmine and Maria above, Clara feels that men want to be with her primarily for sex.

Discussion

In the book *Gender Play* (1993), Thorne discusses her observations of young boys and girls. She describes a 'heterosexual market' where girls receive an added sense of self worth when involved in a relationship with a boy. Thorne describes a context where adolescent girls experience a diminished sense of self, self-esteem and self worth at the same time that they begin to enter into heterosexual relationships. Although relationships appear to provide a sense of self worth for these girls, in actuality, it is a false sense of worth. Because girls enter into relationships on unequal terms, they often experience relationships where they are unable to partake equally. Relationships are about keeping a boy rather than finding a mutually beneficial companionship. Rather than finding themselves, girls lose themselves in a false sense of security.

The experiences of MTFs in this study resemble aspects of Thorne's 'heterosexual market'. Because MTFs experienced stigma and discrimination, their own sense of self worth had been greatly diminished. While the diminishment of self-worth for young girls can be difficult to locate in complex social processes involving gender, for MTFs this phenomenon is clearly located in the verbal and physical harassment they experience in the public sphere. Having a male partner was one way that they could regain a sense of self-worth and protection. Gender within the lives of MTFs plays a complicated role that interacts greatly with stigma and discrimination and together increases HIV risk for them.

The interview data reveal a process of risk that emerges from stigma and discrimination. Stigma and discrimination create a context whereby the private sphere becomes a place where they can escape from the dangers present in the public sphere. The home is where MTFs are free to live according to their desired gender roles. The presence of a man adds to the feeling of being accepted and loved.

HIV risk emerged in two ways. First, MTFs wanted to find a male partner who would accept them for being transgender. Because all MTFs in the sample experienced severe forms of stigma and discrimination, a partner would provide them with one person in their lives who loved and accepted them for who they are. The need to have such a person may make safer sex a distant priority for them. Second, because many MTFs felt that they would not find a partner, they also felt doomed to lead a lonely and difficult life. Because their lives were filled with stigma, discrimination and an inability to find a partner who loved them, many felt their lives were very hard. Some, like Clara, may feel that becoming infected with HIV would provide an escape from this life. Figure 1 represents a model of how stigma and discrimination lead to HIV risk through the need to feel loved and accepted by a male partner.

The quest for a home and a romantic partner are common in society; however, among MTFs in this study these needs were heightened. The need for someone to accept and love participants was important and understandable given the difficulties they encountered in their everyday lives. Although gender roles are important and do play a role in HIV risk, it is important to place gender roles and their relation to HIV risk within the larger context of the stigma and discrimination experienced by MTFs.

The concept of a 'heterosexual market' is important to consider for MTFs. Evidence suggests that MTFs' experience in the public sphere severely limits their abilities to enter into relationships in terms where they are able to demand equal power from their male partners. Because the relationship is more meaningful and valuable for them, many MTFs may feel compelled to give in to their male partners not only with regard to condom use but with a whole range of behaviours that may lead to increased emotional and physical vulnerability. HIV-prevention efforts for MTFs may need to take into account how stigma and discrimination influence MTFs romantic relationships.

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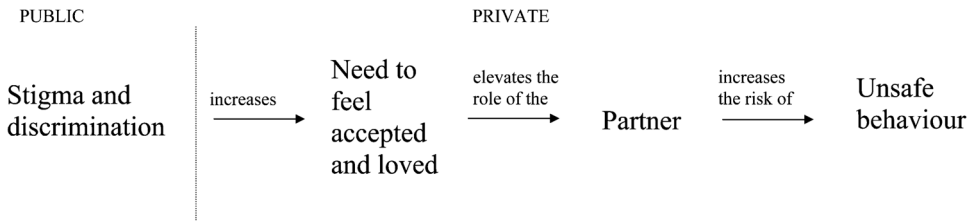

Figure 1.
Stigma and discrimination lead to increased risk of unsafe behaviour by increasing the need to feel accepted and loved, which elevates the role of the partner and places MTFs at risk for HIV.