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Gender Affirmation and Body Modification Among Transgender Persons in Bogotá, Colombia

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Abstract

This paper examined structural, social, and personal characteristics that shape the processes of gender affirmation and body modification among transgender persons (assigned male at birth) in Bogotá, Colombia. Qualitative data from life-history interviews (N=14) and a focus group (N=11) explored research questions concerning the ways in which the internal psychological and external contextual processes influence individuals' decisions and behaviors concerning hormonal treatment, injections, or surgery. Research questions concerning practices and consequences of treatment performed without medical supervision were addressed through qualitative data, as well as quantitative data from 58 transgender participants. Findings indicated variation in ways participants conceptualized gender (e.g., binary or fluid), but an increased feminine presentation was a strong personal desire expressed by many and often encouraged by romantic partners and transgender friends. Transgender individuals within participants' social networks were frequently instrumental not only in providing information about hormones and contouring injections, but also in carrying out procedures—sometimes with negative consequences. Body modification procedures occurred primarily outside the health care system, due to limited access to or awareness of medical care, societal stigma, social norms within the transgender community, and personal decision-making. Public health approaches to protect the health of transgender persons undergoing body modification were suggested.

Keywords

Gender affirmation; body modification; transgender; gender non-conforming; Colombia

Introduction

A binary gender system divided between male and female identities organized according to birth sex is predominant in many societies (Bem, 1995; Kozee, Tylka, & Bauerband, 2012; Lewis, 2008). For some people, however, gender identity does not correspond to the assigned sex at birth. Transgender is a term that encompasses those individuals whose identity, expression, or behavior does not match that which is typically associated with their natal sex (National Center for Transgender Equality, 2014).

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Psychological and physical treatments can alleviate distress associated with gender incongruence, and many transgender individuals take steps to achieve an identity that is consistent with their internal sense of gender, which may be binary or continuous (Bockting, 2008). This paper examines gender affirmation and body modification among transgender persons in Bogotá, Colombia. The transgender population of interest in this study consists of those who were originally assigned male sex at birth; for the sake of brevity, we use the term *transgender* here to refer to this segment of the transgender population.

Gender Affirmation

Because transgender people do not conform to societal gender norms and expectations, they often face discrimination and rejection (De Santis, 2009; Norton & Herek, 2013; Sevelius, 2013). In addition, many experience internalized stigma and struggle with self-acceptance. As with other stigmatized groups, the support of similar others plays an important role in fostering the identity development of transgender individuals (Bockting, 2014). Social support and affirmation of one's gender identity from friends, partners, and family members have been associated with greater well-being (Mullen & Moane, 2013; Nuttbrock et al., 2009; Nuttbrock, Rosenblum, & Blumenstein, 2002; Sevelius, 2013). Moreover, although gender affirmation can be the result of social interactions, individuals can also be the source of their own affirmation (Mullen & Moane, 2013).

Body Modification

Since 1979, hormone therapy has been considered the appropriate treatment for transgender individuals, as specified in the Standards of Care proposed by the World Professional Association for Transgender Health (WPATH) to guide health professionals in their assistance of transgender individuals (Coleman et al., 2012). In many countries, including the United States and Colombia, in order to obtain medical treatment to achieve body modification, an individual must undergo a psychological evaluation and receive a psychiatric diagnosis of gender dysphoria. In addition, because hormone therapy or sex-reassignment surgery involve significant physiological and emotional changes, procedures to ensure that transgender individuals are educated and certain about their decisions are standard medical care.

Hormone therapy in Colombia

Hormonal treatment is available through the medical system in Colombia and is covered under the Mandatory Health Plan (*Plan Obligatorio de Salud*), which is the basic health insurance available to the general population. Access to treatment is limited by barriers that include limited financial resources, lack of awareness of available services, and limited availability of endocrinologists (Triana Duarte, 2013). In addition, stigma is evident in medical settings and can result in inadequate care for transgender individuals and other sexual minorities (Poteat, German, & Kerrigan, 2013), including in Colombia (Reisen et al., 2014). Research has indicated that barriers to medical care lead some transgender persons to seek alternative ways of achieving feminization, such as self-administration of hormones and implants (Clements-Nolle, Marx, Guzman, & Katz, 2001; Garofalo, Deleon, Osmer, Doll, & Harper, 2006; Rotondi et al., 2013; Sanchez, Sanchez, & Danoff, 2009; Xavier,

Honnold, & Bradford, 2007). Indeed, in Colombia hormones are available without prescription, and an ethnographic study noted that hormonal treatment through the medical system was not common, even among transgender persons with health insurance (Garcia Becerra, 2009).

Hormone treatment supervision

Although hormonal therapy can result in desired changes such as smoother skin, thinner body hair, weight gain, and breast and nipple growth (Winter & Doussantousse, 2009), unsupervised treatment involves certain risks. Administration of hormones requires careful medical supervision and an individualized regimen to ensure that hormones remain within appropriate physiological levels (Meriggiola & Berra, 2013). Research has indicated that self-administration of high-doses of hormones among Colombian transgender persons is common (Garcia Becerra, 2009). Treatment without medical supervision can result in liver, kidney or heart damage (Winter & Doussantousse, 2009), and although long-term effects are not well understood, evidence has shown increased risks of thromboembolic and cardiovascular events (Wierckx et al., 2012) and cancers (Mueller & Gooren, 2008).

Silicone injections in Colombia

In contrast to hormones, surgical procedures such as breast or hip implants are deemed aesthetic and therefore are not covered by the Colombian health care system (Garcia Becerra, 2009; Prada Prada, Herrera Galvis, Lozano Ruiz, & Ortiz Gómez, 2012). In Colombia as elsewhere, injection of silicone or other fillers is seen as desirable because it creates an immediate contouring effect (Wallace, 2007). The self-administration of industrial-grade silicone, however, can cause body disfigurement, skin damage, fever, cough, apnea, allergic reactions, respiratory emergencies, and severe autoimmune and connective tissue disorders (Garcia Becerra, 2009; Wallace & Rasmussen, 2010; Wallace, 2007). Studies suggest that transgender individuals tend to be uninformed about the longer term and life-threatening effects of such treatments (Pitts, Couch, Mulcare, Croy, & Mitchell, 2009; Winter & Doussantousse, 2009).

Current Study

Although gender affirmation and body modification of transgender persons have been studied, there is limited information on these procedures in middle and low-income countries. Understanding the context of these procedures in South America is important because procedures such as self-administered industrial silicone injections are more prevalent in these regions (Pan American Health Organization, 2012). This study examined how personal and social factors affect gender affirmation and body modification among transgender persons in the context of Bogotá, Colombia. Qualitative research questions concerned the ways in which the internal psychological and external contextual processes influence individuals' decisions and behaviors concerning hormonal treatment, injections, or surgery. Additional research questions, addressed through qualitative and quantitative data, focused on the practices and consequences of self-administered treatment performed without medical supervision.

Methods

The data for this investigation came from a larger study examining HIV prevalence, sexual behavior, and attitudes toward circumcision among Colombian gay, bisexual and transgender individuals and men who have sex with men (MSM) (Bianchi et al., 2014; Reisen et al., 2014; Zea et al., 2013, 2015). The original study included an initial qualitative phase, followed by a quantitative phase. Body modification was not the original focus, but because it emerged in early life-history interviews, we added additional interviews with transgender individuals and a few questions in the quantitative survey to address this issue.

Qualitative Phase

Participants and procedure—Data collection took place in Bogotá, Colombia, and participants were recruited between fall 2008 and spring 2010. Convenience sampling of transgender individuals was used. Table I shows descriptive characteristics of the participants, with pseudonyms to protect the identities of participants. See Zea et al., 2013 for a fuller description of broader social context in Colombia for these transgender participants (as well as the MSM who were included in life-history interviews of the larger study).

Life-history interviews: Participants in life-history interviews included 14 transgender persons. Ages ranged from 22 to 46, with a mean of 30.4 years, and years of education ranged from 4 to 16, with a mean of 8.6 years. Interviews were conducted by either of two research associates: one was a self-identified gay man, and the other was a woman with extensive knowledge of the LGBT community in Bogotá. The original semi-structured interview guide was used to encourage detailed narratives of the participants' lives, including experiences from childhood to adulthood, traumatic experiences, gender identity, social networks, and sexual behaviors. Modifications to the original guide for the additional interviews with transgender individuals included emotional, physical, and financial aspects of body modification, social support in the transgender community, and experiences of discrimination. Each interview lasted about three hours and was audio-taped. Participants also completed a brief demographic questionnaire. They were compensated with 100,000 Colombian pesos, which was approximately US$60 at the time of the interview.

Focus group: One focus group was conducted with 11 transgender persons between the ages of 21 to 41, with a mean of 27.9 years. The average number of years of education was 12.3, with a range from 5 to 16 years. The focus group lasted about two and a half hours and was facilitated by a member of the LGBT community in Bogotá and a note-taker assistant. The session was digitally audio-taped with the participants' consent. The facilitator followed a semi-structured guide with open-ended questions that encouraged the description of the social and sexual climate for transgender individuals in Bogotá. The guide included questions about social networks, patterns of behavior, identity, and attitudes toward the LGBT community. Additionally, participants were asked to complete a brief demographic questionnaire and were compensated with 60,000 Colombian pesos, which was approximately US$34 at the time of the interview.

Data analysis—The audio-recordings from the focus group and the in-depth interviews were transcribed in Spanish by a team of Colombian researchers. The transcripts were then coded by two transnational teams of five Latino researchers, composed of two native Colombians living in Bogotá and three Spanish-speakers residing in the United States. NVivo8—qualitative data analysis software—was used. The coding process followed a pre-established set of codes based on the interview guides; however, codes were often revised and expanded in response to important insights that emerged during coding process. Each data source—life-history interview or focus group—was coded by at least two researchers, and codes were then compared and reviewed in order to identify areas of disagreement. The identified discrepancies were later resolved during weekly meetings of coders using Skype software. The current paper focuses on the themes that emerged in relation to gender affirmation and body modification.

Quantitative Phase

Participants and procedure—Quantitative data were collected in 2011, and the sample was recruited through respondent-driven sampling (RDS). Participants completed a questionnaire using Audio Computed-Assisted Self-Interviewing (A-CASI) and received pre- and post-test counseling, a rapid oral HIV-test, and a confirmatory blood test if results of the rapid test were reactive. Because issues of body of gender affirmation and body modification were not the focus of the larger study, there was limited coverage of these issues. The quantitative findings were included here to provide information concerning the extent of the use of body modification procedures.

The criteria for inclusion in the larger study consisted of currently living in Bogotá, having male sexual assignment at birth, having had sex with a man in the previous six months, and being between the ages of 18 to 49. Of the total sample of 1000 participants, 58 self-identified as transgender. This group constituted the sample used for this paper. Among the 58 transgender persons, the average age was 29 years, with a range from 18 to 47 years. Participants reported that their education ranged from none to graduate degree.

Data analysis—Descriptive methods were used to analyze the data of the 58 participants. All statistical analyses were conducted using SAS 9.3.

Results

Because the quantitative data for aspects of gender affirmation and body modification were limited, results reported here are based on qualitative data sources unless otherwise noted.

Personal Motivation and Satisfaction of Gender Affirmation and Body Modification

The desire to achieve a more feminine body was a powerful force motivating participants to undergo body modification. For many individuals, the discomfort caused by the feeling of discrepancy between their external male bodies and their internal female selves began at an early age. The presence of male anatomy was a source of psychological distress for some participants.

> At eight years old, I didn't feel like a boy, instead I felt like a girl… I had terrible conflict with my masculine genitalia,… and I still struggle. I didn't learn how to clean my penis until I turned 13 or 14. For me it was a forbidden place, and I couldn't even touch it… (Mariana)

Many participants spoke of their growing acceptance of themselves over time, and with it, their increasing efforts to be feminine. Rocío described how she felt after dressing as a woman for the first time:

> I was unrecognizable when I saw myself in the mirror. Then I said, "This is what I want. I definitely do not want to be a man. I want to look more womanly." That is what I thought, and I felt good… (Rocío)

Others expressed satisfaction at receiving attention in their female identities. For example:

> I had already started to use hormones…. My sister…could not recognize me because she had never seen me as a woman. She said, "You have changed." I said, "Yes but for the better." (Mariana)

Some transgender persons described their own process as a continuum that began with changes in presentation (e.g., clothing, hair) and progressed to efforts to acquire secondary female sex characteristics. This sequence was captured by one of the participants who summarized the initial steps:

> I started my transformation. I arrived in a subtle way, started to change my way of dressing, to obtain my own identity, to dress in a polished manner, to buy good things-- women's things… My hair was very short, so I bought extensions. I looked more feminine. Then I felt that I was lacking the breasts, so I started the hormonization process… (Paola)

Many participants who used hormones reported pleasure at the physical effects. One noted: "*It enhances my skin; it hides the veins and the little hair; it helps me develop breasts." (Linda).* Another participant was gratified by the decreased erections: "*Now with the hormones, my penis does not have erections, and I think that is my appropriate behavior." (Luisa).* A third participant described her mammary gland development and increased attraction to men:

> I started feeling the desire to dress up as a woman, to put on make- up. I started feeling a sensation in my breasts. Everything itched. Later I had the desire to have sex with men, … and then I started feeling like that totally. (Rocío)

Although the goal of a strictly feminine identity was primary for many participants, others acknowledged and accepted the continued presence of both masculine and feminine attributes. A participant noted the greater importance of presenting one's authentic self:

> Projecting yourself as a woman is complicated, because you could look extremely feminine but there will always be something giving it away. It could be the Adam's apple, big hands…, even if you get your testicles and penis removed…. Therefore… it is not all about projecting external beauty; the internal beauty is what matters… (Focus Group Participant)

Other participants did not experience themselves in a transition process from masculine to feminine, but rather saw their gender identities as fluid. For example, a participant spoke of feeling comfortable with a variable androgyny:

> I transitioned between the one gender and the other: one day I was a boy, and another day I was a girl. I started to understand that in a way this is identity too. You don't have to be 100% guy or 100% girl. You can keep yourself at the border and transition between the two. (Luisa)

Social Context for Gender Affirmation and Body Modification

The process of gender affirmation for transgender persons occurs within a social context that is often rejecting, including in Colombia. In many cases, the drive for gender affirmation among our participants was so strong that it persisted even though it was met with great disapproval. Moreover, the social stigma associated with gender nonconformity sometimes triggered inner conflicts and negative feelings about the self. More than half of the participants in life-history interviews described encountering rejection from their families. Discrimination and censure from classmates and neighbors were also common. One participant told of her experiences as an adolescent, when she was aware of her transgender identity but could not accept herself:

> When I was around 12, I liked everything associated with women, dressing as a woman, dolls. I have always been like this, but I was never able to assume a feminine identity due to fear of rejection…. My mom asked me what was happening to me, and I told her I wanted to be like this. It was a difficult process because the neighbors, my cousins, and my entire family were against me… (Janet)

The conflict with families was particularly hard because of the strong emotional ties. As one participant explained:

> I have feelings that are extremely difficult to bear. You can't develop completely, due to your family and society's disapproval. Because you love your family a lot and you don't want to harm them, [it's very upsetting]. That is what happens to me now. I'm not ashamed of being a Trans person, and I'm not ashamed of being called Luisa. At the end of the day this is who I am… (Luisa)

Only one participant recounted receiving her family's full support of her transgender identity. The process was complicated, however, and caused pain to the family:

> It was very difficult when my family found out. It was very difficult for my dad…. He even fainted…, got sick, and stayed in the hospital for eight days…. Even though my old man suffered a lot…, he gave me the support that I needed in that moment. When he did…, I was able to rest. My dad cried; I felt awful but I was also felt relieved. Since that moment, I have gone to my family for support… (Linda)

Transgender participants reported much support for body modification from their peers. Four participants noted that their romantic partners encouraged them to embark on developing a more feminine presentation. Partners offered emotional and sometimes financial support, and one participant recounted: *"And he said, 'I want to see you more*

feminine.' He started buying me women's clothing, very feminine clothing, like blouses." (Carmen) The desire to please the partners was an important motivation for undergoing physical transition. One participant noted:

> I did it for vanity, but more than vanity, I did it for the love I felt for that guy. I wanted to be more of a woman for him, so that he could be with me. (Rocío)

An even more common source of encouragement for body modification was a social network of transgender persons. Most participants reported that they started using hormones and silicone with the assistance of their transgender friends, who often acted as "mentors" in the processes involved in body modification. For example, Alexandra described her initiation of hormone treatment this way:

> When I arrived in Pereira, I was staying with a transvestite, and she told me: "I want you to get prettier. If you want, you can use hormones so that your hair grows and your breasts develop." I had never seen a tranny with breasts. She was the first one… so I listened to her and started using hormones. She helped me find the hormones, and … I started developing little nipples. (Alexandra)

Similarly, decisions to get silicone injections were strongly influenced by the other transgender persons. As Mariela reported:

> They would put make-up on me. I used to watch how they used make-up, because I had never done it. Then came the silicone.… I had not put anything on my body; I was normal, as God made me. And they were telling me, "You should get this and that done. You would look pretty because you are thin." (Mariela)

Although transgender persons often served as a resource concerning the body modification, sometimes the information conveyed was inaccurate. One misconception was that hormonal treatment could lead to voice changes. A more dangerous belief was that self-administration of hormones posed no risks. For example, one participant reported:

> I think that I injected hormones three times a month. It doesn't have any dangerous effects, and the hormones keep me well… It does not affect gastritis or anything… The only thing is that it develops my feminine genes and my skin; there are no problems with the rest… (Monica)

Other participants held shared mistaken beliefs about ejaculation. As one person noted, *"You have to try not to ejaculate, because that's where the hormones' effectiveness lies, and when you ejaculate, everything comes out."* (Paola). The belief that ejaculation would result in the elimination of injected hormones through semen led some to avoid being the insertive partner. As Cristina reported:

> When one is using hormones… then one has to be the passive one [receptive partner] so that you do not ejaculate…. When I have to be the active one [insertive partner], then I just don't ejaculate. (Cristina)

Other Findings

Lack of medical supervision—To a large extent, body modification procedures among transgender women occurred outside the health care system. Hormones are freely available

in pharmacies in Colombia and other parts of Latin America, and many other substances are not regulated. As a participant noted: *"It is very common for Trans to go to the pharmacy and buy a box of whatever [without a prescription] and get it injected, and then the complications are horrendous…" (Luisa)*

Financial constraints constituted a major reason that many transgender persons self-administer treatment. Limited money also led to sporadic hormonal treatment. As one participant reported:

> This year, because of lack of money, I used hormones for only two months, about five or six months ago… Each costs 15 or 20 thousand pesos (approximately US$8-US$ 9), and I have to get a minimum of 2 or 3 for each application… (Carmen)

Services for transgender individuals are not widely available through the health care system. Indeed, one participant reported being unaware that doctors would supervise body modification. Two participants in the qualitative interviews indicated that they had consulted a health professional about feminization. Both were able to obtain care because of special circumstances. One received medical attention after unsupervised treatments led to complications:

> As a consequence of all the problems that I have, of all the things I applied to my body six years ago, the doctor told me that I needed to get a number of tests before the hormonal treatment, to see… if it is possible. (Rocío)

The other participant had been internally displaced and was therefore entitled to special insurance coverage for displaced individuals.

Quantitative findings also indicated that most injection of substances by participants hoping to achieve a more feminine appearance occurred without medical involvement. Of the 58 transgender individuals in the quantitative sample, nearly half (27 participants) had injected a filler substance in their bodies. The majority of injections had occurred in homes or beauty salons: 62% for breasts and 88% for buttocks.

Thirteen participants had received breast injections, and of these, six reported having had medical input, although only three said that they had done the procedure in a health clinic or hospital. Injections into the buttocks were more common and less likely to have been done under medical supervision. Of the 25 participants who reported having had buttocks injections, only three individuals had done so in a medical setting or with medical supervision.

The filler substances used for injections varied. For breast injections, two individuals had used cooking oil, four had used silicone, and seven used something else—most likely a mixture. The majority of injections in the buttocks were performed using silicone (21 people); two people used motor oil and two people used something else. It is likely that in many cases, the purported silicone was not medical grade.

Negative consequences of unsupervised treatment

The lack of medical care and the misconceptions within the transgender community resulted in negative consequences for some participants. Marisol reported: *"In the time of my craziness of wanting to look feminine quickly, I oversaturated my body hormonally. I used to inject hormones every four days, and because of that I had health problem." (Marisol)*

Other participants were aware that they were taking a risk, but the desire to have a more feminine body outweighed concerns about risk. After the negative consequences, there was often a sense of feeling accountable. One participant noted: *"I already made the mistake. I wanted it. I made a mistake, and that's it. I'm taking responsibility-- knowing that it can get dangerous in any moment. (Monica)*

Another participant, who also took responsibility for her treatment and its effects, thoroughly described her experience of having silicone injected in her home by a transgender peer:

> She gave me 6 bottles of it… First you need cattle needles, 16 caliber,… and they place 4 needles in each buttock. They inject the rizocaina [local anesthesia] and you wait for your butt to fall asleep. Then they insert the needles, and … they start pouring in the liquid, and they fill it, but with the needles inside. [Your butt] grows and you have to tie your waist… The first time I couldn't do it, because I got cold and scared. She used one bottle then… The second time I tied my waist, and she injected it again… two and a half bottles… It is one's own responsibility if you get it done, if you die, or stay alive… It took me fifteen days [to recover]… (Mariela)

Several participants experienced negative body changes as a result of injected silicone. One described the results:

> I committed the worst mistake of my life, which was to self-inject silicone. That completely harmed my body… I am ashamed of my body now… My skin turned black; I have hard patches. In this part of my body, I have wrinkles that look ugly… I have extra skin. (Linda)

Discussion

Colombian government policies aimed at increasing health care coverage for the general population have been instituted; however, discrepancies in care remain substantial (Comisión de Regulacion en Salud, 2012), and administrative, economic, and bureaucratic barriers to care are common (Abadia & Oviedo, 2009). Our findings suggest that in Colombia, such barriers lead to body modification procedures outside the medical system, as has been found elsewhere (e.g. Clements-Nolle et al., 2001; Garofalo et al., 2006; Rotondi et al., 2013; Sanchez et al., 2009; Xavier et al., 2007). Only two participants in the life history interviews had received medical feminization treatment, and they had specific characteristics (medical condition or status as internally displaced) that enabled them to receive care.

Personal and social factors shaped the motivation to engage in a body modification. The desire for change was often driven by the emotional distress arising from the discrepancy between sex at birth and self-perceived gender. Consistent with previous research (Morgan

& Stevens, 2012; Sevelius, 2013), findings from this study highlight the importance for transgender women in Bogotá of being affirmed in their gender identity by themselves and by others. It has been suggested that in addition to reducing emotional distress, gender affirmation procedures also result in stigma reduction by allowing transgender persons to "pass" in the general population (Sevelius, 2013). However, "passing" may not be the goal for many transgender persons.

Results of this study also indicated that social peers—be their partners or other transgender persons—constituted an important source of encouragement and acceptance. In contrast, stigma associated with gender non-conformity and rejection from family were common social challenges to gender affirmation.

Although transgender peers often encouraged body modification, the consequences of their influence were not always as positive as their intentions. Consistent with previous findings (Pitts et al., 2009; Winter & Doussantousse, 2009), results suggested that other transgender persons were often misinformed, and therefore they conveyed inaccurate information about hormone use or injections. In addition, they frequently were actively involved in the process of injecting substances in the breasts or buttocks for each other, and their mutual lack of knowledge concerning possible short- and long-term negative effects contributed to increased risk of health complications, as did the use of non-medical-grade fillers. It was also alarming that some participants were unaware of the need for medical supervision of hormone treatment or injections. Thus, in addition to barriers to medical access, lack of knowledge served to increase the potential for health problems.

Limitations of the Present Study

A limitation of this study stemmed from the relatively small sample. Findings in this study are a product of the characteristics of this particular sample of transgender women and have limited generalizability. Furthermore, the quantitative survey did not cover hormone use without medical supervision, which was a prominent topic in life history interviews. Nevertheless, the qualitative findings portrayed personal and social factors related to gender affirmation and body modification among transgender persons in Bogotá, and the quantitative findings provided some indication of the extent to which this process occurs outside of the medical system.

Implications

Public health efforts should be undertaken to implement policies to decrease barriers to care including stigma and discrimination against transgender individuals among health care providers. Stigma and discrimination inhibit transgender women from seeking medical care. In addition, previous research has shown associations between experiences of stigma and discrimination due to transgender identity with increased rates of HIV, substance use, depression, suicide attempts, barriers to employment, and barriers to health care access (De Santis, 2009; Guadamuz et al., 2011; Sugano, Nemoto, & Operario, 2006). Health care providers are often insensitive or do not have the knowledge and experience to serve the transgender population (Guadamuz et al., 2011; Sugano et al., 2006). Professional training on the health needs of transgender people and gender affirmation services could result in

better service and healthier outcomes for transgender individuals (Sanchez et al., 2009; Sevelius, 2013). The Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People provides clinical guidance with global applicability that could be a resource for service providers in Colombia (Coleman et al., 2012).

Because transgender friends and peers play an important role in encouraging and often delivering feminization procedures, interventions should follow a peer-health educator approach to train members of the transgender community (Wallace & Rasmussen, 2010). These interventions could address information concerning the dangers of self-administered treatment. Furthermore, although hormones are available without prescription in Colombia, transgender persons should be encouraged to consult health care providers so that they understand potential risks, as well as the importance of achieving and maintaining appropriate physiological levels (Meriggiola & Berra, 2013). An active campaign including such measures is needed to protect the health and well-being of transgender persons who choose to undergo body modification as an aspect of their gender affirmation.

Future studies exploring gender affirmation and body modification more fully and with larger, representative sample of transgender women is an important next step. Studies should also determine suitable intervention approaches for the transgender population in Colombia. For instance, harm reduction programs in Peru do not support the provision of clean needles to transwomen for hormone and silicone injection as a suitable program for transgender women in Peru (Silva-Santisteban et al., 2012).

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Table 1

Demographic characteristics of the focus group (n=11) and life interviews (n=14)

Name[a]	Age	Years of Education	Relationship Status	Hormonal Treatment	Silicone Injection	Oil Injection
Focus Group						
Gina	25	16	Partnered			
Noemi	28	11	Partnered			
Patricia	24	15	Partnered			
Ana	41	11	Single			
Carla	30	14	Partnered			
Maria	21	5	Partnered			
Sofia	N/R	16	Single			
Andrea	31	14	Single			
Estefania	24	12	Single			
Paula	30	13	Partnered			
Daniela	25	8	N/R			
Life Interviews						
Linda	29	5	Partnered	Yes	Yes	Yes
Rocio	30	7	Single	Yes	Yes	No
Carmen	46	5	Single	Yes	No	No
Celia	24	9	Single	Yes	No	No
Alexandra	37	8	Single	Yes	No	No
Monica	22	7	Single	Yes	Yes	No
Paola	32	11	Partnered	Yes	No	No
Mariela	27	11	Partnered	Yes	Yes	No
Marisol	33	11	Single	Yes	No	No
Janet	24	9	Partnered	Yes	Yes	No
Cristina	23	9	Partnered	Yes	No	No
Melody	33	8	Single	Yes	No	No
Mariana	35	4	Single	Yes	No	No
Luisa	30	16	Single	Yes	No	No

[a] All names in this table are fictitious

N/R Not reported