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Decision-Making at the Intersection of Risk and Pleasure: A Qualitative Inquiry with Trans Women Engaged in Sex Work in Lima, Peru

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Abstract

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Declarations

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Ethical Approval Protocols and study materials were approved by the UCLA Office for Human Research Participant Protections (IRB #13-001898), and the *Comite de Etica* of the *Asociacion Civil Impacta Salud y Educacion* (IRB #0089-2014-CE).

Consent for publication All subjects provided verbal informed consent prior to participation and were informed, as part of the consent process, that data may be used for publication. No images or personal identifiers have been included in this manuscript.

Informed Consent All subjects provided verbal informed consent prior to participation.

To inform culturally relevant HIV prevention interventions, we explore the complexity of sex work among Peruvian transgender women. In 2015, we conducted twenty in-depth interviews and demographic surveys with transgender women in Lima, Peru to examine how transgender women enact individual- and community-level resistance strategies within a context of pervasive marginalization. Although 40% self-identified as “sex workers,” 70% recently exchanged sex for money. Participants described nuanced risk–benefit analyses surrounding paid sexual encounters. Classification of clients as “risky” or “rewarding” incorporated issues of health, violence, and pleasure. Interviews highlighted context-informed decision-making (rejecting disrespectful clients, asserting condom use with specific partner types) demonstrating that motivations were not limited to HIV prevention or economic renumeration, but considered safety, health, attraction, gender validation, hygiene, and convenience. These findings underscore the complex risk assessments employed by Peruvian trans women. These individual-level decision-making and context-specific health promotion strategies represent critical frameworks for HIV prevention efforts.

Keywords

Transgender; Sex work; Peru

Introduction

Given overlapping systems of oppression and marginalization, sex work (i.e., the exchange of sex for money or goods) is commonly reported as a primary or supplementary source of income for transgender (trans) women globally [1–5]. While sex work is not inherently a risk factor for HIV, power dynamics during client interactions (manifesting as: restricted ability to control condom use or determine sex acts performed; violence or coercion related to condom use; pressure by clients to use drugs or alcohol during sex) can increase trans women’s vulnerability to HIV [2, 6]. Recognizing the disproportionate burden of HIV among trans women, estimated to be 19.1% among trans women worldwide and 27.3% among trans women who engage in sex work, attention should be paid to sex work practices in order to inform culturally-relevant HIV prevention interventions [2, 7–9].

In Peru, epidemiologic research estimates that 30% to 45% of trans women are living with HIV [10–12] compared to 0.3% of the general population [13]. Factors such as discrimination, transphobia, and extreme economic and social marginalization heighten HIV vulnerability among Peruvian trans women [14]. Most trans women in Lima (64%) report active engagement in sex work [11], and motivations for entry into sex work by trans women are diverse. Commonly, sex work is related to migration from rural provinces to larger cities of Iquitos, Lima and Callao [9]. For many, sex work is an economic necessity driven by exclusion from other forms of employment, regardless of earned degrees [15]. In some cases, trans women cite influences by community-level cultural expectations and social norms (e.g., friends encouraging entry into sex work), validation of gender identity by sexual partners, or adventure, sexual experimentation, and pleasure [15]. Literature has evidenced that sex work encounters among trans women mostly occur in public spaces (75.5%), but also in semi-public areas like beauty salons, erotic cinemas and trans sex work houses [16].

While sex work is common among trans women in Lima, scant literature has assessed how sex work influences HIV prevention practices and needs.

Despite the high prevalence of sex work and associated risks for HIV, engagement in the cascade of HIV care by trans women is suboptimal, and there are numerous gaps in testing, linkage, and retention within the health system [17]. An estimated 24–30% of trans women are aware of their HIV status [18, 19]. Structural barriers (e.g., clinic operating hours, geographical distance and transportation time to access clinics across Lima, requirements for identity documents consistent with gender), compounded by high levels of stigma and discrimination encountered in healthcare settings and associated mistrust of healthcare providers, limits the accessibility of HIV prevention services to Peruvian trans women [9, 20]. Access to condoms is limited, with condoms provided at 7.4% of sex work venues, and free of charge at only one venue [16]. Institutional uptake of biomedical prevention strategies is slow: While pre-exposure prophylaxis for HIV (PrEP) was approved by the Peruvian Ministry of Health in 2016, availability for trans women is mostly limited to research studies or demonstration projects [16, 21]. PrEP is not covered by social insurance, and the $100 USD monthly cost is prohibitive for trans women in an area where the minimum monthly wage is approximately $200 USD [22]. Further, some Peruvian trans women report other concerns including PrEP mistrust [23], HIV stigma (e.g., reluctance to carry “HIV medication”), and fear that PrEP might negatively affect medical gender affirmation (through impaired effectiveness of hormone therapy or complications with surgical procedures) [22]. Given this constellation of factors increasing HIV vulnerability for trans women sex workers, development of interventions that are tailored to the cultural context and needs of this population are imperative.

A recent modeling study suggests that the combination of culturally-tailored condom promotion efforts, mobile test and treat services, and PrEP interventions among trans women sex workers in Peru could avert 50–60% of new infections among trans women, their stable romantic partners, and their clients over the next 10 years [19]. However, to succeed in applying a combination HIV prevention approach, potential interventions must be grounded in a thorough understanding of sex work practices, community and individual sexual behaviors, and perceptions of potentially associated risks. Importantly, research among trans women who are engaged in sex work globally has underscored that sex work can present social opportunities that extend beyond economics, for example interpersonal bonding, gender affirmation, empowerment, and pleasure [2, 24–28]. Prevention interventions must consider the multidimensional needs and desires of trans women sex workers, and the diverse motives that drive decision-making, and further, must include considerations of sexual wellbeing, satisfaction, and rights.

Addressing calls to explore the role of sexual pleasure and rights [29] this paper explores social contexts and lived realities to better understand the multifaceted dimensions that influence how trans women engaged in sex work navigate HIV prevention. Utilizing qualitative interviews to learn from Peruvian trans women this paper: (i) Characterizes the sex work experiences of trans women in Peru; (ii) Describes occupational hazards associated with sex work routinely faced by trans women that increase vulnerability to personal safety and HIV; and (iii) Highlights strategies employed by trans women to manage the perceived

risks and benefits of sex work, including personal agency, use of traditional HIV prevention methods, and situation-specific risk–benefit assessments.

Methods

In May 2015, a mixed-methods formative assessment was conducted in Lima, Peru to inform a PrEP adherence intervention for trans women (TransPrEP, R34 MH105272; clinicaltrials.gov registration #NCT02710032). Data presented here are derived from formative work which consisted of individual interviews (N = 20) with trans women in Lima, Peru. All interviews were conducted by native Spanish speakers with extensive experience in qualitative research on gender, sexuality, and HIV prevention with trans women. Qualitative interviews were 30–45 min in length and were preceded by a brief pen and paper demographic survey. Interviews were conducted in sequential stages as follows: (i) interviews with trans women community leaders, selected by study staff based on the leaders' expertise and knowledge of the greater trans community, followed by (ii) interviews with trans women recruited through snowball sampling.

Recruitment and Eligibility

A purposive sampling approach was used across data collection. The study recruited 5 trans women community leaders and 15 trans women [30]. Community leaders were recruited by study staff based on findings from previous ethnographic work, who, following their own interviews, identified seed participants to recruit members of the trans community through snowball sampling. For both stages of the qualitative process, enrollment was limited to individuals who were at least 18 years old, were assigned male sex at birth, self-identified as trans women or on the trans-feminine continuum (e.g., "trans", "transgender", "travesti"), and provided verbal informed consent. Participation was not restricted according to HIV serostatus.

Data Collection

Qualitative work was conducted in stages. Stage one interviews with community leaders were utilized to gain high-level perspectives of the trans community in Lima; stage two interviews with trans women probed in-depth on the sexual and social network composition of individual participants. As formative work was designed to inform a social network-based PrEP intervention, question guides aimed to garner perspectives on topics such as social support, social network composition, the existence and structure of a trans community in Lima, sexual health, and HIV prevention. Question guides and data collection were conducted with the primary aim of informing the intervention, which has been previously presented [31]. For sexual network assessments, participants were queried on their sexual and romantic relationships. Participants were asked to identify different types of partners in within their life (i.e., romantic partners, casual partners, and paid partners). Participants who disclosed engagement in sex work were asked follow-up probes such as condom use with clients, how potential clients were selected, and sexual practices with clients.

Data Analysis

Interviews were conducted in Spanish, audio recorded, and transcribed verbatim. Transcripts remained in Spanish to retain linguistic nuances and were only translated into English for manuscript preparation. Qualitative data were analyzed using an immersion crystallization approach to identify themes and relationships between themes [32]. The analytic process was divided into multiple stages: (i) A core group of 2–3 study staff, with previous experience in qualitative analyses, independently reviewed the transcripts, interview guides, and sociodemographic surveys, and then coded each of the interviews; (ii) Initial sets of themes were independently assessed by two members of the research team who subsequently met to compare themes, discuss and reconcile any differences, and refine a set of codes and their definitions; (iii) A structured codebook was developed transforming the themes into codes; (iv) The coding scheme was applied by two members of the team with any discrepancies discussed and resolved with a third member of the qualitative analysis group [33]. All qualitative analysis was conducted using Dedoose Version 5.0.11 (Socio Cultural Research Consultants, LLC, www.dedoose.com). Descriptive analysis of demographic survey data was conducted using Stata 14.0 software (StataCorp, College Station, TX).

Human Subjects Protection

Protocols and study materials were approved by the UCLA Office for Human Research Participant Protections (IRB #13–001,898), and the *Comite de Etica* of the *Asociacion Civil Impacta Salud y Educacion* (IRB #0089–2014-CE) prior to initiating any study procedures. All subjects provided verbal informed consent prior to participation. Participants were provided 15 *Nuevos soles* (approximately $5 USD) as compensation for transportation costs associated with study participation.

Results

Results presented below are derived from in-depth qualitative interviews with 20 trans women aged 21–42 years (mean 29.8 years). Two participants (10%) completed primary school, with the remaining 18 participants (90%) having completed secondary school. All participants describe their gender identity as trans, transgender woman, or *travesti*. (Table 1). Self-reported occupations are noted in parentheses.

Description of emergent thematic analysis below are reported in three interrelated themes: (i) Engagement with sex work; (ii) Occupational hazards; and (iii) The role of personal agency and decision-making in sex work. As a transversal link across the three emergent themes, this analysis highlights the role of social dimensions of sexual health decision-making and potentially associated HIV vulnerabilities.

Engagement with Sex Work

Although 40% of participants (n = 8) self-identified as a “sex worker” in the demographic survey (Table 1), 70% of participants in qualitative interviews (n = 14) described recently exchanging sex for money. Participants described the perception that sex work is ubiquitous

amongst trans women and is a lived reality in their community where, "*almost 90% of trans women are sex workers."* (*Interview 12*) Interviews highlighted nuanced and diverse experiences related to sex work and associated practices; while some trans women identified sex work as their primary occupation, others described sex work practices as supplemental to their primary income as hair stylists, peer-health promoters, or other occupations. Participants actively sought clients through street-, venue-, or internet-based self-promotion, and also received unsolicited propositions from prospective clients encountered on the internet (e.g., through a personal Facebook page) or during their daily routines.

Transactions with clients ranged from one-time anonymous interactions to regular, long-term relationships with steady clients. In addition to paid relationships, participants described relationships with unpaid romantic partners (e.g., boyfriends). At least two participants described relationships with a primary romantic partner that began as a client relationship: *"Well I met him because he was my client … one day he told me that he liked me, that he wanted to be with me, that he wanted to live with me, that he was living alone, and then I told him yes. And here we are." (Interview 13, Age 27, Sex Worker)* Multiple participants described forming trusting bonds with clients over the course of years, and transitioning their relationship from strictly business to one of friendship or partnership.

Occupational Context and Associated Hazards

Interviews highlighted occupational hazards which were faced routinely during sex work including violence, police surveillance and harassment, use of drugs and alcohol, and/or exposure to infectious diseases. To mitigate these potential risks, participants reported employing various sexual health promotion strategies during client interactions. For example, some participants described the use of the internet to identify clients and avoid the vulnerabilities associated with being on the street. "*Yes of course, [there is a lot of sex work]* via *the internet, because now the situation is very difficult, there are a lot of serenazgo [private police forces], the police detain us, one has to keep going, they have even detained me for defending myself." (Interview #20, Age 40, Administrator)* Meeting clients on the street heightened visibility and exposure to police; conversely, meeting clients online allowed trans women to maintain privacy and to be physically located within the setting of their choosing, providing the opportunity to vet potential clients through conversation and negotiate terms prior to meeting.

Exposure to drugs and alcohol is common; participants reported that clients often drink or take drugs in their presence, and may request that participants join them. While one participant reported consuming drugs or alcohol for an additional price, others noted that they consistently refused, or drew strict limits. For example, one participant *(Interview #16, Age 23, Sex worker)* noted that she refuses drugs but will consume a glass of wine with a client. Willingness to endure intoxicated clients varied between participants, and was influenced by perceptions of client behavior, for example, if clients are likely to become abusive when intoxicated. One participant described a trusting friendship with a regular client: *"He is a normal boy, he knows how to behave." (Interview 11, Age 29, Health promoter)* Given their established mutual trust, the participant felt unconcerned when

approached for sex despite the fact that her client was intoxicated, and felt safe engaging with him.

The Role of Personal Agency and Decision-Making in Sex Work

Interviews highlighted numerous strategies leveraged by trans women, such as carefully selecting clients, deciding when to use condoms, and asserting which sexual acts they are willing to engage in, to navigate occupational hazards and mitigate potential sexual health risks. Furthermore, such strategies were often utilized regardless of financial benefit as participants described various instances when they declined offers for further compensation when it conflicted with their standards or desires.

Participants described condom use negotiations with clients and elaborated on factors that weighed into their decision-making process. Over half of participants interviewed stated that they unequivocally demanded condom use at all times: "*Of course, with clients, I use a condom. People have touched me [that I didn't want] but I told them no, I didn't give it to them. They leave. They're crazy. Go, if you want to, I tell them. [Even if they offer more money] I don't want to, I won't do it." (Interview #13, Age 27, Sex Worker)* Importantly, multiple participants described declining offers of additional compensation for condomless sex, signaling that economics are not the exclusive drivers of decision-making.

Interviews showcased how the type of sexual acts engaged in with clients (i.e., receptive and/or insertive anal sex, oral sex, etc.) factor into the decision about whether or not to use condoms. While some describe consistent condom use, even during oral sex, many describe using condoms for anal sex only.

Condom use is often negotiated with new clients prior to initiating an encounter, a practice that is particularly common with clients met online or over the phone.

> Some people say 'I'll give you something more [to have sex] without a condom.' I tell them 'But I do not know you,' [and they reply] 'No, but I'm very well, I'm very healthy.' [I tell them] 'Ah, it's your word against mine, I know what I have and I know that I'm healthy, but I do not know about you, [I don't know] about your sexual past.' I go through the trouble of explaining that to them. Sometimes they resent me and they hang up the phone and [I say] 'Ok then, bye.' (Interview #17, Age 38, Taxi Driver)

Others describe that the decision to use condoms is made on an individual basis according to their assessment of the potential "riskiness" of a client, and commonly cite participant age as an important factor in this assessment. In some cases, older clients are perceived to be lower risk, for example:

> No, with him I don't use a condom, but with the rest of the people that I encounter, I do. Since he's old, as they say, who is going to pay attention to him now? A person of his age should already know the risks that he has. (Interview #1, Age 21, Sex Worker)

In other cases, younger and more attractive clients may be perceived as more desirable and worth the potential risks of condomless sex, regardless of compensation:

> In some cases, the clients that they see are handsome, they have a good body, and even though [these clients] pay them little, [the women] do not take care of themselves in that moment. When the clients are of older age, that's when the girls use a lot of condoms, but when the girls see that the boy is young, handsome, has a good body, has a car, regardless if he pays her less, that is the reality; based on their beauty, they pay little and [the women] have sex with them without a condom. (Interview #3, Age 35, Sex Worker)

As observed by a community leader, this behavior implies that trans women have more to gain from select partners of their choosing, and that forces such as attraction, pleasure, or social status may influence decisions about how and with whom to practice sex work.

Participants cited two primary motivations for condom use, specifically exposure to infectious diseases, and personal hygiene. *"I tell him 'put on a condom' and he puts it on himself. [I do this] to take care of myself, infectious diseases are the norm." (Interview #1, Age 21, Sex Worker)* One community leader observed a common practice among trans women to use condoms when they assume the insertive role during intercourse, but not for receptive sex with sex work clients. She notes that their motivation is primarily due to hygiene concerns.

> When [the trans women] are in the insertive position, they often use condoms. It's a good method of protection, they use a condom because they do not want to get [feces] on themselves when they penetrate a client, because this is what they are disgusted by. But when they are going to be receptive, that is, when the client is going to penetrate them, they do not use a condom. (Interview #3, Age 35, Sex Worker)

The same decision-making process is employed by many trans women when selecting clients. Factors such as age, personality, and manner of soliciting sex weigh heavily into this decision. Participants recounted the practice of assessing a potential client's demeanor (e.g., perceived mental stability and respectfulness). One participant noted that, upon meeting a potential client online, she spoke with him and decided to exchange numbers because he seemed to be "*more or less stable*", and then met with him in person to further observe his personality and behavior: *"I went to get to know him better, to see what his manner of being is like, and he behaved like a gentleman and he treated me like a lady. He did not behave like a jerk, and he respected me." (Interview #1, Age 21, Sex Worker)* The same participant later elaborated that she often selects older clients due to their perceived maturity.

> Well, I do not go out much with chibolos [young kids], I do not like the kids, in my opinion they are indecisive, they are not prepared mentally…normally when I know people are older, I like it. I like people from 40 up, I like older people with experience. They already have their thoughts and ideas well put on the ground and furthermore, from an older person you always learn something. (Interview #1, Age 21, Sex Worker)

Multiple participants reported receiving frequent, unsolicited advances from would-be clients via their personal phone number or Facebook page:

> There are people who do offer you [money online]. [They say] 'I see your photos, you're cute, what a good ass, good tits.' Oh yes, thank you…I try to be as well-mannered as possible and then, I cut them, I block some of them, I eliminate them and that's it. (Interview #4, Age 25, Cosmetologist)

The same participant described receiving unsolicited requests throughout her daily routines and while at work in a beauty salon:

> No, I do not usually accept them, I say no. Because I'm not always alone [in the salon], but there are always those who don't care that there are other people around, and he comes and asks you 'How much do you charge me for…I want this…' or like they say vulgarly 'I want to put my penis in you' or 'I want this, I want to make love to you' and all that. [I say] No, my love, this is a salon, not a brothel, you can leave. There is no shortage of this kind of person who asks you directly, right? (Interview #4, Age 25, Cosmetologist)

Participants also described negotiating sexual roles with clients prior to initiating their interaction, discussing which acts they are willing to perform and which are off-limits. Several participants noted that some clients request receptive anal sex, and while some consider this role to be acceptable, others unequivocally decline to perform insertive sex, regardless of the money.

> I have had clients [who ask me to penetrate them] but I tell them no, I won't do it. I do not do that kind of work … I do not like it, I do not want to, it doesn't come naturally to me.(Interview #6, Age 32, Sex Worker)

Our data revealed the complexity of sex not only related to erotic acts but how these behaviors were impacted by geographic location, economics, and physical attraction. For example, participants described varying motivations for willingness to perform a variety of sexual acts (oral sex, receptive sex, insertive sex) but valued different acts, or for performing them in different locations (i.e., in the street, at a hotel, or at their place of residence) differently. One participant noted that her hourly rate hour includes oral and penetrative sex (insertive and/or receptive), but kisses or hugs are not included. Additional sexual acts may be negotiated for a price.

> The price includes everything [penetrative or oral sex], but if they ask me for additional things, I'll rim them, I'll dance with them, I'll consume whatever they are consuming, but I'll charge them more…some customers want to suck me, everything … (Interview #11, Age 29, Health Promoter)

Another participant similarly described being asked to show her penis to clients, but she insisted that this would cost extra, with payment up front.

> I ask them 'what do you want, my love' and they say, 'take it out, I want to see it.' 'Ok, but that costs extra' 'and how much will you charge me? 'You pay me first and in the room I will let you see.' (Interview #14, Age 30, Sex Worker)

As with client selection or condom use negotiations, participants displayed a willingness to lower their price for clients who they perceived to be younger and more attractive.

> A young man, probably in his twenties, approached and he asked me 'how much do you charge?' [And I said] '20, 50 full. 'And how is that?' 'Oh love, it's with chupadita [blow job], blow job is full service' and he said 'but I like to be sucked without a condom.' The boy was handsome, a handsome dark guy, so I looked at him and I asked, 'but are you going to pay the price?' and he said "'No, I do not have that.' 'And how much do you have?' 'Here, I have 20 but I want full service.' 'Not even 30?' 'No, I really have 20.' And then, I gave him a blow job. He was handsome, and so, I accepted. (Interview #14, Age 30, Sex worker)

The rationale behind reducing prices, modifying which services are offered, and agreeing to forgo condoms with select clients further supports the perception that finance is not the only driver of decision making and highlights that attraction to clients is something both considered and valued by trans women when negotiating boundaries and sex work interactions.

Discussion

Our findings highlight the complexity of sexual health risk assessments employed by Peruvian trans women who engage in sex work as they navigate the intersections between economic income, danger (e.g., physical violence, arrest and police harassment), and pleasure. Participants underscored that the boundaries drawn with clients and the decisions to mandate behaviors such as condom use and other sexual health strategies are shaped by diverse needs and desires. Jointly, these findings suggest the need to conceptualize sex work not only as a potential source of HIV vulnerability but also as an occupation where desire and pleasure can both support and detract from STI prevention strategies. Recognition of the social realities of sex work yields a tremendous opportunity for public health researchers to learn from the expertise of trans women and how they navigate personal safety and potential sexual risk-reduction with the sometimes competing values of sexual desire, gender affirmation, and economic need. A critical challenge for the development of combination prevention interventions will be to understand how trans women employ these existing decision-making matrices to support context-specific HIV prevention.

These interviews underscore the importance of personal agency related to when, how, and with whom trans women practice sex work. These choices are driven by diverse socioeconomic factors, including sexual health, evasion of violence, financial compensation, gender affirmation, attraction, romantic pleasure, sexual excitement, practical convenience, and others. Importantly, these decisions are not primarily driven by concerns about HIV. For example, the choice to use condoms during insertive but not receptive anal sex can be driven by concerns about personal hygiene. Likewise, perceptions of risk and desirability, and associated decisions to manage potential risk, are informed by the greater occupational contexts in which they occur. While HIV is one of many realities faced by trans women in their daily lives and occupations, physical, structural, and symbolic violence against trans women are also well documented in Lima [9]. This finding is not unique, but mirrors the contextual experiences of trans women sex workers in other regional settings where

pervasive stigma, discrimination, and violence are a daily reality [34]. For example, many of our participants voiced that their concerns about personal safety or violence outweighed concerns about HIV such that they prioritized clients perceived to be safe, respectful, or affirming, even if those clients refused condom use. For others, sexual pleasure or romantic commitment may outweigh health concerns and lead to the temporary suspension of personal sexual health promotion strategies.

These heterogenous examples of engagement in sex work illustrate the care, complexity, and savvy of trans women's evaluation of client characteristics and assessment of whether a client is likely to present potential hazards to their sexual health and safety. Some trans women reported dedicating more time to speaking with and learning about new clients, while others make rapid assessments based on momentary interactions and/or the need to conduct sexual transactions in potentially hazardous public spaces. Factors like client age, appearance, demeanor, coupled with the method of encountering the client (and whether the client is known) weigh heavily into these assessments. For example, in interviews where HIV was described as the driving concern, an older client was frequently perceived to be of lower potential risk based on the assumption that he has fewer partners and is more likely to be aware of his HIV status. Importantly – client characteristics that trans women associate with risk are highly individualized; While some are more willing to practice condomless sex with older men who they perceive to be lower risk, others are more willing to vary their practices (i.e., to accept less money, or to have condomless sex) with younger, more attractive clients. This decision-making process has important implications for the design and implementation of prevention interventions that recognize the motivations, risks, and benefits of sex work for trans women. These findings urge HIV prevention interventions to not only consider the complex set of priorities influencing the sex work practices of trans women, but to learn from trans women's perceptions of risk, pleasure, and desire in sex work in order to tailor health promotion efforts accordingly. Interventions must not narrowly focus on condom-negotiation strategies but should also meaningfully engage trans women in a dialogue about their shifting perceptions of risk, pleasure, desire, and work, and how to prioritize sexual health concerns as a part of their contact-specific risk–benefit calculations.

At the same time, we acknowledge the impact of structural issues of economic marginalization and housing instability on the willingness or ability of trans women to mitigate behaviors associated with HIV risk, and the ability to reject or enforce boundaries with clients. While previous scholarship has highlighted the role of systemic oppression and the lack of economic opportunity framing sex work, recent studies also emphasize the importance of agency and empowerment [9]. Employment discrimination among trans women (particularly those living with HIV) is well documented. For some, the practice of sex work is not a choice, but an economic necessity that at least 40% of trans women sex workers have tried (and failed) to leave behind [9, 35]. In this context, agency may be linked to feelings of insecurity given the realities of precarious employment, pervasive violence, and limited access to healthcare that affect the daily lives of Peruvian transgender women [9]. The ability to employ certain sexual health promotion strategies is also dependent upon on access to institutional resources. For example, use of the internet to meet and schedule clients to avoid vulnerabilities associated with street-based sex work depends on access to the internet and a computer or smartphone. Structural factors may also foster a greater sense

of agency among trans women; for example, those who are willing to turn down clients may have more stable housing and a social support network, or primary employment in another profession (i.e., taxi driver, health promoter, hairdresser) that enables them to prioritize non-economic factors in their sex work calculus.

Findings presented here build on the growing scholarship evidencing the importance of recognizing pleasure, resistance, and bodily autonomy enacted within and through sex work (or sex work adjacent) relationships among trans sex workers globally [25, 26, 36, 37]. Acknowledging these forces while respecting the sexual rights and choice of trans women is key to effective HIV prevention efforts. As noted by Barrington et al., in a study of trans women in San Salvador, where over 80% of trans women reported engagement with HIV educational interventions, simply reaching trans women through prevention interventions is often insufficient for achieving real world impact [38]. These findings seek to address this gap by emphasizing that pleasure, while frequently omitted in health promotion, is one of many drivers of sexual decision-making. Implementation and real-world acceptability of HIV prevention strategies that target trans women who engage in sex work require recognition that interactions with clients may offer positive benefits to trans women (for example, through gender affirmation, safety from violence, and sexual pleasure). Building on existing global literature [25, 26], we feel this paper contributes insight into the nuanced priorities and diversity of desires felt by trans women when selecting clients and making decisions about their bodies, and points to specific areas to address in future research on HIV prevention with this community.

Our data is aligned with scholarship calling for diverse definitions of gender, sex, and agency that accurately address lived experiences of sex work, including casual, intermittent, and primary practices of sex work among trans women [9]. Not all trans women in our sample who reported exchanging sex for money identified as a “sex worker”, and multiple women reported that potential clients sent them unsolicited requests for sexual services online, while at their job, or during their daily routine. Beyond the cultural and psychological significance of this behavior (i.e., the inability to merely exist in one’s identity as a trans woman without receiving unsolicited monetary offers from would-be clients), there are public health implications of this highly stigmatized occupation. Studies or interventions designed to primarily reach trans women who are actively seeking clients may underestimate the potential impact of *clients* who are actively seeking *trans women*. Likewise, prevention services and service delivery models must be tailored to the unique practices of trans women engaging in sex work (e.g., motivations for entering sex work, methods of encountering clients). Findings from Guatemala City highlight differences in demographics (socioeconomic status, education level) and HIV vulnerability (number of clients, compensation, concurrent partners) among trans women reached via RDS methods through NGOs and social networks versus time location sampling at sex work hotspots, such as saunas [39]. A multitude of sexual health promotion strategies must be deployed to effectively reach trans women who might benefit from HIV prevention tools, as well as their sexual partners and clients, and to integrate these tools into their existing sex work.

Limitations

Our findings have several limitations that need to be considered in relation to the associated implications. As in any qualitative study, our sample reflects individuals from a specific social and geographic context and may not be applicable to other trans women communities. Although the interviewers in our study have extensive experience in working with HIV and STI prevention with trans women in Peru, both interviewers were cisgender and may have affected participants' willingness to discuss private issues of gender and sexuality.

Conclusion

Peruvian trans women who engage in sex work use complex matrices of factors to make decisions and enforce boundaries with clients that seek to promote their sexual health, optimize pleasure, and maximize financial gain. While HIV acquisition is a consideration in these decisions, it is only one of many contextual realities that drive choices related to sex work practices. Perceptions of client desirability, sexual pleasure, and affirmation of gender identity are balanced by considerations of financial gain, disease transmission, and potential violence. How these characteristics are read, interpreted, and acted upon is highly variable and a client that one trans woman may reject might be another's ideal. Effective HIV prevention strategies must leverage a sex positive approach recognizing the power of pleasure, learn from the intricacies of risk assessment practices, and acknowledge the agency of trans women in defining their lives. HIV prevention delivery models must be inclusive of the diverse definitions and lived experiences of trans women and develop context-specific interventions that can adequately address the pleasures and potentially associated risk of sex work.

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Table 1

Participant demographics (N = 20)

	Mean
Age	29.75
	N (%)
Highest education level attained	
Completed primary school	2 (10)
Completed secondary school	18 (90)
Sexual orientation	
Trans	13 (65)
Straight/Heterosexual	6 (30)
Gay/Homosexual	1 (5)
Occupation	
Sex worker	8 (40)
Student	2 (10)
Cosmetician/Hairdresser	3 (15)
Peer health promoter	2 (10)
Other	5 (25)