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Lost in Transition:

Transgender People, Rights and HIV Vulnerability in the Asia-Pacific Region



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Lost in Transition: Transgender People, Rights and HIV Vulnerability in the Asia-Pacific Region

Sam Winter
May 2012



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“ We see a pattern of violence and discrimination directed at people just because they are gay, lesbian, bisexual or transgender. There is widespread bias at jobs, schools and hospitals, and appalling violent attacks, including sexual assault. People have been imprisoned, tortured, even killed. This is a monumental tragedy for those affected – and a stain on our collective conscience. It is also a violation of international law.”

Ban Ki-Moon

United Nations Secretary General

Geneva, 7 March 2012

“ We have to confront head on the social, sexual and gender norms which drive vulnerability to HIV. [Including] discrimination against homosexual and transgender people, and in many places the criminalization of their sexual behaviour”

Helen Clark

UNDP Administrator

New York, 8 June 2011

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The 'Lost in Transition: Transgender People, Rights and HIV Vulnerability in the Asia-Pacific Region' report aims to provide a research and strategic information framework. It will guide governments, civil society, donors and key stakeholders to design and produce relevant research as part of collective effort to reduce the extreme vulnerability of transgender people to HIV, while protecting their rights in the Asia-Pacific Region.

The conceptualization and development process underlying this report arose out of two meetings: the *Asia Pacific Regional Dialogue of the Global Commission on HIV and the Law* held on 17 February 2011 in Bangkok, Thailand and the *Men Who Have Sex With Men and Transgender Populations Multi-City HIV Initiative Regional Action Planning Meeting* held on 6-9 December 2010 in Hong Kong. During both meetings transgender participants called for increased targeted research relating to transgender persons, human rights and access to health services.

Findings and recommendations from this report support the UNESCAP *Resolution 67/9 Asia-Pacific regional review of the progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS* which "noted with concern the continuing barriers to access to HIV prevention, treatment, care and support faced by key affected populations particularly sex workers, injecting drug users, men who have sex with men and transgender populations."

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/ Acronyms and abbreviations

AAI	AIDS Accountability International
ACJ	Advisory Council of Jurists
AHRC	Australian Human Rights Commission
AIDS	Acquired Immuno-Deficiency Syndrome
amFAR	Foundation for AIDS Research (previously American Foundation for AIDS Research)
APA	American Psychiatric Association
APCOM	Asia Pacific Coalition on Male Sexual Health
APNSW	Asia Pacific Network of Sex Workers
APTN	Asia Pacific Transgender Network
ARROW	Asian-Pacific Resource and Research Centre for Women
CBO	community-based organization (here including non-registered networks and groups, as well as more formal and/or funded organizations)
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CETH	Centre of Excellence in Transgender Health
CONGENID	International Congress on Gender Identity and Human Rights (The 'Barcelona' Conference)
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
DSM	Diagnostic and Statistical Manual of Mental Disorders
EQUINET	European Network of Equality Bodies
FSW	female sex worker(s)
GATE	Global Action for Trans*-Equality
GID	Gender Identity Disorder
HIVOS	Humanist Institute for Development Cooperation
HIV-PJA	Human Immuno-Deficiency Virus - Prevention Justice Alliance
HRW	Human Rights Watch
HSV2	Herpes Simplex Virus 2
IAVI	International AIDS Vaccine Initiative
ICAAP	International Conference on AIDS in Asia and the Pacific
ICCPR	International Covenant on Civil and Political Rights
ICD	International Statistical Classification of Diseases and Related Health Problems
ICESCR	International Covenant on Economic Social and Cultural Rights
ICJ	International Commission of Jurists
ICPD	International Conference on Population and Development
ILGA	International Lesbian, Gay, Bisexual, Transgender and Intersex Association
ILO	International Labour Organization
INPUD	International Network of People who Use Drugs
IOM	Institute of Medicine
LGBT	lesbian, gay, bisexual and transgender
MSM	men who have sex with men
MSW	male sex worker(s)
MSMGF	Global Forum on MSM and HIV
NGO	non-governmental organization
NSWP	Global Network of Sex Work Projects
NZHRC	New Zealand Human Rights Commission

PUCL-Karnataka	People's Union for Civil Liberties - Karnataka
RAI	receptive anal intercourse
Schorer	The Netherlands Institute for Homosexuality, Health and Well-Being
SOC	formerly (in version 6) the Harry Benjamin International Gender Dysphoria Association Standards of Care for Gender Identity Disorders. Currently (in version 7) the WPATH Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People
STI	sexually transmitted infection
STRAP	Society of Transsexual Women of the Philippines
TREAT-ASIA	Therapeutics Research, Education and AIDS Training in Asia
THAA	Thamil Nadu Aravanigal Association
TMSM	trans* men who have sex with men
TSW	transgender sex worker(s)
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
URAI	unprotected receptive anal intercourse
USAID	United States Agency for International Development
WHO	World Health Organization
WPATH	World Professional Association for Transgender Health

/ Executive summary

The Asia-Pacific region is home to a large number of trans* people; individuals whose gender identity, and/or expression of their gender, differs from social norms related to their gender of birth.¹ Across the region it can be speculated that there are possibly 9-9.5 million trans* people, though existing research is scattered and small-scale, and is largely limited to trans* women.² Asia-Pacific research, again scattered and small-scale, indicates alarming numbers of trans* women are HIV positive, with prevalence rates as high as 49 percent. There appear to be no data at all on HIV rates among trans* men, an emerging identity group. The number of trans* people of either gender who have died of AIDS, or what proportion they represent of overall AIDS-related deaths, is unknown.

The regional HIV epidemic among trans* people is strongly linked to stigma and prejudice. This review, focusing on the literature post-2000, seeks to examine literature on laws, regulations, policies and practices that prompt, reinforce, reflect or express stigma and prejudice towards trans* people. It seeks to identify vulnerabilities to HIV and barriers to access or uptake of HIV related healthcare services, and attempts to establish a research agenda aimed at providing the sort of data that will enable a reduction in future risk, as well as better access to treatment, care and support for trans* people living with HIV.

Research on Asia-Pacific trans* people, scattered and often small-scale, has tended to focus on young and urban communities of trans* women, and has neglected the elderly and rural, as well as trans* men.³ That said, the research indicates that stigma and prejudice are major problems for trans* people, and are rooted in a range of beliefs (either traditional or modern, depending on the culture concerned) about sexuality and gender norms and nonconformity. The stigma and prejudice appear to put large numbers of trans* people onto a slope (a 'stigma-sickness slope'), prompting patterns of discrimination, harassment and abuse (verbal, sexual and physical) in the family, at school, in the workplace, in the provision of services (including health) and in society more broadly (including in the law and law enforcement). Trans* people commonly report dropping out of or being excluded from education, and experiencing difficulty in finding, keeping and advancing in employment. Trans* people become marginalized, both socially and economically. Asia-Pacific legal environments serve to marginalize trans* people further, failing to offer trans* people sufficient protection against discrimination (or indeed against the more serious forms of sexual assault), and discriminating by withholding either practical or legal recognition of self-affirmed gender, criminalising trans* people's sexual or gendered behaviours, and subjecting trans* people to gender-inappropriate detention or incarceration practices, as well as contributing to police abuses.

There is good reason to believe, in the absence of much Asia-Pacific research in this area,

- 1 Following the practice of organizations such as GATE (Global Action for Trans*-Equality) the term trans* people is used as an open-ended social umbrella term, rather than a descriptor of a specific identity or cultural classification, acknowledging the wide range of identities, and identity-based communities, within this population and across the Asia-Pacific region.
- 2 Based upon 2010 UN population data for the region, and an estimate that 0.3 percent region wide may fall within the definition for being transgender. See main body of report for more detail.
- 3 Trans* women here are birth-assigned males identifying and/or presenting as female, or (in those cultures in which it is accepted that there are more than two genders) as members of another broadly feminised gender. Trans* men are birth-assigned females identifying and/or presenting as male or as another broadly masculinised gender.

that these experiences can damage trans* people's psychological and emotional well-being, conspiring with other factors such as poverty to tilt them into life situations and patterns of behaviour that put them at risk of HIV (as well as risk of other threats to their physical health and well-being). Unsafe sexual practices and engagement in sex work appear common among communities of trans* women.

It is known that Asia-Pacific trans* women commonly engage in unprotected receptive anal intercourse (URAI), but we know little about any safer sex behaviours (other than condom use) in which they engage (either in or out of sex work). Although many trans* women in the region appear quite badly informed about HIV risks, it is clear that many of those who are well-informed nevertheless engage in unsafe sexual practices. There is little research to indicate why. The lack of information on these matters mirrors more general (and global) ignorance on risks associated with neo-vaginal intercourse and lubricants (especially those that are not water-based and developed for lubrication during sex), and of how trans* women's use of cross-sex hormones, hormone blockers and silicon injections, or their cis-male partners' use of penile implants and drugs for erectile dysfunction might raise trans* people's HIV vulnerability.⁴

Across much of the Asia-Pacific region, many trans* women engage in sex work at some point in their lives. It is likely trans* men also do sex work, providing services as female sex workers (FSWs) or as male sex workers (MSWs). In each case (trans* women and trans* men) the numbers of trans* sex workers (TSWs) remain uncertain. It is highly likely that sex work raises their HIV risk, though little work has been done in this area, especially to examine the ways in which different reasons for and patterns of sex work might contribute to risk.

Across the region, there are numerous reports documenting problems in healthcare for trans* women - whether for general, transition or sexual health. The challenges facing trans* men remain severely under-researched. Trans* people approaching health services commonly report that providers are uncooperative or hostile with staff addressing or responding to the trans* person in a gender inappropriate way, adopting a mocking or ridiculing attitude, withholding or refusing healthcare, or even offering 'reparative' treatments. Providers may lack competence in regard to trans* health care. Services are often difficult to access or costly. Costs, especially in regard to transition healthcare, serve to push trans* people towards sex work. Trans* people often seek out whatever health services there may be, relying on word-of-mouth recommendations. They pay for whatever transition they can afford; gender affirming surgeries, implants and/or high-quality silicone injections (for those trans* people that have the money), or (traditional or backyard) castration and/or industrial quality silicone from medically unqualified 'fillers' and 'pumpers' (for those on a budget). Some take care of their own healthcare needs as best they can (e.g. getting hormones wherever and whenever they can and taking them with little or no medical supervision). Those who seek gender affirming surgeries find that they are likely to be the most expensive procedures they ever undergo. Requirements for psychiatric evaluation before provision of hormones and/or surgery may add to the expense. Public subsidies for gender affirming surgeries are rare. In many countries transition-related surgeries (especially gonado-genital) are simply unavailable or else are prohibitively expensive. For some communities castration has proved to be

4 Cisgender people identify and present in a way that is congruent with their birth-assigned sex. Cis-male refers to birth-assigned male who identifies and presents as male.

a much cheaper, and more easily available, route to feminisation (or more precisely, emasculation).

Trans* people often find that sexual healthcare services are not suited to their needs, focused instead on female and (more recently) on gay men and other MSM. The challenges facing trans* men again remain severely under-researched. Trans* women are likely to be denied women's services, and even turned away from MSM services. Confidentiality is not always assured, especially in regard to mandatory HIV testing for sex workers. HIV positivity often compounds the problems in accessing appropriate care. Trans* women (perhaps especially TSWs where sex work is stigmatized or illegal) are often reluctant to seek sexual healthcare services, unless and until they experience a symptomatic sexually transmitted infection (STI). Across the region, few trans* people step forward for HIV testing.

The failure to address trans* people's sexual health needs is to some extent symptomatic of a more general failure extending across the broader sexual minority spectrum. However, it is also clear that throughout much of the history of the global HIV response, trans* people have been invisibilised; in that they have seldom been properly recognised as a distinct population for purposes of confronting the HIV pandemic. Trans* women attracted to males have often been subsumed, researched and reported as MSM, or as a subpopulation within that behavioural group. The portrayal of these persons as MSM is often in direct conflict with their own identities as female or third gender. It undermines their frequently voiced claims to be treated as female. It often conflicts with the identities of their partners as heterosexual, or 'real men'. Trans* men again have been completely left out of any kind of reporting; even trans* men who have sex with men (TMSM), a group which (ironically, and unlike trans* women) are best thought of as a sub-group of MSM.

To some extent NGOs and CBOs have in recent years stepped in to provide sexual health services. However many in trans* communities region-wide remain out of the reach of these services, and their work of these organizations has sometimes been hindered through actions of police and officials who harass both the providers and recipients of these services, detaining outreach workers, confiscating materials, and raiding offices and events.

There is an increasing tendency for trans* people to be seen as communities distinct from MSM. The increasing ability of Asia-Pacific trans* communities, especially trans* feminine communities, to organise themselves for advocacy can only help this process along. In this regard trans* men lag behind their female counterparts.

A research agenda is proposed that can facilitate reduction in future HIV risk for trans* people, as well as promoting better access to treatment, care and support for transgender persons living with HIV in the Asia-Pacific region. Donors may want to bear this agenda in mind when making funds available for research, or assessing individual research proposals. Recommendations are that:

1. Researchers (particularly those involved in HIV-related health and rights research) should work to end the invisibility of trans* people, researching them in their own right and, when necessary, disaggregating them from other groups in a research study. This will enable the building of a data base on trans* people's HIV vulnerabilities

and healthcare needs. Research should seek to recognise diversity within trans* communities, and the existence of hitherto under-researched communities of trans* people; in particular the elderly and rural, as well as trans* men, about whose life circumstances and needs little is known.

2. Researchers should avoid letting cisgenderism (a way of thinking that demeans trans* people and privileges those who are not transgender) enter their research work, and note it in other's research, bearing in mind that such practices can reinforce stigma and prejudice, and undermine trans* people's claims for gender rights.
3. Researchers should engage with trans* people as partners, involving them as key members of research teams, paid on an equal-pay-for-equal-work basis alongside their cisgender colleagues. This helps avoid cisgenderism, facilitates more informed and sensitive research, and helps build researcher capacity. Research capacity can also be enhanced by improved access to international research (translated and summarised where necessary).
4. Research is needed that attempts to ascertain or estimate how many trans* people there are across the region, including elderly and rural trans* people, trans* men, and trans* sex workers (male and female). With good population data for trans* people (including for TSWs), and good HIV prevalence data, it should be easier to plan targeted health services, including HIV prevention programmes.
5. Research (especially multidisciplinary) is needed which seeks to understand the HIV vulnerabilities of trans* people, especially key populations like trans* sex workers, the young, the elderly, and the rural. Trans* men, hitherto little studied, are another key population. Among potentially important research studies are those which throw more light on patterns of sexual behaviour, and some of the ways in which those patterns of behaviour may impact on HIV risk. Another important initiative would be a central data base documenting rights violations against trans* people, as well as research which aims to understand more fully the nature of life on the stigma-sickness slope. Multi-disciplinary, comprehensive, large-scale and longitudinal research may be particularly valuable, enabling a more thorough assessment of the effects of stigma, discrimination, harassment, abuse and marginalization upon trans* people's lives, and making possible an examination of the impact of *changes* in laws and law enforcement.
6. Research is needed that goes beyond risk factors for trans* people and looks instead at protective factors and personal qualities conferring upon trans* people resilience against the effects of stigma and prejudice, discrimination, harassment and abuse, and consequent marginalization. Research of this sort may facilitate the development of programmes that help trans* people avoid slipping down the stigma-sickness slope, as well as countering a view of trans* people as passive victims.
7. Research is needed that examines ways to make trans* CBOs and relevant NGOs more effective in work by and for trans* people. Local, national and regional organizations already serving the trans* communities should be mapped, perhaps building on earlier initiatives. A comprehensive mapping will identify service gaps, and provide a basis for recommendations aimed at extending services, and evaluating improvements in service provision. There is a particular need for research, perhaps

longitudinal, examining ways in which the effectiveness of CBOs may be enhanced so as better to meet local needs, including those of underserved populations such as rural communities, elderly trans* people, and trans* men, as well as trans* people in migrant and ethnic/cultural/religious minority groups. While it is difficult to generalise, it is likely that those needs will include any or all of following four key components, as per the remaining four recommendations.

8. There is a need to document information about innovative and good practice in regard to efforts to help the public (and key social agents such as police, judiciary, health workers, teachers, and various media etc) become better informed regarding trans* people, and more sensitive to their needs. Such research, properly disseminated, may prove useful in helping CBOs to develop more effective (and scaled up) education campaigns.
9. It is important to document the ways in which key conventions, declarations, court judgements and juridical and jurisprudential reports can be used to advance the rights of trans* people across the Asia-Pacific, and to find ways in which transgender communities across the region (and their advocates) can use that information in ways that make sense in the societies in which they live.
10. It is important to document means (both well-established and innovatory) by which trans* communities can effectively get access to important health information. Also useful would be research aimed at identifying ways of getting health information to the hard to reach in trans* communities – particularly the elderly and the rural, who may neither be members of community groups nor linked to the internet, and may have limited literacy.
11. Research is needed which documents good practice in the provision of trans* positive, competent, comprehensive and accessible healthcare, that is out there.⁵ Especially useful is research which helps CBOs and other key stakeholders work with healthcare providers to scale up existing services, and to develop new initiatives, adapted to local context but drawing on what has been learned elsewhere (particularly in relation to behavioural interventions in the field of HIV).

5 Trans* positive here refers to practice that affirms trans* people's rights to their gender identities and expression, and support their ability to lead their lives with respect, equality and dignity.

/ A. Introduction: objectives, definitions and method

This review examines existing literature on trans* people's human rights and HIV vulnerability across the Asia-Pacific region. For present purposes Asia-Pacific includes all those nations and territories on the continent of Asia (from the Mediterranean to the Pacific) and in Australasia and Oceania. The focus in this report is therefore mainly (though not exclusively) on lower income and middle income countries of the region. This is not to suggest that trans* people in more affluent countries do not experience challenges. On the contrary, they often find themselves excluded from economic opportunities enjoyed by others and end up facing many of the same challenges of survival as do trans* people in less developed economies.

The objectives of this review are:

- (a) to examine literature on existing laws, regulations, policies and practices that prompt, reinforce, reflect or express stigma and prejudice towards trans* people;
- (b) to identify vulnerabilities to HIV and barriers to access or uptake of HIV-related healthcare services; and
- (c) to establish a research agenda aimed at providing the sort of data that will enable a reduction in future risk, as well as better access to treatment, care and support for transgender persons living with HIV.

This review concerns Asia-Pacific trans* people. The term **trans* people** (transgender people) is defined here as *'individuals whose gender identity and/or expression of their gender differs from social norms related to their gender of birth. The term ... describes a wide range of identities, roles and experiences which can vary considerably from one culture to another'*.⁶ This inclusive definition embraces a wide range of people who identify as male, as female, as genders beyond these two, or identify in ways that transcend gender. It embraces those who are comfortable with their bodies and therefore feel no need for hormones, surgeries or other body modifications, as well as those who seek to modify their bodies. Some may identify as transgender, others as transsexual. Others identify by way of indigenous community labels that have much greater cultural relevance for the people concerned (and the contemporary societies in which they live) than these modern Western terms - and a much longer history too. The term trans* people is used in this report only as a convenient, if arguably Western-imposed, umbrella term or placeholder, reflecting the very wide range of identities and expressions these individuals and their communities represent across the Asia-Pacific.

This review refers specifically to **trans* women** and **trans* men**. Trans* women are birth-assigned males who identify and/or present as female, or as members of another broadly feminised gender (in those cultures in which it is accepted there are more than two genders). Trans* men are birth-assigned females who identify and/or present as males, or as another broadly masculinised gender. Throughout much of the Asia-Pacific region trans* male identities (in contrast to those that identify masculine-identifying women) currently have an emerging status. Trans* men, as we will repeatedly point out in this

⁶ Definition adopted from USAID / UNDP (2010).

review, remain severely under-researched.

The review is of largely post-2000 material, focusing as far as possible on literature that addresses trans* people and their concerns exclusively, or treats them as a group distinct from other sexual and gender minorities. There is a particularly heavy focus on material post-2008. This emphasis on very recent material is because there are so many fast-moving developments in our knowledge of the HIV epidemic among trans* people, and of social and legal influences upon that epidemic. In some parts of the region the social and legal environments are themselves fast changing. The material reviewed includes basic research involving surveys and case material (in journal articles and reports, as well as in university theses and book chapters) as well as other material (e.g. reports from government agencies, NGOs and CBOs) in which research is reviewed and/or additional case material is provided. Other work consulted includes a large number of newspaper, magazine and blog reports, though they tend not to be cited in this review, which concentrates on more research-oriented materials (in which those newspaper reports are in any case often referenced).

During the period May to August 2011 material was identified using Google Scholar search terms 'transgender+Asia', 'transgender+Pacific' and 'transgender+Oceania' (and similar search terms). Other material was located elsewhere, for example by way of the website of the TransgenderASIA Centre at the University of Hong Kong.⁷ Finally, a series of e mails were sent to 15 key CBO leaders throughout the Asia-Pacific region (in Malaysia, Thailand, Singapore, Nepal, India, Samoa, Fiji, Indonesia, Philippines, China, Mongolia, and Pakistan) seeking relevant material in either English or in local languages, noting that, in the case of the latter arrangements, might be made for translation. This e mail (sample in Appendix 1) elicited ten responses from eight countries.

In October 2011 a draft report was circulated to members of the APTN, with a request for comments. A presentation based on the draft was made at the Governing Board Meeting, held 5-7 December 2011, at which time members were invited to give further comments. This draft represents an update, incorporating those comments, as well as further published work that has become available in the months up to the end of December 2011.

Upon examining the literature on Asia-Pacific trans* people, it is immediately obvious that it predominantly focuses on urban, young trans* women. Rural and elderly trans* women, as well as trans* men (urban or rural, elderly or young), have been severely under-researched. One reason for the dearth of material on trans* men is that the trans* male identity (in contrast to various identities for masculine women) appears to be an emerging one across much of the Asia-Pacific region.⁸

7 <http://web.hku.hk/~sjwinter/TransgenderASIA/bibliography.htm>.

8 See e.g. Jun (2010).

/B. Some background: trans* people, HIV and the trans*-experience in Asia-Pacific

Trans* people in the Asia-Pacific

The terms 'transgender' and its derivatives (including trans* person, 'trans* woman' and 'trans* man') are Western and modern. Many 'transgender' individuals across the Asia-Pacific are in fact likely to identify using indigenous labels.⁹ These labels often reflect a sexual and gender worldview in which sexuality (orientation and behaviour) and gender (identity and expression) were once closely associated, and diversity was much better accepted than in much of recent Western history (even in some cultures celebrated).¹⁰ For some cultures there was once an energetic 'gender pluralism' in which those who nowadays would be called transgender were able to thrive.¹¹ Despite a range of 'modernising' influences, vestiges of that gender pluralism still remain in parts of the region, for example South and Southeast Asia.¹²

How many trans* people are there in the Asia-Pacific?

There is very little information on how many trans* people there are in the Asia-Pacific

9 Examples of terms for trans* women, some conferring respect and dignity, others (at least nowadays) more derogatory and demeaning, are: *kathoey* (Thailand, Laos), *pumia*, *pumae*, *phet tee sam*; *sao*, *phuying praphet song* (Thailand); *acault* (Myanmar); *bayot*, *bayog*, *asog*, *bantut*, *bakla*, *binabae* (Philippines); *maknyah* (Malaysia); *waria* (throughout Indonesia); *banci* (old Batavia); *calabai* (Bugis); *kedie* (Java and Bali); *kawekawe* (Makassar and Bugis); *wandu* (Java); *yen yiu* (China); *yirka-la-ul-va-irgin*, *ne-uchica* (Northern Siberia); *khanith* and *xanith* (Oman); *hijra* (India, Pakistan and Bangladesh), *kothi* and *aravani*, (India); *chakka* and *meti* (Nepal); *khusra* and *zanana* (Pakistan); *ponnaya* (Sri Lanka); *donme* (Turkey); *ah kua* (Singapore); *lai cai*, *bong cai*, *bong lai cai*, *dong co*, *be de* (Viet Nam); *mahu* (Hawaii); *fa'afafine* (Samoa), *vakasalewalewa* (Fiji). Some of these terms are imprecise thus often ill-suited to the goals of community activism. Consequently, some rights groups have started to construct their own vocabulary of gender identity variance. Filipino trans* activists have introduced the Tagalog-English term '*transpinay*' (*Filipina trans* woman*) and '*transpinoy*' (*Filipino trans* man*); see STRAP (Society for Transsexual Women of the Philippines) press release, 4 May 2008. In Thailand activists have recently introduced the terms *khon* (or *phuying*, *phuchaaï*) *khaam phet* (a person who has crossed sex), *khon* (or *phuying*, *phuchaaï*) *plaeng phet* (a person who has changed sex); Krisana Mamane, Nada Chaiyavit and Prempreeda Pramoj Na Ayutthaya, e-mail communications with author, 5 May 2008, 16th May 2008, and 26th November 2008, respectively. Attempts to construct a vocabulary that conveys both dignity and precision may be an essential first step for trans* people to achieve recognition as a distinct community able to promote its members' interests and press for their rights. Across much of the region the trans* male identity (and indigenous equivalents) appears to be far less well developed. But this is changing. For example, Sampoorana, formed in 2004 in India, is a network which actively involves and works with trans* men. Moreover, CBOs originally formed by and for trans* women are increasingly finding that there are trans* men out there who want to become involved, and are consequently broadening their work. For example STRAP, formed in 2002 in the Philippines, hitherto working for trans* women's rights, now has transpinoy (trans* man) members. Similarly, APTN, a regional organization formed in 2009 by and for trans* women, recently decided to broaden its scope and membership to include trans* men.

10 For more on indigenous cultures of gender variance in the Asia-Pacific see e.g. Winter (2002, 2009a) for Asia; Matzner (2001b) for Hawaii; Vasey and Bartlett (2007) for Samoa; Nanda (2000a) and Somasundaram (2009) for India; Hahm (2010) for Pakistan; Boellstorff (2004), Graham (2001, 2002), Oetomo (2002) and Graham-Davies (2007) for Indonesia; Coleman, E., Colgan, P., & Gooren, L. (1992) and Urbani (2006) for Myanmar; Wilson et al. (2011) for Nepal; Brewer (1999; 2001) and Nanda (2000b) for the Philippines; Nanda (2000b), Jackson (2003), Costa and Matzner (2007), Winter (2008a), Wong (2003), and Ojanen (2009) for Thailand; Earth (2006) for Cambodia; Khan (2008) for Afghanistan; Worth (2006), Vasey and Bartlett (2007), Nanda (2000c), Bavinton et al. (2011) for the Pacific region. See also Scherer (2006) in relation to Buddhism more generally. See also various country articles in two useful encyclopaedias - Stewart (2010) and Francoeur and Noonan (2004).

11 For more on this see Peletz's (2006, 2009) work on 'gender pluralism'.

12 Winter (2009a).

region? The same is true worldwide. This is in stark contrast to the abundance of data relating to MSM prevalence (whether in terms of orientation, behaviour or identities). This absence of numbers is a matter for concern. Arguably, minorities do not count until they are counted. It can be speculated that the proportion of the population aged 15 and above who are transgender may be around 0.3 percent. This figure broadly matches community estimates for numbers of trans* women in countries such as India, Thailand and Malaysia, which gravitate around a prevalence rate of 1:300¹³, a figure that matches very closely one offered by Gates (2011)¹⁴ for persons in the US who identify as trans*. This 0.3 percent figure yields a region-wide population estimate of around 9 to 9.5 million. But this is just a rough estimate, and is based on UN population data from 2010.¹⁵ Better numbers are crucial to properly ascertaining the severity of the HIV epidemic among trans* people, as well as for proper social and healthcare planning. They help us 'know our epidemic' better. In the West, there have been clear calls for better data collection on trans* people.¹⁶ The censuses currently being conducted in India and Nepal (and recording the way people identify) indicate one way forward for Asia-Pacific on the matter of numbers.

The HIV transgender pandemic; how big is it?

The information on this is patchy, and is overwhelmingly focused on trans* women. Among trans* women there are indications that, internationally, infection prevalence has reached alarming levels. Worldwide, the available evidence suggests that, HIV prevalence rates reach as high as 68 percent in trans* communities, with new case incidence from 3.4 to 7.8 per 100 person-years.¹⁷ In the USA, rates for newly identified infections among trans* women exceed those of men and birth-assigned women by factors of around 3 and 9 (and exceed those of trans* men by much greater multiples).¹⁸ The Asia-Pacific situation is equally alarming, with prevalence rates reported to be up to 49 percent (albeit from scattered and often small-scale research).¹⁹ All these rates far exceed the general population. They commonly exceed the rate for MSM, sometimes substantially so.²⁰ Young trans* women are thought to be at particular risk, although the comparative lack of data on elderly trans* people makes an assessment of comparative risk difficult. Possible factors contributing to youth HIV risk include their levels of sexual activity, use of alcohol and drugs, multiple partners, lack of information or misperceptions about risk, lack of information about safer sex, or simple impulsiveness and perceived invulnerability. Whatever the causes, alarming figures from one Asian city (Jakarta) have suggested that over a recent four year period 2003-2007 HIV prevalence among trans* people (evidently

13 See Winter and Conway (2011).

14 See Gates (2011).

15 This figure is based on the following population figures published by the United Nations Population Division (United Nations, Department of Economic and Social Affairs): Asia (2010) 4.16 billion, of which 74 percent are aged 15 and above. Oceania (2010) 36.6 million, of which 76 percent are aged 15 and above. Figures retrieved March 30th 2012 from <http://esa.un.org/unpd/Excel-Data/population.htm>

16 HIV-PJA (2011).

17 Figures cited in WHO (2011).

18 National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (2011).

19 Figures cited in WHO, UNDP and UNAIDS (2009) and Godwin (2010). Together they cite city figures as follows: Lahore, 0.5 percent; Bangkok 11 percent; Phuket, 12 percent; Bandung, 14 percent; Chiang Mai 17 percent and 18 percent (two studies); Surabaya, 25 percent; Jakarta, 22 percent and 34 percent (two studies); Phnom Penh 37 percent; Mumbai, 42 percent; Delhi 49 percent.

20 Godwin (2010).

trans* women) rose from 25 percent to 34 percent.²¹ Region-wide we lack statistics on the number of trans* people who have died of AIDS, or on what proportion of overall AIDS-related deaths are attributable to trans* people.

Epidemiological research for other STIs indicates high rates for syphilis, rectal gonorrhoea, rectal Chlamydia and other STIs among Asia-Pacific trans* women.²² These conditions are believed to put infected individuals at added HIV risk. The recently widely reported emergence of a drug-resistant strain of gonorrhoea aggravates concerns over co-infections. The Commission on AIDS in Asia has predicted that by 2020 trans* people and MSM will together constitute the majority of new HIV infections in Asia.²³

Much of the alarm over the trans* HIV epidemic comes from the perception that trans* women are a vector for the transmission of HIV and other STIs into the wider population, often through male partners who themselves commonly engage in sex with cisgender (birth-assigned) women.²⁴ That said, HIV positive trans* people are more than vectors. They are also victims.

The situation facing Asia-Pacific trans* men in regard to HIV and other STIs is severely under-researched. This is worrying, as common sense suggests that several subgroups may be at particular risk; including TMSM, as well as trans* men (particularly more feminine ones, or those who are still in transition) who engage (including as FSWs) in sex with cis-men, or fall victim to sexual assault by them.

The Asia-Pacific trans* experience

Worldwide a body of research is available on trans* people, their lives and the risks they face in their lives. Together the research identifies a slope from stigma to sickness.²⁵ *In many countries the daily experience of social stigma and prejudice, as well as associated discriminatory, harassing and abusive practices, is so consistent and marked as to nudge many trans* people towards the social, economic and legal margins of society, and damage their psychological health and well-being. In many cases the forces marginalising trans* people intersect with those that marginalize ethnic minorities, foreign and rural migrants, the poor, the poorly educated and women, so that trans* people belonging to one or more of these other groups encounter even greater challenges leading a life of respect, equality and dignity. Some, despite all the hurdles, lead fulfilled lives. Many others however are tilted*

21 Reported in USAID/UNDP (2010).

22 e.g. Studies by the National AIDS Control Programme (2005) and Hawkes et al. (2011) in Pakistan, Chemnasiri et al. (2010) in Thailand and Joesoef et al. (2003) in Indonesia. In the National AIDS Control Programme study transgender prevalence rates for syphilis were at 60 percent, with rectal gonorrhoea at 29 percent and rectal chlamydia at 18 percent. The Chemnasiri et al. study reported a history of STIs among 71 percent of the sample (and 10 percent were HIV positive). STI infection may also be high in more developed societies; in a small sample of 43 TSWs Higashi et al. (2011) found self-reported chlamydia, candida, gonorrhoea and syphilis (as well as pubic lice). There are reports that in at least some communities HPV and associated symptoms such as genital warts may also be common.

23 Reported in USAID/UNDP (2010).

24 Bockting, Miner and Rosser(2007).

25 See e.g. Clements-Nolle et al. (2001), Nemoto et al. (2004), Reback et al. (2005), Harcourt (2006), Grossman and D'Augelli, (2006), Garofalo et al. (2006), Herbst et al. (2008), Wilson et al. (2009), Reisner et al. (2009). Much of the research work has recently been reviewed by Herbst et al. (2008), Nemoto et al. (2008), Operario et al. (2008) and Keller (2009). See also large scale regional or national reports by e.g. Xavier et al. (2007); Grant et al. (2011) (USA), Whittle et al. (2007) (UK), and Motmans et al. (2010) (Belgium). The transgender experience somewhat mirrors that for gays and lesbians, e.g., Wright and Perry (2006); Meyer and Dean (1995); Abelson et al. (2006).

towards situations and behaviour patterns (including sexual) that leave them open to many risks, including to HIV infection. Worse, on the way along that slope they often encounter poor healthcare (for transition-related, sexual or general health). Depending on where they live, the HIV positive trans person may encounter few care and treatment services, or may be marginalized by and excluded from those that exist. Poverty, involvement in sex work and HIV infection can all add to the stigma they face.*

The stigma-sickness slope is as much part of the Asia-Pacific trans* experience as outside the region, if not more. There is now a large amount of anecdotal, case study and survey evidence that makes clear the slope exists,²⁷ even in those parts of the region where there was once a more inclusive culture of gender variance (culture which has often decayed when exposed to forces of modernisation and Westernisation). Sadly, there are researchers in the Asia-Pacific and beyond who by their work arguably ensure the slope's place in the lives of trans* people.²⁸

Largely as a result of awareness of this stigma (and what the stigma leads to) there is today a wide acceptance that HIV programmes targeting sexual and gender minorities should aim to combat stigma and focus on rights, and should engage affected communities to achieve that aim. This was very much part of the message in a recent Asia Pacific Coalition on Male Sexual Health (APCOM) pre-conference satellite at the 10th International Congress on AIDS in Asia and the Pacific (ICAAP10) in Busan, Republic of Korea. It echoes the message in a range of reports and policy documents, both international²⁹ and regional.³⁰ For trans* people a clear milestone in the campaign to put rights centre stage was the Barcelona Conference of June 2010; the Conference brought trans* people together in large numbers from across much of the world, threw a spotlight on gender identity and human rights, and involved a pre-conference organised by and for trans* people.³¹ Nevertheless, there is clearly a long way to go on trans* rights and HIV. Even now, rights-based HIV programmes seldom appear to target trans* people or involve them in planning and implementation.³²

One contributory factor is that Asia-Pacific trans* people have only recently started to organise themselves for advocacy, and often only after a lengthy period immersed in

“If you ask me (if I) am ...happy to be like this, I would say I am not happy to be like this. But I am happy despite the fact that I am like this, I have done many things for other people and society. Moreover, I have not yet failed to be true to myself.”

– Sou, 68 years old, trans* woman, Cambodia²⁶

26 Communications to author, previously unpublished transcription.

27 Leaving aside (for the moment) more localised studies (and many of these will be cited later in this report), there are a range of national studies and reviews such as South and Southeast Asia Resource Centre on Sexuality (2008); Winter (2009a), Sood (2009), TREAT-ASIA (2006) (all with an Asia-wide focus); APNSW, UNFPA and UNAIDS (2011) and Godwin (2009) (both with an Asia-Pacific focus). See also the following Australasian research: Pitts et al. (2006) (Australia); NZHRC (2007); and Couch et al. (2007); (Australia and New Zealand).

28 e.g. A good example is the work of Noraini et al. (2005) in Malaysia, whose portrayal of 'effeminate males' (or 'softies') as deviant individuals in need of correction has reached an international audience. See Winter (2008b) for a fuller review of their book. The international literature is replete with other examples of cisgenderism. See a recent highly critical review by Ansara and Hegarty (2011).

29 e.g. NGO Delegation to the 26th UNAIDS Board Meeting (2010); UNAIDS (2010); HIVOS and SCHORER (2009); WHO (2011); CETH et al. (2011); UN AIDS Reference Group on HIV and Human Rights (2011).

30 e.g. O'Keeffe, A., Godwin, J., & Moodie, R. (2005) (for the Asia-Pacific), and Lim and Chan (2011) (for East and Southeast Asia).

31 CONGENID (2010).

32 See UNAIDS (2010) p124 .

(sometimes submerged in) MSM movements. Once formed, these CBOs (and here we use to term to include non-registered networks and groups, as well as more formal and/or funded organizations) have often found an unsupportive (or even hostile) social and legal environment in which to work.³³ As a result local and national CBO coverage region-wide is uneven.³⁴ Trans*-specific CBOs going beyond the local and national level are even more recent in origin.³⁵ Some of the local and national organizations have in a very short time proved themselves effective advocates for respect, equality and dignity. Some have engaged in education initiatives and established services within trans* communities (often focused on vocational, health and rights issues). Others have worked with government bodies, law enforcement agencies, health authorities, universities, NGOs, other CBOs and the general public (including through the mass media) to build awareness of transgender issues. Still others have engaged in more direct forms of activism, often aimed at promoting changes in the law, or changes in policies impacting on trans* people's rights. Still others have engaged in community based research initiatives.³⁶ Some very effective work appears to be done in drop-in centres and through outreach.³⁷ Sadly, across the Asia-Pacific region significant capacity building is still needed. When a working group from the American Psychiatric Association recently did a worldwide survey of 201 'organizations concerned with the welfare of transgender people' to tap opinions on 'Gender Identity Disorder', the pathologising and therefore highly controversial diagnosis often applied to trans* people, it was only able to get responses from two organizations in Asia, and (apart from Australia and New Zealand) none at all from the Pacific!

As time progresses one hopes CBOs (local, national and regional) will work more effectively to challenge the stigma and prejudice that has been so much part of Asia-Pacific trans* people's lives. There is real urgency to that task. As noted earlier, the Commission on AIDS in Asia predicts that by 2020 trans* people and MSM will together constitute the majority of new HIV infections in Asia. If this prediction proves correct, then HIV may in the public mind become ever more associated with these two communities. If HIV still carries the stigma it does today, MSM and trans* people will themselves become ever more stigmatized as community epicentres of HIV. As always is the case, trans* people can expect the stigma to be harder than MSM to avoid; their very appearance and manner, as well as ID documentation that fails to reflect their gender identity, commonly advertises in a very public way that they are trans*.

The rest of this review examines what is known about the stigma-sickness slope for Asia-Pacific trans* people (Section C) and about health services for trans* people (Section D). The research is overwhelmingly about trans* women and their health. The review concludes with recommendations for further research aimed at reducing HIV vulnerability in trans* communities (Section E).

33 See Godwin (2010).

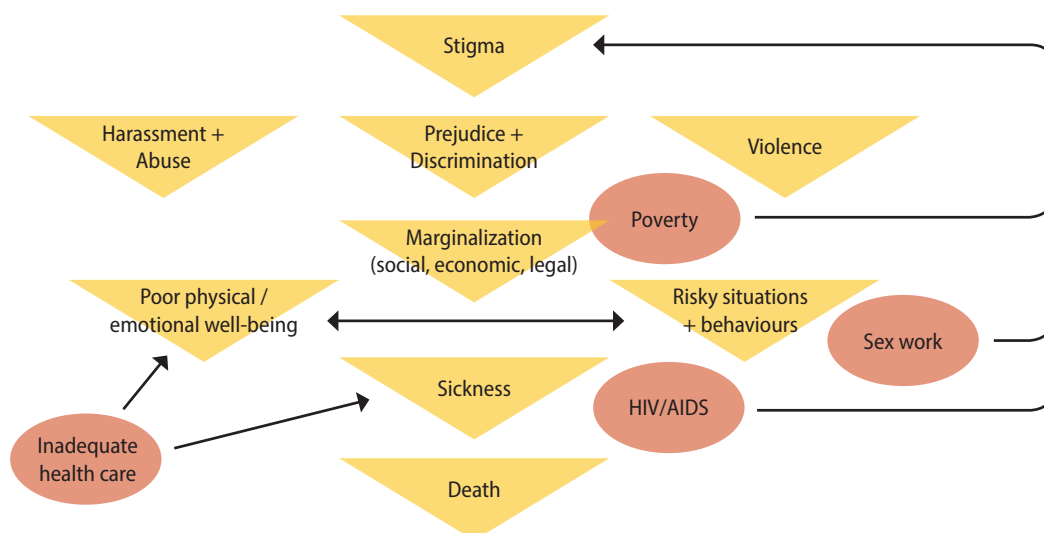
34 See e.g. the results of a mapping exercise for South Asia conducted by SAATHI (2008).

35 APTN was established in late 2009 and has remained largely unfunded for much of the time since.

36 To give some examples of CBO work, groups in the Philippines have been using the ICCPR optional protocol (to which their country has signed up) as a way of promoting rights. They have also been promoting an antidiscrimination law. LABRYS, a leading group in Kyrgyzstan has been campaigning for administrative mechanisms that would enable trans* people to change their legal gender status. In Hong Kong and elsewhere trans* women have participated in awareness education on university campuses, as well as in training for healthcare providers. In India trans* women have worked as peer ethnographer researchers.

37 See for example AIDS Network Development Foundation (AIDSNet) of Thailand. (2011).

/C. The stigma-sickness slope



The stigma-sickness slope (above) represents what is commonly the lived experience for Asia-Pacific trans* people. They often face stigma, prejudice and discrimination, as well as harassment, abuse and violence. These experiences push many trans* people towards the margins of society, where two common consequences are involvement in risky situations and behaviour patterns, and poor physical and emotional well-being. These two consequences can reinforce each other. Many trans* people fall sick. Some die. Poverty, involvement in sex work, and HIV sero-positivity and AIDS all act to add to stigma. Inadequate healthcare across much of the region (in regard to general, sexual and trans* related healthcare needs) adds to the challenges faced by many trans* people in regard to well-being and health.

Stigma and prejudice

Across much of the region trans* people are stigmatized (believed to be in some way less worthy than others) and the object of prejudiced beliefs (unfavourable stereotyping). Stigma and prejudice are evident at many levels of society,³⁸ and appear to rest on beliefs, common across the region but variously held from place to place, that trans* people are (a) unnatural (an aberration of nature), (b) sick (mentally disordered), (c) sexually deviant (promiscuous), (d) deceptive (presenting as they do as a way of finding a potential sexual partner) or (e) otherwise immoral (contradict God's Will).³⁹ All these beliefs share a common element; that the trans* woman is actually a man (albeit unnatural, sick, deviant, deceptive or immoral) and the trans* man actually a woman. These beliefs all therefore have the effect of undermining trans* people's claim for recognition in their self-affirmed gender. The links between these beliefs on one hand and stigma and prejudice on the other have not been the subject of much research. One study looking at some of the links found that the 'sickness' belief was linked to a range of transphobic attitudes.⁴⁰ Where do these ideas come from? The research that has been done suggests the following cultural factors may feed (and reflect) them. They include:

38 For research in various parts of the Asia-Pacific see e.g. Matzner (2001a), Winter (2006c), Winter et al. (2009a), Winter et al. (2007, 2008a, 2009), King, Winter and Webster (2009), Harn et al. (2010), Teh (2002); Bavinton et al. (2011). See also some autobiographies (e.g. Babu, 2007; Jun, 2010) and autobiographical compilations in books (Costa and Matzner, 2007) and on the web (e.g. on the TransgenderASIA website). Note also reports for Australia and/or New Zealand: e.g. Couch et al. (2007), Pitts et al. (2006), and NZHRC (2007).

39 e.g. Winter (2009a). See also Winter et al. (2009).

40 Winter et al. (2009).

“ People think that we are risk factors for spreading AIDS. May Allah ...not make anyone like us.”

– Reema, 24 years old, trans* woman, Pakistan ⁴¹

- (a) norms for masculinity and femininity, which stigmatize trans* people, as well as beliefs on sex and gender (sometimes linked to Christianity and Islam), which portray sexual relationships between trans* women and men (and trans* men and women) as same-sex relationships (and therefore immoral).⁴² Sadly, the common practice of NGOs and government agencies in conflating MSM and trans* people,⁴³ and of researchers in using language which mis-genders trans* people (e.g. male pronouns for trans* women),⁴⁴ only reinforce these ways of thinking.
- (b) modernising forces associated with economic development, urbanisation and globalisation (which have sometimes led to the disappearance of roles trans* people once played in their indigenous communities, and in some places have introduced Western mainstream medical views of gender variance as mental disorder (across much of the region, e.g. Hong Kong). In some places gender variance is even seen as mental disability (as in Indonesia),⁴⁵ or as permanent psychosis (until recently in Thailand).⁴⁶ The ‘psychopathologisation’ of gender variance remains a strong force in modern Western psychology and psychiatry, very much alive in the research literature,⁴⁷ despite being roundly condemned by a large number of organizations (including in 2010 by WPATH, the international organization of professionals working in the field of transgender health).⁴⁸
- (c) sexuality and gender education (in schools and in the general community) which is often inadequate⁴⁹ or is sometimes limited by strict laws against pornography,⁵⁰ and which therefore fails to provide information to break cycles of stigma and prejudice.
- (d) trans* women’s involvement in sex work (itself largely a consequence of their marginalization, but leaving them vulnerable to stigma associated with sex work), and
- (e) media coverage, which often adopts a pejorative, sensationalist, comedic and/or commoditising approach to trans* people (for example in Thailand, the Philippines and Hong Kong)⁵¹ and/or which is regulated by government authorities (for example in Indonesia, Malaysia and Singapore).⁵²

It appears some Asia-Pacific trans* people may employ coping strategies to prevent them

41 Communication to author, previously unpublished transcription.

42 Winter (2006a). See also Godwin (2010).

43 For one example among many see Sheridan et al. (2009).

44 A practice examined and energetically condemned by Ansara and Hegarty (2010).

45 See Godwin (2010) p77.

46 Ojanen (2009).

47 See the Ansara and Hegarty (2010) critique.

48 WPATH Board of Directors (2010).

49 See Sood (2009).

50 See Godwin (2010) p80.

51 See Godwin (2010) for material on media coverage across the Asia-Pacific. See also Na Ayutthaya (2003) for a discussion on media coverage in Thailand.

52 See Godwin (2010), p79 onwards, and Global Commission on HIV and the Law (2011).

from internalising the transphobia, protect their self-esteem (their sense of worth as human beings, their overall confidence in themselves) and provide a degree of resilience.⁵³ These strategies have not been well researched. It is clear that for many others the stigma and prejudice get internalised and damages their emotional well-being and health. This will be discussed more in detail later.

Discrimination, harassment and abuse, social and economic marginalization.

Across the region stigma and prejudice lead to discrimination, social and economic marginalization (withholding of opportunities), harassment (intended assaults on dignity), and abuse (intended harm). The evidence is available in a range of case study compilations, surveys, reports and reviews of research (local, national international).⁵⁴ It is also evident in autobiographical accounts.⁵⁵ This research paints a picture of discrimination, harassment and abuse across society, and confronting trans* children and youths in their families and in their schools and colleges, as well as transgender adults in the workplace, in housing, at places of worship, in access to health and other services, in access to spaces that are otherwise open to the public, and in other aspects of public life (opportunities for marriage, adoption, or even to give blood). Those trans* people considered too 'obvious' or 'flamboyant' are especially at risk of being targeted. Many youngsters are driven out their homes or leave home early, and become cut-off or estranged from their families. They often drop out or are driven out of school (which are often rigidly organised on gender lines), or otherwise are deprived of the same educational opportunities their peers enjoy. Those who remain in education, often in strongly gendered settings, find their ability to concentrate on their studies severely compromised.

Early school drop-out, or failure to achieve up to their educational potential, puts trans* people at a crucial disadvantage when they enter the workforce. Already stigmatized by being transgender, they suffer the additional employment challenges that come from being perceived as poorly educated. Even if they have suitable qualifications, they often experience difficulties getting a job, at least one that is full-time and commensurate with their abilities. Often migrating to cities in search of a better life (particularly if cut-off from their families), trans* people may be confronted with the same employment difficulties there, and without being able to draw on any network of support.⁵⁶ In order to get a

53 An exception is Winter (2006a).

54 Sood (2009) provides a good regional review of discrimination, harassment and abuse, as well as providing some cases studies of her own. See also Sanders (2008, 2010), Godwin (2010), APNSW, UNFPA and UNAIDS (2011), NGO Delegation (2010), and Global Commission on HIV and the Law (2011) for more region-wide information. For country-specific material see e.g. HRW (2003) (Bangladesh); Pant (2005), HRW (2006) and Wilson et al. (2011) (Nepal); Hahm (2010) (Pakistan); People's Union for Civil Liberties–Karnataka (2003), Chakrapani et al. (2007) (India); LABRYS (2006); LABRYS (2010) (Uzbekistan); UNAMI (2010) (Iraq); Teh (2001) and Slamah (2005) (Malaysia); Jenkins, C., (2008) (Cambodia); Alegre (2006) and International Gay and Lesbian Human Rights Commission (2011); (Philippines); Nichols (2010) (Sri Lanka); Jenkins et al. (2005), Cameron (2006), Costa and Matzner (2007) and Winter (2011) (Thailand); Polat et al. (2005) (Turkey); Couch et al. (2007), Pitts et al. (2006), NZHRC (2007) and AHRC (2011) (Australia and/or New Zealand); Teh (2002) (Malaysia); Bavinton et al. (2011) (Fiji); HRW (2012) (Kuwait) and much of the material in an edited book by Ordek (2011) (Turkey). See also various material (country reports, and more egregious cases of abuse) on the TransgenderASIA site.

55 e.g. Revathi (2005) and Babu (2007) (India); Costa and Matzner (2007) (Thailand); Jun (2010) (China); Alegre (2006) (Philippines); and (although strictly speaking it is outside our area of focus) Matzner (2001b) (Hawaii). See also some autobiographical material on the TransgenderASIA site.

56 See for example the situation facing *hijra* in Pakistan, detailed by Hahm (2010). Note that in another Pakistani study (Hawkes et al, 2011), it was found that TSWs (as compared with FSWs and MSWs) were more likely to live outside their family and less likely to have any source of income other than sex work.

job, they may have to conceal their trans* status (going to work each day in 'drab' – that is, dressed in a way that matches their birth-assigned sex but is incongruent with their gender identity). In highly transphobic societies such as Kuwait (in which even the voice, facial appearance, skin and demeanour of a trans* person can put him or her at risk of being prosecuted for 'imitation of the opposite sex'), this is often easier said than done.⁵⁷ Poverty is common in transgender communities; which serves to push youngsters into sex work. The subject of sex work will be revisited later in this report. As is so often the case, trans* men are severely under-researched; anecdotal evidence suggests many are pressed against their will into marrying cisgender men, or are rejected or disowned by their families and enter sex work to survive (often working as FSWs).

Sometimes politicians and government officials, educators and others have become anxious about the trans* people assuming too high a profile in the media, in colleges and elsewhere. They have taken action, which can fairly be described as repressive (e.g. regulating media portrayals of trans* people, regulating trans* people's vocational opportunities, supporting the work of gender reparative therapists, or actually organising 'sissy' boot camps' for trans* youth). Sadly, local academics have sometimes ridden the wave of repression, feeding it further.⁵⁸ Worse, trans* people have sometimes become targets of discrimination within the broader sexual and gender minorities communities (and their activist movements) from which they might reasonably hope for support and protection.⁵⁹

Across much of the region violence, or the threat of it, stalks trans* people's lives. The violence is often sexual, and reports of sexual coercion are common.⁶⁰ Rape is commonly reported, and is often of a 'curative' kind, perpetrated against trans* men. Violence is perpetrated at home, in schools, and in broader society. Offenders may include gang members (criminal and ultra-conservative), sex work customers (actual or prospective), or by bystanders who assume (perhaps wrongly) the victim is involved in sex work. It is commonly homophobic or misogynistic and is sometimes directed on groups of trans* people coming together for social, leisure or activist events (as for example in Chiangmai and various locations in Indonesia in the last couple of years). Violence against trans* people has sometimes been systematic and sustained. Miscreants have broken into trans* people's homes, even when occupied.⁶¹ Transgender sex workers (TSWs) may be at particular risk.⁶² Fatalities have been widespread. An ongoing project documenting murders of trans* people worldwide reports 63 documented murders in the Asia-Pacific region in the four years from Jan 2008 to December 2011 (86 if Turkey is counted as part

57 HRW (2012).

58 e.g. Noraini et al. (2005).

59 Noted by Sood (2009).

60 Numerous human rights reports cite cases of sexual violence against trans* people, including by police. See for example HRW (2003, 2012) (Bangladesh and Kuwait); People's Union for Civil Liberties – Karnataka (2003) (India); LABRYS (2008) and HRW (2008)(Kyrgyzstan); LABRYS (2010) (Kyrgyzstan); Nichols (2010)(Sri Lanka); Jenkins et al. (2005; 2008) (Thailand and Cambodia); LGBT Center (2010) (Mongolia), and much of the material in a book edited by Ordek (2011) (Turkey). There are also reports of sexual assault in more academic research literature. See for example Hawkes et al. (2011) found that 18 percent of their Pakistani TSWs recalled that their first sex was forced sex, a percentage higher than either FSWs or MSWs. See also a Thai study by Chemnasiri et al. (2010), in which substantial numbers of trans* women reported a history of sexual coercion. See the TransgenderASIA site for reports of sexual violence in various countries in Asia (at time of writing these include Mongolia and Viet Nam).

61 See for example accounts by Hahm (2010) in a report on Pakistan.

62 e.g. Hawkes et al. (2011); Hahm (2010); Collumbien et al. (2011).

of Asia).⁶⁴ Sadly, more trans*-murders may occur without documentation. Alarming, some of violence has been reportedly committed by police, the government agency one would expect to protect the weak. They commonly harass trans* people involved in (or assumed to be involved in) sex work, as well as other trans* people. There are clear cases of police violence (as for example in Bangladesh, Nepal, Karnataka in India, Cambodia, Kyrgyzstan, Kuwait and Iraq).⁶⁵ The perpetrators sometimes benefit from a culture of impunity surrounding their acts. In some places the impunity sometimes appears government-backed.⁶⁶

A few countries in the developed West (for example UK, USA and Netherlands) have offered refuge to Asia-Pacific trans* people fleeing or afraid to return to their home country on grounds that include fear of violence (for example recent cases of trans* people from Mongolia, Hong Kong or Malaysia).⁶⁷ This is despite the fact that transphobic violence extends across much of the world,⁶⁸ and in some cases is observed even in those countries offering refuge.⁶⁹

“ I did go for several interviews, but I always got the same stereotype. Transexual(s) can't do office work. I am always underestimated because I am a transexual. I am the rejected candidate, although I have the qualification. But that was not important for the employer. For them I'm only qualified to work at a beauty salon despite the fact I have a degree in management.”

– Gracie, 25 years old trans* woman, Malaysia⁶³

Legal marginalization

Throughout much of the region, trans* people find little comfort in the legal environments in which they live. Rather, in ways that both reflect and reinforce stigma and prejudice, they act to marginalize trans* people further. They fail to offer protection from discrimination. They themselves discriminate against trans* people by failing to recognise self-affirmed gender (either practically or legally), by criminalising trans* people's sexual or gendered behaviours, and by subjecting them to gender-inappropriate detention or incarceration. In some parts of the region they even fail to offer sufficient trans* people protection against the more serious forms of sexual assault. Much has already been written on the legal

63 Communication to author, previously unpublished transcription.

64 See the record of murders (at least, those which have been documented), compiled by Transgender-Europe (TGEU) in their 'Trans*-Murder Monitoring Project', part of a broader project on 'Transrespect-versus-Transphobia'. For updates see <http://www.transrespect-transphobia.org>. The greatest number of murders, aside from Turkey (23) (which can for the purposes of this review be classed as part of the Asia-Pacific region), Pakistan (12), Philippines (10), India (10), and China and Malaysia (6 each). Other murders are recorded in Afghanistan, Iran, Thailand, South Korea, Singapore, Indonesia, Australia, New Zealand, Fiji, and New Caledonia.

65 For extensive reports of violence (including by police) see HRW (2003, 2006, 2012) (Bangladesh, Nepal and Kuwait); People's Union for Civil Liberties – Karnataka (2003) (India); LABRYS (2010) (Uzbekistan); LABRYS (2008) and HRW (2008) (Kyrgyzstan); Nichols (2010) (Sri Lanka); Jenkins et al. (2005; 2008) (Thailand and Cambodia); UNAMI Human Rights Office/OCHCR (2011) (Iraq); and some of the material in a book edited by Ordek (2011) (Turkey). See also the TransgenderASIA site which documents cases of violence (Turkey, Viet Nam and Mongolia at time of writing).

66 For example in the case of Iraq, which recently rejected calls by UN member states to act to protect sexual and gender minority groups, and bring perpetrators of hate crimes to justice (UNAMI Human Rights Office/OHCHR (2011)).

67 In a case involving one of their citizens applying for refugee status in the UK, the Malaysian government (perhaps unintentionally spotlighting the situation back home) reportedly threatened to punish the petitioner for bringing "great shame" on her country. She recently won her right to stay in the UK.

68 See data from the TGEU Trans*-Murder project, as well as scattered national reports e.g. Grant et al. (2011) (USA), Whittle et al. (2007) (UK), Motmans et al. (2010) (Belgium).

69 e.g. Grant et al. (2011) (USA), Whittle et al. (2007) (UK).

environments in which Asia-Pacific trans* people live.⁷⁰ Particularly welcome, however, is a report by the High Commissioner for Human Rights (commissioned by way of a UN Human Rights Council resolution) drawing attention to human rights violations on the grounds of sexual orientation and gender identity.⁷¹ Welcome too will be a forthcoming International Lesbian, Gay, Bisexual, Transgender and Intersex Association (ILGA) report (due for publication in the first half of 2012), involving a mapping of trans* people's legal situations in 126 countries worldwide. For the purposes of this review, a short summary of legal issues facing Asia-Pacific trans* people follows.

Absence of legal protection

A few jurisdictions (for example most states in the Australian federation) offer trans* people legal protection against discrimination. However, across much of the Asia-Pacific region the situation is less satisfactory. Part of the problem is that human rights mechanisms are less well developed regionally than in, say, Europe. While many Asia-Pacific countries have signed up to international human rights instruments such as the International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic, Social and Cultural Rights (ICESCR), Convention on the Rights of Persons with Disabilities (CPRD), Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and Convention on the Rights of the Child (CRC), others have not,⁷² or do not match their international commitments under these conventions with legislative actions and enforcement at home – at least in regard to the rights of trans* people and sexual minorities more generally.

Where any potentially useful anti-discrimination legislation exists, it is often limited in scope (e.g. Hong Kong's Bill of Rights Ordinance, modelled on ICCPR but offering protection only in the Government sector), remains untested in the area of trans* rights (e.g. Hong Kong's Sex Discrimination Ordinance), or premised on trans* people taking the unpalatable step of pleading disability (e.g. Hong Kong's Disability Discrimination Ordinance).⁷³ In some jurisdictions (e.g. the Philippines and Hong Kong), attempts to protect the rights of sexual and gender minorities through legislation have met with opposition, and whatever progress has been made has occurred through litigation. Even where protection seems available, the costs of mounting a legal case can put legal action outside the reach of many trans* people. They are therefore left vulnerable to discrimination in education, housing, employment, services, and other areas detailed earlier. Note, however, that some Asia-Pacific jurisdictions appear to be moving forward in extending rights and offering protections to trans* people (for example Thailand, India (especially the state of Tamil Nadu), Nepal, Pakistan, and Fiji).⁷⁴ Recently, UNDP India and ARTICLE 39, a division of the Center for Legal Aid and Rights, convened four Access to Justice and Social Inclusion Public Hearings to increase awareness and accountability towards transgender and *hijra* communities in India.

70 See many of the references at Footnote 54.

71 UN High Commissioner for Human Rights (2011).

72 For texts of key international treaties see the Office of the UN High Commissioner for Human Rights at <http://www2.ohchr.org/english/law/>. For a list of state ratifications, accessions and successions see the United Nations Treaties Collection website at <http://treaties.un.org/Pages/Treaties.aspx?id=4&subid=A&lang=en>.

73 See Chan (2005).

74 See Godwin (2011) for a good review of recent progress.

As will be seen in the next section, trans* people across much of the region are unable to change their legal gender status. Where this is the case, trans* women often find themselves inadequately protected in law in yet another way. The problem arises when laws on sexual assault are framed so that the criminalised act involves penetration of a vagina, or so that only women can be victims. With offences defined in this way, those who perpetrate non-consensual penetrative sex against a trans* woman are not liable for prosecution under the same laws as would apply if the victim was a birth-assigned woman. Unusually for countries across the Asia-Pacific, Thailand has recently moved forward in this area, changing the law on rape so that perpetrators of rape against trans* women can be prosecuted (albeit only because the law has been extended to male victims, and trans* women in Thailand are regarded in law as males).⁷⁵

Failure to extend gender recognition

Asia-Pacific countries allowing a change in legal gender status (or other documentation changes) are in the minority. The majority allow neither. The result is that trans* people not only lack all legal rights in their self-affirmed gender identities, but also are daily 'outed' in all they do that requires them to show identity documents. This is an important privacy issue for many trans* people. For many more, it is also an equality issue, as it leaves them even more vulnerable to discriminatory treatment than would otherwise be the case.

Where trans* people are denied gender identity recognition, they often encounter difficulty conducting their everyday affairs; entering contracts in employment, housing, goods or services. They may also encounter difficulties wherever security forces check their ID, or when travelling through immigration points. In at least one country in the region, Nepal, the trans* community reports that the failure to extend recognition goes even further, with trans* people unable to gain the identity documentation they need to enable them to vote.

Crucially for many trans* people, they may also be unable to enter a heterosexual marriage, and enjoy the usual benefits that accrue thereto (e.g. official recognition of one's relationship with one's partner; opportunities to adopt a child; taxation advantages; rights to public housing for married couples; joint loan, insurance and inheritance rights; and hospital visiting rights etc). As far as it is possible to ascertain there are currently only 10 countries and territories in the region in which it is possible for trans* people to gain gender status recognition *as reflected in their right (clear or apparent) to marry heterosexually* (i.e. a trans* woman marrying a man, a trans* man marrying a woman) and enjoy the rights that come with married status). They include (at time of writing, and moving broadly from East to West): New Zealand, Australia, Japan, Indonesia, China, South Korea, Taiwan, Viet Nam, Singapore and Iran.⁷⁶ In some (for example South Korea

⁷⁵ For more see Sood (2009).

⁷⁶ Nepal is in the process of making changes that, by allowing a third gender status, may have the effect of allowing heterosexual marriage (though conceivably it may result in allowing marriage of each of the other two genders). Recent developments in Tamil Nadu and Pakistan appear to give certain rights to trans* people (though not, as far as can be seen, the right to marry heterosexually). A 2007 court decision in the Philippines has had the effect of revoking the right that trans* people once had to seek legal gender status changes there. Recent court decisions in Hong Kong (2010) and Malaysia (2011) have upheld their respective governments' refusals to change legal status. A campaign to allow Thai trans* women to change the gender marker on their ID cards ('Mr' to 'Miss') (a campaign that held the promise of legal gender recognition) has so far been unsuccessful.

and Singapore) the right to gender recognition is by statute (enacted law). In others (for example Indonesia) legal recognition is available to those who are able successfully to argue their case in court. Outside this list of 10 countries and territories, trans* people's right to marry are, in effect, restricted to the same-gender kind (a trans* woman marrying a woman, a trans* man marrying a man). This is an irony not lost on the region's same-sex communities, whose members do not generally enjoy the right to same-sex marriage, and may in some places even be prosecuted for their same-sex relationships.

Where trans* people enjoy any sort of gender status recognition, it is usually strictly controlled. Conditions apply. They can be onerous. For example, in China requirements include gender affirming surgery, living and working in the gender that matches the new anatomy, informing direct relatives, divorcing if married, and being free of any criminal record. This presents a serious problem for many trans* people. Employment discrimination against trans* people is common, and sex work may often be the only way of earning money for surgery. With common police action against TSWs, the requirement to be free of a criminal record can be difficult to satisfy.⁷⁷

Region-wide, the most common condition for legal gender recognition is that the persons concerned must have undergone gender affirming surgery. Gender affirming healthcare can involve a range of surgeries; including breast and facial. However, it is gonado-genital surgery (the only one that remains invisible in everyday encounters) that often appears to have legal significance. In the case of a trans* woman, it usually involves removal of penis and testes (and construction of a neo-vagina). In the case of a trans* man, it often involves removal of the uterus and/or ovaries (and some sort of surgery to create a neo-phallus). In most countries region-wide, this sort of surgery is prohibitively expensive. Often coming on top of other transition costs (hormones, breast augmentation or removal, facial feminisation surgery etc) this surgery imposes an additional budget pressure on individuals who may, because they are transitioning, be unable to get a job. The result is additional pressure to enter sex work. For those who cannot afford surgery, or choose not to enter sex work to fund it, legal gender status change effectively remains out of their reach.

Those who can afford surgery are faced by another choice. Gonadal surgery is in effect one that sterilizes people. It may indeed make possible a (heterosexual) marriage (e.g. between a trans* woman and a man). But it also has the effect of making impossible any involvement in child conception.⁷⁸ Rights to marriage and family are widely considered to be fundamental. But trans* people often have to choose between the two.

In some of the countries not allowing change in legal gender status, it is nevertheless possible to obtain identity documentation (ID) that records the person's self-affirmed gender, facilitates a range of daily activities, and/or enables access (e.g. in parts of South Asia) to goods, services and political rights. For example, in Hong Kong trans* people after gonado-genital surgery are able to apply for issue of a new ID card that reflects their self-affirmed gender.⁷⁹ A more unusual ID card arrangement (apparently available to all trans* women, regardless of surgical status) is the food ration or family card used

77 Mountford (2009).

78 In some parts of the Asia-Pacific it may be possible to arrange sperm or egg banking, but this can prove prohibitively expensive in many places.

79 Emerton (2004a).

in the Indian state of Tamil Nadu, which now identifies trans* people as third gender.⁸⁰ This last development is linked to a number of other measures, which together appear to constitute a thoroughgoing social reform programme – one involving a Welfare Board and including, electoral, educational, housing, pension and health opportunities, and even an officially sponsored Transgender Day.

In summary, the failure (or explicit refusal) of many Asia-Pacific governments, either to employ gender affirmative policies in regard to legal gender status and documentation, have resulted in restrictions on trans* people's rights in regards to employment, housing, a range of other goods and services, as well as rights to privacy, marriage and family, and in some cases rights to participation in political life.

Legal and law enforcement issues related to gendered or sexual behaviour

Key areas here are laws used to prosecute trans* people on the grounds of their sexual behaviour, their pursuit (or perceived pursuit) of sex work, or simply the way they look; as well as issues concerning the incarceration of trans* people, and concerning prosecution of those who engage in sexual violence towards them.

As was seen earlier in this paper, in many jurisdictions there is no opportunity for trans* people to gain legal recognition in their self-affirmed gender status. A consequence is that heterosexual behaviour (e.g. between a trans* woman and a man) is commonly criminalised under same-sex behaviour laws (for example in Bangladesh, Malaysia, Pakistan, Papua New Guinea, Samoa, Tonga etc). Such laws hinder safer sex practices.⁸¹

In those places in which trans* people are (for various reasons outlined later) heavily involved in sex work, and where sex work is criminalised (for example Pakistan, Laos, Cambodia, China, Thailand) or otherwise regulated (India, Malaysia, Singapore, Hong Kong), they find themselves targeted by law enforcement authorities. Across the region TSWs and others suspected of being TSWs are often arrested on sex work charges (sometimes with possession of condoms or lubricant as evidence), or on the basis of public order offences such as loitering, vagrancy, public nuisance, or begging.⁸² Region-wide, laws against human trafficking have been used (unsuccessfully) in an attempt to stamp out sex work.⁸³

The case of Cambodia spotlights how laws against sex work can be both ineffective and oppressive. The recent (2009) law criminalises not only sex workers, but also anyone who has an association with them, even sexual health workers. It has led to grave concerns about arbitrary detentions, and abuse of and sexual violence towards trans* people by police. Brothels have been closed down, only to be replaced by other entertainment venues which, while providing a venue for sex work, present another face to the authorities by ostentatiously banning condoms on their premises. In an ominous sign of what the future may bring, it is reported that sex workers are now reluctant to attend sexual health clinics. Many have been forced into rehabilitation

80 For more see Sood (2009).

81 For more see Godwin (2010).

82 For general overviews see Sood (2009), and APNSW, UNFPA, & UNAIDS (2011). For a country-specific report see for example Hahm (2010).

83 For more see Sood (2009), APNSW, UNFPA, & UNAIDS (2011), and Kirby (2011).

programmes against their will.⁸⁴

In some Asia-Pacific countries, laws criminalise the way trans* people look by outlawing cross-dressing as imitation or impersonation of the other sex, seen as un-Islamic or as indecent behaviour (Afghanistan, Malaysia, Samoa and Tonga).⁸⁵

Laws such as the ones already outlined (laws on same-sex behaviours and sex work, as well as public order laws on loitering, vagrancy, public nuisance, begging, cross-dressing, or 'imitation of the opposite sex') often provide the context (perhaps sometimes the pretext) for much of the police violence against trans* people described earlier. Those detained by police, as well as those later imprisoned, run the risk of enforced haircuts, gender inappropriate uniform and curtailed access to gender transition healthcare.⁸⁶ Trans* people may be incarcerated with inmates of their birth assigned sex rather than their self-affirmed gender. This puts trans* women particularly at very great risk of sexual assault (including rape) by other inmates and prison staff.

In summary, Asia-Pacific legal environments serve to marginalize trans* people in many ways, failing to offer trans* people sufficient protection against discrimination and abuse, and themselves discriminating by withholding either practical or legal recognition of self-affirmed gender, criminalising trans* people's sexual or gendered behaviours, or subjecting trans* people to gender-inappropriate detention or incarceration practices. An attempt was recently made to categorise Asia-Pacific legal environments and law enforcement practices on a five-point scale running from highly prohibitive environments to those (at the other extreme) offering protection with recognition (in regard to sexual and gender minorities). Only three Asia-Pacific countries and territories (Australia, New Zealand and the Pitcairn Islands) clearly fell into the category 'protection with recognition measures'. By contrast, 'highly prohibitive' countries included Afghanistan, Brunei, Bangladesh, Cook Islands, Kiribati, Maldives, Malaysia, Myanmar, Nauru, Pakistan, Palau, Papua New Guinea, Solomon Islands, Samoa, Tonga and Tuvalu. A large number of other countries were listed as 'moderately prohibitive'.⁸⁷

The United Nations have been consistent in calling for removal of laws that marginalize trans* people (and MSM), pointing out that they constitute barriers to provision of and access to HIV services.⁸⁸

Psychological health and well-being

Relatively little systematic research has been undertaken to examine the health and wellbeing of trans* people in Asia-Pacific. However, it seems likely that the daily experiences of stigma and prejudice, discrimination, harassment and abuse, and consequent marginalization, often impact on Asia-Pacific trans* people's health and well-being, as is the case for their counterparts elsewhere in the world.⁸⁹ Case reports,

84 For more on the Cambodian law see Overs (2009) and Godwin (2010).

85 For more see Sood (2009) and Godwin (2010). For a very detailed focus on the effects of a recent Kuwaiti law on 'imitation of the opposite sex' see HRW (2012).

86 For a discussion of incarceration issues see Global Commission on HIV and the Law (2011).

87 Godwin (2010), adapting the categorization system developed by Caceres et al. (2008).

88 e.g. Commission on AIDS in Asia (2008); Commission on AIDS in the Pacific (2009).

89 For example see Nuttbrock et al. (2010), Grant et al. (2011); IOM Committee on Lesbian, Gay, Bisexual and

“Internalized transphobia is what it is called. Because some people are transphobic, I every now and then, admittedly and with all honesty, feel transphobic towards myself. It seems most true when I am with people whom I love deeply. I can take the name-calling when it is directed towards myself. What I find more difficult and painful is when other people, especially those I love, are supposedly shamed because of me. My parents, for example. I don't want them to feel that my being a transsexual is a reflection of their parenting. This is why I used to refrain from participating in family get-togethers or affairs that involve my parents, myself, and other people.”

– Dee, 33 years old trans* woman, Philippines⁹⁰

biographies, autobiographies and surveys suggest a commonly shared pattern of low self-esteem and self-confidence, as well as social isolation, social anxiety and stress, likely leading to feelings of helplessness and depression, risk-taking behaviours (such as alcohol and drug abuse) and in some cases hopelessness and suicide (attempted or actual).⁹¹ The risks associated with injected drug use need no elaboration here.

Intimate relationships pose a particular problem.⁹² Research suggests that the majority of Asia-Pacific trans* women and trans* men identify as heterosexual (are attracted to males and females respectively), to an extent greater than is commonly found in Western studies.⁹³ Many of their partners identify as straight (often dubbed 'real') men, may be married, certainly have sex with (birth-assigned) women, and are wary of entering any

Transgender Health Issues (2011) for the USA, and Whittle et al. (2007) (UK), Mottmans et al. (2010) (Belgium), Pitts et al. (2006) (Australia), and Couch et al. (2007) (Australia and New Zealand).

90 Communication with author, previously unpublished transcription.

91 e.g. Sood (2009), Godwin (2010), APNSW, UNFPA and UNAIDS (2011). See also studies by Pitts et al. (2006), Couch et al. (2007) for Australia and/or New Zealand; Kim et al. (2006) for South Korea; Guadamuz et al. (2010) for Thailand, Teh (2002) for Malaysia, and Yuksel et al. (2000) for Turkey. Note also a Lao study (Winter and Doussantousse, 2006) indicating that lifelong experiences of being transgender predict trans* people's mental health - in terms of self-esteem, depression, fear of negative evaluation, loneliness, general well-being, satisfaction with one's appearance, comfort being known as a trans* woman, and suicidal thoughts and behaviour. Other findings of note were that trans* women who had more fully transitioned, and were more comfortable with their gender identity and appearance, also enjoyed better mental health and well-being. Trans* women who believed that gender variance was a disorder (whether mental, physical or moral) displayed poorer mental health and well-being. All these findings imply that stigma, prejudice, discrimination and marginalization can have a damaging effect on trans* people.

92 For more on this topic see e.g. Bavinton et al. (2011) (Fiji).

93 Almost all Asia-Pacific research in this area concerns trans* women; Malaysian, Singaporean, South Korean, Thai, Filipina, Lao, and Japanese. Most studies reveal that the most common pattern of sexual preference among trans* women is towards men (a heterosexual orientation when displayed by trans* women). In Malaysia, Teh (2002) reported that 97 per cent of her trans* female participants had a history of attraction to men and had a male as their first date. A similar figure (presumably largely the same participants) reported never being attracted to women. In a now old Singaporean study, Tsoi (1990) found that all the trans* woman participants in his study reported attraction to men. Kim et al.'s (2006) found that 98 per cent of the trans* women in their Korean study reported attraction to men. Winter, Rogando-Sasot, and King (2007) found that 95 percent of their Filipina participants reported attraction to men. In Laos and Thailand the corresponding figures were 94 percent (Winter and Doussantousse, 2006) and 98 percent (Winter, 2006b). The only major exception to this picture of overwhelming heterosexuality is in a Japanese sample of trans* women, only 40 per cent of whom were attracted to men (though a further 14 per cent appeared to be bisexual): Okabe et al. (2008).

long-term relationship with a trans* woman, whom they know to be a member of a widely stigmatized group, and with whom they cannot enter marriage or have children.⁹⁴ Indeed, freedom from pressures to marry a trans* woman, and from concerns that she may bear a child, likely makes her a more attractive partner for a man wanting casual sex. At any rate, trans* women often feel that it is difficult to meet someone ready to commit to a long-term intimate relationship.⁹⁵ The same may be true for trans* men; we just do not know. At this point we turn to a more detailed consideration of trans* people's sexual (and other) behaviours that put trans* people at risk.

Risky sexual (and other) behaviours

General vulnerabilities

As is so often the case for research on trans* men in the Asia-Pacific, we know very little about the sexual practices that may place trans* men at heightened risk of HIV infection. Much of what follows therefore concerns the sexual practices of trans* women.

Most Asia-Pacific trans* women are attracted to men and, consistent with their female (or feminised) social role, and in many cases their female identity, tend to adopt a receptive sexual role as penetratee, although it is clear a minority also engage in the insertive role, engaging in penetrative intercourse with their male partners.⁹⁶ Their partners commonly resist gay and MSM labels (or local equivalents), identifying as straight (or 'real') men on the basis of their role as penetrator. It is known that unprotected receptive anal intercourse (URAI) is a high risk sexual behaviour, and puts the receptive trans* woman at substantially greater risk of HIV infection than her partner. For comparison, the risk of transmission (around 1.4 percent per act) is around 18 times higher than for vaginal intercourse.⁹⁷ As for trans* women who have undergone gender affirming surgery, the tissue which forms the neovaginal wall is clearly not identical to that which forms the wall of a birth-assigned woman's vagina. Nor apparently is the microfloral environment.⁹⁸ It is not known what this means in terms of HIV transmission risk, although presumably there is a heightened risk of transmission for a trans* woman if the lining of the neovagina is damaged. Research is sadly lacking in this area.

What about the sexual preferences of Asia-Pacific trans* men? Two studies are relevant here, both Asian. They suggest an overwhelming pattern of attraction to women (i.e. once again a heterosexual pattern). Similarly, Tsoi's (1990) Singapore study indicated that a majority of the trans* men in his study were attracted to women, though on this matter the precise figures are rather unclear. In Japan, Okabe *et al.* (2008) reported that 92 per cent of trans* men were attracted to women.

How do these figures compare with Western countries? The most reliable research in this respect appears to be a study of 113 consecutive trans* women referred to a Dutch gender identity clinic, which reported that only 54.5 per cent who were exclusively attracted to men, a figure well below most of the Asian figures (Smith *et al.*, 2005). A very recent European study by Nieder *et al.* (2011) reveals a similar figure (47 percent of trans* women in the sample reporting being attracted to men), and in addition provides some figures for trans* men (a much higher figure, 92 percent, reporting exclusive attraction to women).

94 This is most certainly true in the West (e.g. Bockting *et al.* 2007, Coan *et al.* 2005). It also seems true across much of the Asia-Pacific (e.g. Costa and Matzner, 2007, for Thailand; and Bavinton *et al.*, 2011, for Fiji).

95 See e.g. Bavinton *et al.* (2011).

96 See e.g. Bavinton *et al.* (2011) (Fiji) and Chemnasiri (2010) (Thailand).

97 Baggaley *et al.* (2010).

98 Weyers *et al.* (2009).

As is found in much of the Western research on trans* women,⁹⁹ protected sex is often inconsistent,¹⁰⁰ and below the consistency level (suggested to be 60 percent) necessary to stabilise the HIV epidemic.¹⁰¹ Reasons are many. A trans* woman may believe that semen makes her stronger.¹⁰² Alternatively the reason may be poor knowledge about HIV, the risks, the various means of transmission and ways to protect oneself. Lack of knowledge may result from inadequate (or nonexistent) sexual health education (particularly at school).¹⁰³ Alcohol and/or drug use may reduce caution.¹⁰⁴ Sometimes condoms may not be easily available or affordable. They may be regarded by police as evidence of sex work, so that trans* women (including those who are not TSWs) are discouraged from carrying them. Among trans* women and their partners there may be a degree of message fatigue or complacency, the latter stemming from an awareness of new treatment regimens that have turned AIDS from a death sentence into a manageable condition.¹⁰⁵ These areas remain under-researched. The absence of research is even more marked in regard to trans* men.

One can speculate that age- and gender-based power relationships may enter the equation, making it more likely that a trans* woman will accede to her partner's reluctance to use a condom. Relevant here are findings that Asia-Pacific trans* women commonly report an early sexual debut, often involving an older partner.¹⁰⁶ In some parts of the region coercive sex is quite common.¹⁰⁷ It is known that early debut may put trans* women at greater lifetime risk of HIV infection,¹⁰⁸ as sexual coercion may. Studies outside the Asia-Pacific region have investigated the use of female condoms in anal intercourse.¹⁰⁹ There appears to be no Asia-Pacific research that examines the role female condoms might play in the lives of trans* women, perhaps as a way of empowering them in matters of safer sex.

Again, we may speculate about other reasons a trans* woman may choose not to insist that her partner use a condom. She may see her role as one of providing pleasure to her insertive partner, and see the condom as diminishing the pleasure she can give.¹¹⁰ She may see condoms as undermining intimacy during the sex act. She may want to

99 e.g. Coan et al. (2005), Bocking et al. (2007).

100 For example, Chemnasiri (2010) found inconsistent condom use in 52 percent of his sample of 241 Thai trans* women. Even though they all reported being sexually active, only 50 percent were carrying a condom at the time of the interview. Only 15 percent of Bavinton et al.'s (2011) sample of Fijian trans* women reported always using a condom. See also the Hahm (2010) and Hawkes et al. (2011) in Pakistan, both of which studies report inconsistent or low condom use in the trans* community.

101 Brown and Peerapatanapokin (2004).

102 e.g. in Cambodia, where this is reported to be a common belief (Chanthan, 2006).

103 e.g. see Boonmongkon (2009) discussing sexuality education in Thailand.

104 Note however, the Bavinton et al. (2011) Fiji study failed to find any relation between alcohol/drug use and unprotected sex (although sadly in this regard the study conflates findings for MSM and trans* women). The Fiji finding conflicts with some of the Western research, e.g. Coan et al. (2005).

105 For example Chemnasiri et al. (2010) found that 34 percent per cent and 37 percent of the 241 trans* women sampled reported not being worried about STIs and HIV respectively, and 62 percent reported never previously undergoing an HIV test. As was reported in an earlier note (Footnote 100), inconsistent condom use was high, and many in the sample reported a history of ever having STIs.

106 See e.g. Bavinton et al. (2011) for Fiji. See also Hawkes et al. (2011) study of Pakistani sex workers, which reports an average age of 13.3 years for sexual debut among TSWs, lower than was the case either for FSWs or MSWs.

107 See e.g. Bavinton et al. (2011) for Fiji.

108 e.g. Guadamuz et al. (2010) in Thailand.

109 See e.g. Kelvin et al. (2011).

110 e.g. Bavinton et al. (2011) in Fiji.

communicate commitment and trust, and respond to signs of each in her partner, by allowing (or even encouraging) unprotected sex.¹¹¹ Her unwillingness to undermine commitment or communicate distrust may possibly be all the greater if she comes to the current relationship with a long history of others that have failed.

The inconsistency is not just about condoms; it is about lubricants too,¹¹² with inconsistent use presumably raising the risk of abrasions and tearing, and consequent HIV transmission. Lubricants, including the water-based kind that can be safely used with condoms, may be difficult to obtain or unaffordable.¹¹³ Worryingly, recent evidence from outside the Asia-Pacific suggests that certain commercially available lubricants may actually raise the risk of STI infection (including HIV) during receptive anal intercourse.¹¹⁴ Little appears known (other than that the oil-based lubricants are liable to damage condom integrity) about the risks (either for the trans* woman or her male partner) associated with some other lubricants used across the region, (e.g. engine oil, baby oil, vasoline, coconut oil, shampoo, moisturiser, saliva etc.)

In a recent article focused on MSM, a leading researcher asked whether risk-reduction practices other than those involving a condom might have a role to play in fighting the HIV epidemic.¹¹⁵ The same question might be asked about trans* people. It seems likely that trans* women, like MSM, probably engage in a variety of safer sex practices that do not involve a condom. Yet, such practices have seldom been researched in the Asia-Pacific region. Exceptions to this pattern are provided by two recent studies, one in Fiji and the other in Japan. The Fijian study appears to suggest that trans* women engage in intercrural sex (sex between the thighs, sometimes called interfemoral sex) approximately as often as they engage in protected anal sex, and that this may be true during sex with both regular and casual partners.¹¹⁶ The Japanese study suggests that, at least among TSWs, fellatio and sumata (rubbing the penis with various parts of the body, including, in the case of the post-op trans* woman, the labia majora) is common.¹¹⁷ These findings beg questions about what other forms of safer sex trans* women and their partners might employ. Other examples may be handjobs, footjobs, intergluteal sex (penis between the buttocks), mammary sex (penis between the breasts), and axillary sex (penis in the armpit), as well as presumably less-safe-but-low-risk practices such as frotteurism (penis-to-penis masturbation). Research into these areas could provide a basis for more nuanced safer sex messaging.

Rather obviously, sexual exclusivity is a form of safer sex practice. There has been some interesting Western MSM research in this area.¹¹⁸ Many trans* women who are sexually active become involved in multiple relationships.¹¹⁹ Sometimes it is linked to a need to 'get the next guy' and thereby reaffirm their gender identity and attractiveness to men

111 For research and discussion on these issues see Melendez and Pinto (2007); and Coan et al. (2005). See also Lertpiriyasuwat and Tantiratanawong (2010) in Thailand.

112 e.g. Lertpiriyasuwat and Tantiratanawong (2010).

113 See Noor (2009).

114 See Begay et al. (2011) and Gorbach et al. (2012), though it remains unclear whether the lubricants studied in these researches are on sale in the Asia-Pacific region.

115 Van Griensven (2009).

116 A rare example is Bavinton et al.'s (2011) Fiji study, which examined a comparatively broad range of sexual practices.

117 Higashi et al. (2011).

118 Sigma Research (2011).

119 See e.g. Bavinton et al. (2011) in Fiji.

(in which case the multiple relationships may be concurrent, even occurring in a group sex setting).¹²⁰ Possibly it is also associated with a persistent and unsuccessful search for a long-term partner (in which case they may be serial). At times some trans* women may (in a reversal of the usual gender pattern) purchase sex from men. Throughout, the trans* women and their partners may not feel that restraints commonly imposed on female sexual behaviour apply to them. For one thing they have an uncertain social status as women. For the other they and their partners do not have to fear pregnancy. All these are currently under-researched areas. Modern technologies (e.g. mobile phones, texting, e mails, chat, videocam and social networking websites) provide new ways of developing sexual networks (and even of doing sex) and may facilitate the forming of multiple relationships.¹²¹ It is known that multiple sexual relationships aggravate HIV vulnerability. They may do so all the more in the case of trans* women, since there is some evidence (albeit Western) that HIV prevalence in male partners of trans* women is somewhat elevated.¹²² There appears to be no corresponding Asia-Pacific research.

In some parts of the Asia-Pacific (e.g. Thailand and Fiji), it is common for men to scar their penises. Others inject olive oil or other substances to enlarge the penis, or insert implants (of plastic or glass beads) to make it more irregularly shaped. Piercing is also practiced. Two recent studies of Thai drug users indicate how common penile modification is. One reported that 26 percent of MSM and 9 percent of 'straight' men had penile bead implants.¹²³ Another, with no indication of sexual orientation, reported a wide range of modifications, with the highest prevalence (61 percent) being for beads.¹²⁴ Such practices may involve the use of unsanitary or shared equipment, and may therefore present a direct risk of male-to-male HIV transmission of a non-sexual kind. We do not appear to know what impact, if any, penile injections or implants have on condom use or breakage. We can only speculate that there may be an increased risk of condom breakage and rectal or vaginal (and neovaginal) tearing, and a consequently heightened risk of sexual HIV transmission to any trans* woman who acts as receptive partner (or indeed to any birth-assigned female partner). For this review it was not possible to identify any regional research on risks associated with these practices.

In the absence of research into the sexual practices of trans* men in the Asia-Pacific we can only assume that many of the safer sex practices detailed above (and perhaps others) might play a part in their lives.

TSW vulnerabilities

A substantial number of Asia-Pacific trans* people evidently enter sex work. There are probably trans* men among them, perhaps in role as female sex workers (FSWs). This is most certainly the case elsewhere.¹²⁵ However, across the region, the involvement of trans* men in sex work (both as MSWs and in the role of FSWs) appears severely under-researched. More research is needed, into the circumstances in which they live, as well as their healthcare needs. In the absence of such research, the following section focuses on

120 See Bavinton et al. (2011) (Fiji).

121 See Ojanen, 2011.

122 Bockting et al. (2007).

123 Beyrer et al. (2005).

124 Thomson et al. (2008).

125 See e.g. Sevelius (2010) in the USA.

“ Since I moved out from my family in 1999, I have understood the difficulty of sex work. We did not want to trade our body for money, but the facts and reality force us to do so, and we did not have other choices. . . . Nowadays, I am still a sex worker, because it is only the money that I can use to take care of myself when I am sick. It is not a discreditable work, I strongly believe that sex work is work, because I do not go to rob or steal. I use my body to earn money.”

– Pech, 41 years old trans* woman, Cambodia¹²⁶

trans* women, and seeks to summarise what is known (or is thought known) about the risks associated with their involvement in sex work region-wide.¹²⁷

Trans* women’s sex work can take many forms; each form with its own levels of working contexts, working conditions, sex acts and payments, sex-payment contingencies, customer bases, and worker-customer relationships.¹²⁸ Given the very different forms sex work can take (and the fact that many if not all forms may be criminalised), it is difficult to ascertain how many TSWs there are in the region. It seems the numbers may be large, at least in some parts of the region. In one sample (Malaysia), 54 percent of trans* female participants reported a history of sex work.¹²⁹ Another estimate (Indian) puts the proportion of trans* women involved in sex work as high as 80 percent.¹³⁰ The World Bank estimates the number of female TSWs in Pakistan to be 35,000 (nearly a fifth of all sex workers nationwide).¹³¹ Another estimate puts the proportion at a quarter of all sex workers.¹³² In much of the region it appears that the customer base for female TSWs is correspondingly large.¹³³ Some of those involved in sex work are very young; one Pakistani report speaks of trans* girls as young as 12 years being sent out to find customers by their guru.¹³⁴

It is likely that sex work presents several benefits for the TSW. Anecdotal evidence indicates that many trans* women migrate from provinces to cities, and lack any supportive partner or network of social connections that may lead to a job, and/or educational qualifications that may make them attractive in the mainstream labour market. We may conclude that sex work presents the prospect of earnings not available elsewhere; not only to cover basic living costs, but also the costs of hormones, injections and/or surgeries whose costs

126 Communication with author, previously unpublished transcription.

127 For further research into trans* sex work in the Asia-Pacific see e.g. Bavinton et al. (2011), Winter and King (2011), and Gallagher (2005).

128 These forms range from street work to work in bars, nightclubs and discos, to higher-end escort ‘out-call’ work. With growing wealth across the Asia-Pacific, and growth in international air travel (regionally and intercontinental), more TSWs nowadays serve a tourist customer base, either serving them when they visit their home countries, or travelling overseas to serve them (albeit often on tourist visas, with consequent risk of breaking the terms of their visas). With the development of the internet some trans* women have entered chat room and videocam sex work (possibly the safest form of sex work around). Some trans* people turn to sex work when need or opportunity arises. Some take payment in forms other than money, and in the context of steady relationships. See Winter and King (2011), Bavinton et al. (2011) and Gallagher (2005) for more discussion regarding forms of trans* women’s sex work.

129 Teh (2002).

130 IAVI-India (2008).

131 World Bank (2010).

132 Khan et al. (2008).

133 Winter and King (2011).

134 Hahm (2010).

might otherwise exceed disposable income.¹³⁵ It is possible that these procedures not only have the effect of physical feminisation; they may also increase earning power.

Trans* women are commonly the youngest among their siblings.¹³⁶ They may sometimes shoulder responsibilities to support aging parents that make income from sex work a particularly attractive proposition. It is possible that a trans* woman may find sex work income even more attractive if it holds out the hope of repairing a relationship with parents that has been strained by their difficulties adjusting to their child's gender issues. Aside from money, a trans* woman may find that sex work makes possible membership of a (hopefully supportive) transgender community, daily (or nightly) re-affirmation of her gender identity and her sense of attractiveness to men, and the prospect of a long term relationship with a customer (including perhaps foreign customers and the prospects of life in another country with better living standards and legal gender status recognition).¹³⁷ Across South Asia, where trans* women often live in *hijra* households to whose finances they are expected to contribute, income from sex work may provide some security in living accommodation, as well as status within the household.¹³⁸ Overall, there is very little research into the motives trans* women have for entering (and the benefits they get out of) sex work.

Along with the benefits of sex work, there are of course costs. First comes stigma. Sex work is widely stigmatized through the region,¹³⁹ though the degree to which sex work is stigmatized varies, and may depend on popular attitudes towards sex work, expressed in (and in turn shaped by) sex work laws in the country concerned. To the extent that sex work carries any stigma, it serves to marginalize trans* women even more than would otherwise be the case. Sadly, there is evidence that TSWs are stigmatized even within transgender communities.¹⁴⁰

Next is increased risk of harassment, hostility and violence.¹⁴¹ Customer violence is common, often (but not exclusively) when a TSW's gender status is discovered late on in a transaction.¹⁴² Police, under pressure to remove persons seen as undesirable elements, or enforce anti-sex work laws, may arrest (sometimes arbitrarily, even on the supposed basis of being a nuisance to tourists), fabricate evidence, abuse, beat up, sexually assault and/or extract money from those that fall into their clutches. As noted earlier, public order laws covering cross-dressing, begging, vagrancy, indecent behaviour, loitering may be used against TSWs who work the streets, or who are assumed by police to be doing so. Possession of condoms or lubricant may be considered evidence of sex work, with the result that TSWs may not have them available when they are needed. For female TSWs

135 See e.g. Suja et al. (2005) and Mahinchai and Ditsawanon (2008) for Thailand, and Winter (2009b) (for Asia more generally).

136 See data in Winter (2006b).

137 For more on the forces underlying the drift to sex work see Winter and King (2011).

138 See for example Hahm (2010), talking about Pakistani *hijra*.

139 See e.g. APNSW, UNFPA and UNAIDS (2011).

140 See e.g. Sood (2009).

141 Much of the material cited earlier in this review in connection with violence (including sexual) is relevant here. The case of Turkey is especially egregious; TSWs there have for some time been especially prone to violence, too often becoming victims of murder. Sections of a book edited by Ordek (2011) are particularly informative here. Customer violence is a phenomenon that is not limited to developing countries; Higashi et al. (2011) report levels of violence against TSWs in Japan.

142 In the Asia-Pacific as elsewhere perpetrators have defended their actions by claiming they had been deceived into thinking that the victim was a woman.

who are imprisoned, incarceration with male inmates (with consequent risk of sexual assault) puts them at even higher risk of HIV infection.

There may be a third cost, at least for some TSWs: relationship distress. Any trans* woman who hopes to find a stable partner through sex work and who becomes emotionally involved with a customer may be putting herself at risk of being abandoned. A customer showing signs of emotional commitment may simply be looking for a reduced or waived fee, or looking for more intimate (i.e. condomless) sex, and may be uninterested in a stable relationship at all. The tourist taking a TSW for a few days of beach holiday may simply regard his companion as sexual luggage, something to make the holiday even more enjoyable. In any case, a holiday romance may not survive beyond his return to his home country.¹⁴³ These and other emotional costs attaching to the work of a TSW remain severely under-researched.

Stigma, harassment and violence and relationship distress are all likely to add to the marginalization experienced by TSWs, and impact on their emotional health and well-being, making risky sexual practices more likely.¹⁴⁴

Where the research has been done on TSWs in the Asia-Pacific, it is commonly found that they frequently engage in URAI.¹⁴⁵ Reasons for inconsistent condom use in trans* sex work are many. Some of those discussed earlier in regard to the general trans* population probably apply here too. For example TSWs, like other trans* people, often lack adequate knowledge about HIV and safer sex,¹⁴⁶ or leave themselves susceptible to emotional manipulation by customers who seem like they are becoming something more.¹⁴⁷ However, special factors apply too, including the imperative to make money (a key consideration when the customer is demanding URAI or is prepared to pay extra for it).¹⁴⁸ Older TSWs may be less attractive to customers, earn less, and consequently have less power to insist on condom use.

The stigma of sex work combines with gender relationships to render TSWs particularly powerless in decisions about protected sex, especially where there is a risk the customer may turn violent. Street TSWs may be especially vulnerable. They may be working the street because they have been barred from indoor venues open to other sex workers. They may not be carrying condoms for fear that they may be used as evidence of sex work. The street sex acts between a TSW and customer may in any case be brief, leaving less time for the *niceties* of a condom.

Use of alcohol and mood-changing drugs, either on the part of the TSW or her partners, may heighten the risk of unprotected sex.¹⁴⁹ A rather different set of drugs, for male erectile dysfunction (Western pharmaceuticals – e.g. Viagra© -- as well as local drugs –

143 For more discussion of these issues see Winter, Slamah and Ordek (2010) and Winter and King (2011).

144 See e.g. Global Commission on HIV and the Law (2011) for an overview.

145 See e.g. Pisani et al. (2004) in Indonesia, and Hawkes et al. in Pakistan, both of which studies involved TSWs. The Indonesian study reported a 22 percent prevalence rate for HIV seropositivity (and 19 percent prevalence for syphilis), and found that 59 percent of the sample reported recent unprotected anal sex with customers.

146 e.g. Hawkes et al. (2011) (Pakistan).

147 See Winter and King (2011).

148 See here data from Higashi et al. (2011) indicating that large numbers of Japanese TSWs encounter clients who are reluctant to use a condom.

149 See findings of Bavinton et (2011) in Fiji indicating no relationship.

e.g. the herbal supplement Gambir©) may heighten risk from unprotected sex, through anal or neo-vaginal abrasions stemming from repeated and lengthy periods of sexual intercourse. There seems to be little data (indeed no Asia-Pacific data) on these risks. But there is good reason to suppose that these drugs are linked in some way to HIV transmission; a recent report drawing on data from a large scale MSM study in the US identifies the use of inhaled nitrites ('poppers'), stimulants and erectile dysfunction drugs as major predictors of HIV infection.¹⁵⁰ The findings were all the more dramatic in view of the fact that these effects were observed even after taking into account the number of URAI partners.

Worldwide there is a growing body of research on trans* women's HIV risk behaviours.¹⁵¹ However, Asia-Pacific research is comparatively scarce. Much of what is known in regard to trans* women in the Asia-Pacific region comes from small case studies and reports of CBOs and NGOs,¹⁵² as well as discussion papers written by individuals who have been researching trans* communities.¹⁵³ Empirical studies looking at factors predicting risk for either unprotected sex or HIV seropositivity are relatively few.¹⁵⁴ Sometimes the findings have been less than surprising (not a bad thing in itself). For example, a recent Thai study reported that inconsistent condom use among trans* female participants was predicted by a history of sexually transmitted infections, worry about HIV infection, and not carrying a condom on the day of the research.¹⁵⁵ However, two studies are worth noting for some less obvious findings. Both aimed to identify predictors for HIV seropositivity in samples of trans* women. The first, a Thai study, found that trans* women who reported being role-versatile and having had a sexual debut under age 13 were more likely to be HIV positive than others. In an indication that there may be transgender underclasses with specific HIV care needs, HIV seropositivity was also more likely among the older participants, and those who had been recruited into the study from a park or from the street.¹⁵⁶ The second, a Pakistani study, found that female TSWs who reported their first sex was forced were at higher risk for infection with HIV/Herpes Simplex Virus 2 (HSV2).¹⁵⁷ This sort of finding underlines how important it may be for research to acknowledge trans* people as a heterogeneous group, taking account of different life styles and histories that may impact on HIV vulnerability.¹⁵⁸

150 Ostrow et al. (2009).

151 For some examples of research outside the Asia-Pacific region see Nemoto et al. (1999, 2004), Reback et al. (2005); Herbst et al. (2008); and Melendez and Pinto (2007).

152 For overviews and discussions in regard to Asia-Pacific trans* people's HIV vulnerabilities see reports such as APNSW, UNFPA and UNAIDS (2011); USAIDS / UNDP (2010); and Godwin (2010). Caceres, Konda et al. (2008) is also useful, though the scope of this report extends beyond the Asia-Pacific.

153 See e.g. Slamah, Winter and Ordek (2010), and Winter and King (2011).

154 Exceptions include Kumta et al. (2006) and Chakrapani et al. (2008) (India); Teh (2002)(Malaysia); Luhrmann (2006), Guadamuz et al. (2010) and Chemnasiri (2010) (Thailand); Bavinton et al. (2011) (Fiji); and Hawkes et al. (2011) (Pakistan).

155 Chemnasiri et al. (2010).

156 Guadamuz et al. (2010). It is worth noting that there are echoes here of some of van Griensven et al.'s (2005) findings for a Thai MSM sample – for example recruitment from a park, versatile sex role, and years since first debut.

157 Hawkes et al. (2011).

158 Indeed, trans* diversity may be a particular feature of the South Asian communities, with clear distinctions evident in the identities and life circumstances of different groups, and (according to Haider and Bano, 2006) up to fifteen subgroups within the *hijra* community in Pakistan.

Gender-transition vulnerabilities

With the focus of research on HIV vulnerability firmly on sexual behaviour, there has been much less research on the HIV risks linked to gender affirming healthcare. Several possibilities exist. First, many trans* women employ injections of hormones and/or silicon as means to modify their bodies.¹⁵⁹ When contaminated syringes are shared, there is quite clearly a risk of HIV transmission. However, the extent of needle sharing is not known. Feminising hormones (including both oral and injectable) usually interfere with the ability to have a penile erection,¹⁶⁰ while gonado-genital surgery removes the possibility altogether. We can speculate that, as a consequence, an individual once capable of taking a penetrative role may now more likely take the (more risky) receptive role. Indeed, to the extent that her female identity may be further affirmed by either hormones or surgery, a trans* woman may in any case begin to prefer a receptive sexual role, as well delegate decision-making about protected sex. In the absence of relevant research, all this is speculation. More research into trans* people's sexual roles and behaviour is needed.

The transition healthcare-related risks do not stop here. As we have seen, hormones and other transition procedures are expensive, eating away discretionary income,¹⁶¹ and tilting some trans* women towards sex work in order to pay for their healthcare. The sex work puts them at increased HIV risk. Moreover, recent research (albeit with birth-assigned women) raises the possibility that injectable hormonal contraceptives may increase risks of acquiring and transmitting HIV (and no effect for oral contraceptives).¹⁶² The implications for trans* women are worrying. Effects (if any) may be quite difficult to examine. On one hand, many trans* women report feminising hormones reduce their desire to have sex (reducing the occasions on which HIV might be acquired or transmitted).¹⁶³ On the other hand, the effects of feminising hormones on trans* women's erectile function may result in them increasingly adopting a receptive sex role (a higher HIV risk activity).

As so often is the case in other important areas, our knowledge of the effects of hormones on HIV risk for trans* men is scarce. Research is badly needed on what impact (if any) injectable testosterone has on a trans* man's body, for example on the vaginal lining, and consequently on his risk of HIV infection.

With so many factors acting to make trans* women vulnerable to HIV, and so many of their sex partners identifying as heterosexual and engaging in sex with birth-assigned women as well as trans* women, it is easy to see how trans* women and their partners have been viewed as HIV vectors. This said, trans* women may have more reason to feel victim than vector. Already stigmatized on account of their transgender status (and perhaps on the basis of being sex workers), HIV positive status adds a third layer of stigma. Belatedly, and with the extent and distinctiveness of the transgender HIV epidemic now being realised (by international organizations if not national governments) there is the beginning of a concerted effort to provide systematic education, prevention, testing, and treatment services for this beleaguered population, explicitly distinguishing their needs and those of their partners from MSM.¹⁶⁴

159 e.g. Winter (2006b) (Thailand); Winter et al. (2007) (Philippines); Winter and Doussantousse (2009) (Laos).

160 Curtis et al. (2007).

161 See e.g. Mahinchai and Ditsawanon (2008), and Suja et al. (2005) (both in Thailand).

162 Heffron et al. (2012), though it should be noted that the participants in this study were *birth-assigned* women (taking hormones for contraceptive purposes) and their partners.

163 e.g. Mahinchai and Ditsawanon (2008), Suppamong et al. (2004) and Somchai et al. (2005) (all in Thailand).

164 UNAIDS (2009).

/ D. Health services for trans* people

Western research suggests health services commonly under-serve trans* people.¹⁶⁵ The same seems to be the case in the Asia-Pacific region, with numerous reports documenting problems in healthcare - whether for general, transition or sexual health.¹⁶⁶ Trans* people attending health services commonly report healthcare providers who are uncooperative or hostile, addressing or responding to the trans* person in a gender inappropriate way, adopting a mocking or ridiculing attitude, withholding or refusing healthcare, or even offering 'reparative' treatments. Access to whatever government healthcare exists may not be straightforward. For example, in Thailand internal migrants (of which there are many in the transgender community) do not always find it easy to access the recently introduced 'universal healthcare scheme' outside their home province. The situation in Kuwait is particularly egregious, with cases of doctors refusing to treat trans* women and/or reporting them to police for breaking the law on 'impersonation of the opposite sex'¹⁶⁷

Access to appropriate transition healthcare (trans*-positive, trans*-competent, accessible and affordable) is often a particular problem. This is true whether the healthcare is pre-, post- or during transition, hormonal, surgical or counselling. The costs of available transition healthcare can be prohibitive. Publicly funded health services may not cover them. The costs sometimes help edge trans* people into sex work. Trans* people often seek out whatever health services there may be, relying on word-of-mouth recommendations. They pay for whatever transition they can afford; gender affirming surgeries, implants and/or high-quality silicone injections (for those trans* people that have the money), or 'backyard' castration and/or industrial quality silicone from medically unqualified 'fillers' and 'pumpers' (for those on a budget). Some take care of their own healthcare needs as best they can (e.g. getting hormones wherever and whenever they can and taking them with little or no medical supervision).¹⁶⁸ Those who seek gender affirming surgery find that it is likely to be the most expensive procedure they ever undergo. The increasing tendency of surgeons and health authorities (most recently in Thailand and China) to mandate a mental health diagnosis (for 'gender identity disorder')¹⁶⁹ adds to the expense (as well as legitimising the idea that trans* people are mentally disordered).¹⁷⁰ Public subsidies for gender affirming surgery are seldom available; Hong Kong, Delhi, Mumbai and the Indian state of Tamil Nadu are rare cases. Moreover, other than Hong Kong it is currently uncertain as to how far these services apply to trans* men. In many countries transition-related surgeries (especially gonado-genital) are simply unavailable or else are prohibitively expensive. In Malaysia there is a *fatwa* banning Muslims from undergoing gender affirming surgery (while a different *fatwa* in Iran legitimizes the same procedure). For trans* women across much of South Asia castration, with or without removal of the

165 e.g. Collins and Sheehan (2004) (Eire); Whittle et al. (2007) (UK); Grant et al. (2011) (USA).

166 See for example regional reports by USAID / UNDP (2010); APNSW, UNFPA and UNAIDS (2011); Godwin (2011); Sood (2009); and more geographically specific reports by Cheung (2010) (Hong Kong); Hahm (2010) (Pakistan); and Cameron (2006) and Ojanen (2009,2010) (Thailand); See also reports from Australia and/or New Zealand by Couch et al. (2007), Pitts et al. (2006) and NZHRC (2007).

167 HRW (2012).

168 e.g. Winter and Doussantousse (2009) (Laos); Guadamuz et al. (2010), and Luhrmann (2006) (Thailand); and Teh (2002) (Malaysia).

169 The diagnostic terms used in DSM-IV and ICD-10, the current diagnostic manuals of the APA and WHO respectively.

170 Winter (2009b).

penis, has proved to be a much cheaper, and more easily available, route to feminisation (or more precisely, emasculation).¹⁷¹ Simple castration has also been available in places such as Thailand and the Philippines.

The shortcomings of transgender healthcare extend to sexual health services. Trans* women often find that sexual healthcare services are focused on female and (more recently) MSM communities. Neither is really suited to the needs of a trans* woman (especially one who has a neo-vagina). A trans* woman is likely to be denied women's services, and turned away from MSM services. Confidentiality is not always assured, especially in regard to mandatory HIV testing for sex workers. HIV positivity often compounds the problems in getting appropriate care. Disaffected and ill-served by health services, marginalized, lacking in confidence and self-esteem, trans* women (perhaps especially TSWs where sex work is stigmatized or illegal) may be reluctant to seek sexual healthcare, unless and until they experience a symptomatic STI.¹⁷² The needs of trans* men, who as we saw earlier may also be at risk of HIV infection (perhaps particularly if TMSM or working as TSWs) are left entirely unrecognised. TMSMs (including those working as a TSW) may find MSM sexual health services ill-suited to their needs. Those working in the role of FSW may view women's services as inappropriate.

Evidence of the challenges encountered by trans* women in finding and making use of sexual health services is evident in various Asia-Pacific studies.¹⁷³ Not surprisingly, across the region few trans* women step forward for HIV testing. Data from Thailand for 2010 suggests around 21 percent of trans* women took an HIV test over a 12 month period. Data from Pakistan suggest 4 percent.¹⁷⁴ We are unable to find any data for trans* men. The failure to address trans* people's sexual health needs is to some extent symptomatic of a more general failure extending across the broader sexual minority spectrum. A recent Global Forum on MSM and HIV (MSMGF) report across 42 low- and middle-income countries (nine of them in the Asia-Pacific region) found that the proportion of total HIV prevention spending targeted at MSM was recently reported at only 2 percent.¹⁷⁵ The failure certainly applies to much of the Asia-Pacific region. An alarming 75 percent of countries region-wide do not have specific funding for MSM in their HIV country plans.¹⁷⁶ In a recent review of low-to middle-income countries, South and Southeast Asia scored worst on four key HIV indicators for MSM (testing, prevention coverage, knowledge, and condom use).¹⁷⁷ Within the greater Mekong sub-region (Cambodia, two provinces of China, Laos, Myanmar, Thailand and Viet Nam) the spending on MSM recently accounted for anything from 0 percent to 3.8 percent of total government HIV prevention spending.¹⁷⁸ A recent research report has called for action on MSM needs in the more economically developed societies of East and Southeast Asia, which, the author noted, have been the subject of particular neglect.¹⁷⁹

171 Hahm (2010) reports that Pakistani hospitals provide emasculation surgery for between 100-200,000 rupees (around US\$1100 at February 2012 exchange rates).

172 APNSW, UNFPA and UNAIDS (2011).

173 For example see Bavinton et al. (2011) for Fiji, and Sood (2009) for a broader Asian perspective.

174 AIDS Accountability International (2001a).

175 MSMGF (2011). In an e mail advertising technical assistance for trans* abstracts for the 2012 Washington International AIDS Conference, MSMGF reported that only 2.6 percent of abstracts at the previous conference (in Rome) had focused on MSM needs.

176 Sarkar (2010).

177 Adam et al. (2009).

178 USAID (2008).

179 Lim and Chan (2011).

All this brings us to a more specific sexual health issue - trans* invisibility. The MSMGF report cited in the paragraph above notes that none of those 42 countries reporting spending on HIV prevention for MSM reported any corresponding figures for trans* people. Not surprisingly then, national statistics are hard to come by. AIDS Accountability International (AAI) notes that few countries (including in the Asia-Pacific region), report national statistics for their trans* female populations (as distinct from MSM) in regard to either HIV testing, HIV prevention or HIV knowledge.¹⁸¹ For example only two Asia-Pacific countries (Thailand and Pakistan) provide 2010 HIV testing statistics.¹⁸² It now seems clear that, for much of the course of the global HIV response, trans* people have been invisibilised; in that they have seldom been properly recognised as a distinct population for purposes of confronting the HIV pandemic. Key reports have subsumed trans* women under MSM, researching and reporting them in a way that implied they were coextensive with MSM,¹⁸³ or an hardly recognised subpopulation within MSM.¹⁸⁴ Even the most proactive of organizations in regard to trans* people's health and welfare have engaged in these practices.¹⁸⁵ In the light of all this, it is unfortunate that the recent UN General Assembly Political Declaration on HIV/AIDS, despite references to a number of high-risk groups (including, for the first time, MSM), entirely failed to refer to trans* women.¹⁸⁶ Crucially, the invisibility of trans* men in key documents on sexual health is even greater than for trans* women. This is true for those whose partners are men as well as those whose partners are women.¹⁸⁷

The portrayal of trans* women as MSM is often in direct conflict with their own identities as female or third gender.¹⁸⁸ It undermines their frequently voiced claims to be treated as female. It often conflicts with the identities of their partners as heterosexual, or 'real men'. It has possibly contributed to an under-recognition of trans* people, their heavy HIV burden and their specific needs for HIV prevention, care and treatment services. TMSM have been left out completely. To a certain extent NGOs and CBOs have in recent years

“ One of my friends works in the medical industry and she tried to find out whatever information she could. She managed to set up an appointment with a doctor whom she thought could prescribe me hormones. I spoke with the doctor and in the end it was a waste of time and money as he tried to 'cure' me by trying to find out why I was this way and encouraging me to get to know more male friends so that I can become 'normal'. Ironically it was . . . my session with the doctor that set me thinking more carefully about my childhood, and affirmed my decision to transition.”

– Ash, 25 years old trans* man, Singapore¹⁸⁰

180 Communication with author, previously unpublished transcription.

181 AIDS Accountability International (2011a, b, and c).

182 AIDS Accountability International (2011a).

183 e.g. Nguyen et al. (2008), and Sheridan et al. (2009).

184 e.g. TREAT-ASIA (2006), Van Griensven and Van Wijngaarden (2010), USAID and UNDP (2009), Wilson et al. (2011), Avrett (2011).

185 For example, MSMGF (an organization which, despite its name, is in fact very much involved in advocacy for trans* people's health and welfare). See one of its recent reports on discrimination (MSMGF, 2010).

186 UN (2011).

187 For the sake of completeness, we should also point out that WSW needs are hardly recognized either.

188 See e.g. Cameron (2006), Beyrer (2008).

stepped in to provide trans* positive, informed and accessible HIV prevention and care services. However, many trans* people, both men and women, remain out of the reach of these services, and their work has sometimes been hindered through actions of police and officials who harass both the providers and recipients of health services, detaining outreach workers, confiscating materials, and raiding offices and events.¹⁸⁹ Such actions may have served to discourage the development of such services, as well as services uptake.¹⁹⁰ In the light of the range of rights abuses suffered by trans* people, and the intersection between rights and health, the recent report by the UN's High Commissioner for Human Rights on human rights, sexual orientation and gender identity is a welcome development.¹⁹¹

Thankfully, the status of trans* people as a special group may be changing. Some recent reports have begun to give trans* women status as a distinct group, albeit a group that shares many of the circumstances, experiences and HIV health and education needs of MSM.¹⁹² Exciting initiatives in places such as India¹⁹³ and Thailand¹⁹⁴ offer models for better HIV-related healthcare. The increasing ability of Asia-Pacific trans* communities to organise themselves for advocacy can only help this process along. The invisibility of trans* men and their health needs remains a serious problem; one that needs to be addressed in the research.

189 Many cases detailed in Godwin (2010).

190 For more details see Godwin (2010).

191 UN High Commissioner for Human Rights (2011).

192 e.g. Godwin (2010).

193 e.g. Chakarapani (2011).

194 e.g. Berry et al. (2012).

/ E. Conclusion and recommendations for a research agenda

To summarise, the available Asia-Pacific research on trans* people is patchy. Across the region some research issues, geographical areas and demographic groups are better researched than others. Where research exists the research samples are often small, and focus on narrow sections of transgender communities (young, urban trans* women, and in a relatively small number of cities at that).

As a result of the patchiness in the research, there is much that remains unknown about Asia-Pacific trans* people and their HIV vulnerabilities. It is not known how many trans* people (whether trans* men or trans* women) there are region-wide, but it is suspected that there are many, and (as already noted) that far too many are HIV positive. Trans* men appear to be an emerging identity group, about whose well-being, health and healthcare needs little is known.

It is suspected that involvement in sex work greatly raises HIV risk for Asia-Pacific trans* people, but little is not for sure. It is not even known how many trans* people region-wide engage in sex work, though it is thought that many are involved at some points in their lives. Clearly there are many different patterns of sex work, but little is understood about the risks associated with each. Trans* men working as TSWs remain severely under-researched.

Next to nothing is known about trans* men's HIV risks in the Asia-Pacific region. By contrast, we know something of the risks which trans* women face across the region. It is known that they commonly engage in URAI. However, much less known about any other forms of safer sexual behaviour in which they engage (either in or out of sex work). Although many trans* women are quite badly informed about HIV risks, many of those who are well-informed nevertheless engage in unsafe sexual practices. It is not understood why. Little is known, either about the risks associated with neo-vaginal intercourse or non-standard lubricants, or about how trans* people's use of cross-sex hormones, hormone blockers and silicon injections, or partners' use of erection improving drugs or penile implants, raise trans* people's HIV vulnerability.

Clearly there is throughout the Asia-Pacific a great diversity within each transgender community. Sadly, the elderly and rural have been almost entirely overlooked in the available research. Yet the elderly may, as a result of accumulated exposure to HIV risk, be bearing a heavy HIV burden, as may the rural, who possibly have been bypassed by whatever HIV programmes are available. Trans* men (urban and rural, and of all ages) have been almost entirely overlooked by researchers.

While the research on Asia-Pacific trans* people is generally patchy, there is a great body of evidence revealing them to be the targets of stigma and prejudice. Though there has been little research into what actually drives this stigma and prejudice, it is clear that together they prompt patterns of discrimination (as well as harassment and abuse) in the family, at school, in the workplace, in the provision of services (including health) and in society more broadly (including in the law and law enforcement). These practices appear to marginalize trans* people (socially, economically, and legally). There is good reason to believe that these experiences can damage trans* people's psychological and emotional well-being, tilting them into lifestyles and behaviour patterns that put them at risk of

“ It’s our talents, our skills, and our abilities that matter - not our gender. Our gender does not determine our potentials. . ”

– Rica Paras, trans* woman, Philippines¹⁹⁵

HIV (and well as risk of other threats to their physical health and well-being). As if this were not bad enough, there is clear evidence that health services are often inadequate to trans* people’s needs, failing to deliver trans*-competent services in an accessible, affordable and trans* positive way. It is likely that inadequacies in healthcare for trans* people have been aggravated by a general failure to recognise trans* women as a distinct group outside the MSM umbrella, and a failure

to recognise trans* men at all. A way forward is offered by trans* people themselves, increasingly organising to work for the enhanced health and well-being of their own communities.

Given the above, it is not surprising that many recent policy briefs and reports touching on HIV and trans* people in Asia and the Pacific have produced somewhat similar recommendations, with all emphasising rights issues heavily.¹⁹⁶ A recent report, produced by UNDP in collaboration with APCOM, focuses almost exclusively on such matters (albeit for MSM as well as trans* women), offering 43 recommendations (out of a total 62) regarding (a) support to leadership, community empowerment and advocacy to improve the legal environment and address stigma; (b) improvements to law enforcement practices and support to judiciary; (c) law reform; (d) legal services (e) research, evidence and monitoring (of laws and legal environments); (f) (legal issues as they relate to) national planning of HIV responses; (g) national human rights institutions (and how their work can contribute to the HIV response); and (h) donors and multilateral organizations (and how their own work can contribute to a rights-based HIV response).¹⁹⁷ A paraphrased summary of those recommendations that are most relevant to trans* people are summarised in Appendix 2. It is to be hoped that the recommendations below (exclusively concerned with setting a research agenda) will align with recommendations in that earlier UNDP report.

Donors may want to bear the following recommendations in mind when assessing HIV-and trans*- related proposals involving a research element. The first three recommendations are strategic in nature, applying to all HIV-related research that involves trans* people.

1. **Ending the invisibility of trans* people.** Researchers (particularly those involved in HIV-related health and rights research) should work to end the invisibility of trans* people. Clearly that means doing research on trans* people. It also means clearly identifying transgender sub-samples in larger research, and analysing data and reporting findings separately for those sub-samples. Only then will it be possible to get the sort of information on trans* people that is needed, including on their HIV vulnerabilities and healthcare needs.¹⁹⁸

195 From ‘Transpinay Rising’ video, accessible on YouTube at <http://www.youtube.com/watch?v=B-EPrYgTYDc>.

196 e.g. Sood (2009), APNSW, UNFPA and UNAIDS (2011), Godwin (2010); Global Commission on HIV and the Law (2011); SAATHI(2008); South and Southeast Asia Resource Centre on Sexuality (2008); WHO (2011); Pant (2005); Cameron (2006); Jenkins et al. (2005); NGO Delegation Annual Report (2006); Couch et al. (2007), Pitts et al. (2006) and NZHRC (2007); CONGENID (2010); Bavinton et al. (2011); AHRC (2011); UNDP et al. (2009); Avrett (2011). Note also Kirby (2011) in regard to sex workers.

197 Godwin (2010).

198 See HIVOS-Schorer (2009), which also makes this point.

Other levels of invisibility should also be addressed; in this case within trans* populations. Research should seek to recognise diversity within trans* communities, and the existence of hitherto under-researched communities of trans* people; in particular the elderly and rural, and trans* men, about whose life circumstances and needs little is known. Research on the elderly may be particularly important in view of the extended periods over which they may have been exposed to HIV risk. So too may be research on the rural, who may have been bypassed by urban-focused HIV programmes. Trans* men, perhaps the most invisibilised of all trans* communities, are in urgent need of research focused on their health and healthcare needs, and on their overall well-being.

2. **Avoiding cisgenderism.** Cisgenderism in HIV-related and trans* research is widespread.¹⁹⁹ Researchers should avoid letting it enter their research work at any stage; from choice of research questions to language used in their research reports. Researchers should be aware of cisgenderism in other people's work and note it when found. Of particular concern is research that portrays trans* people's gender identities as signs of mental disorder, or denies trans* people their gender identities (e.g. in references to trans* women as male). Such practices are likely to reinforce stigma and prejudice, and undermine trans* people's claims for gender rights.
3. **Trans* people as research partners.** Researchers should engage with trans* individuals and their communities as expert partners, encouraging them to participate as key members of research teams (paid on an equal-pay-for-equal-work basis alongside cisgender team members) in any research concerning their communities. This approach, which one might call 'trans*-researched trans*-research', is an effective way of avoiding cisgenderism in research. It also has the effect of facilitating more culturally sensitive and informed research on trans* issues. Finally, it also helps to build researcher capacity in trans* communities, and to enable trans* people as lead researchers. Across the region many examples of trans*-researched trans*-research already exist.²⁰⁰ The approach is consistent with the basic principle of 'engaging those who would benefit'.²⁰¹

A key step in building capacity may be to ensure that internationally published research (which is almost always in the English language) is made available (in summary if not in full) in the languages spoken (and written) by the very communities reported on in the research. There are clearly roles for international agencies (and donors) in all of this.

More specific recommendations now follow on the subject of important research directions for addressing trans* HIV vulnerabilities.

4. **Counting trans* people to make them count.** It is not known with any certainty how many trans* people live in the Asia-Pacific region. It is likely that the numbers are large,

199 Cisgenderism is a way of looking at the world which gives preferred status to those whose gender identities are congruent with both their bodies and the roles society expects of them (i.e. 'cisgender' people; those who are not transgender). See Ansara and Hegarty (2011) for more information.

200 For example Jenkins et al. (2005); Winter et al. (2007); Alegre (2006); Jun (2010); LABRYS (2008, 2010); Na Ayutthaya (2007); Slamah (2005), IAVI-India (2008); Slamah et al. (2010); Avrett (2011).

201 Avrett (2011).

well beyond those suggested by research on Western clinic-based populations.²⁰² Large numbers of trans* people appear to be involved in sex work, though again the numbers are not known with any certainty. Large numbers appear to be HIV positive, though the available studies are small and scattered. Research is needed that attempts to ascertain (or at least estimate with some degree of confidence) the size of the various transgender communities across the Asia-Pacific region, including elderly and rural trans* women, and all trans* men (three under-researched groups), as well as trans* people who are engaged in sex work. Census exercises of the sort undertaken in Tamil Nadu,²⁰³ then more recently throughout India and Nepal, are indicative of what can be done at national level given the political will. Ideally we need to know how many trans* people suffer from AIDS-related illness and what the death toll is (both in absolute terms and as a proportion of the total figures). With good population data for trans* people (including for TSWs), and good HIV/AIDS related data, it may be easier to plan targeted health services, including HIV prevention and treatment programmes.²⁰⁴ Methodologies may have to be flexible, taking account of the wide diversity in ways of sexual and gender identification across the region.

5. **Documenting and understanding trans* vulnerability.** More research is needed on aspects of trans* people's lives that contribute to their vulnerability to HIV. In view of the way many factors (e.g. legal, social, economic, and psychological) intersect, combining to increase HIV vulnerability, it is important that research is multidisciplinary in nature.²⁰⁵ Some key populations are in particular need of being studied; e.g. TSWs (believed to bear a heavy HIV burden)²⁰⁶, young trans* people (sexually active and therefore at risk of HIV), the elderly (on account of an HIV burden accumulated through years of risk earlier in life), the rural (possibly untouched by HIV prevention programmes) and trans* men (who have been entirely ignored in Asia-Pacific HIV research).

It is important to know about patterns of sexual behaviour (beyond receptive anal intercourse) in which trans* people commonly engage. Examples include those sex acts that potentially can lower risk of HIV transmission (e.g. axillary sex, intercrural sex, handjobs, footjobs, intergluteal sex, mammary sex, frotteurism, tribadism, and sumata), those that may heighten risk (e.g. group sex such as that which is common in Fiji)²⁰⁷, and those whose risk is entirely unknown (e.g. neovaginal sex, neo-vaginal or anal sex involving non-standard lubricants including saliva). It is important to know more about the ways in which patterns of sexual behaviour may impact on HIV risk.

While the laws, regulations, policies and practices that make life difficult for trans* people in the Asia-Pacific are relatively well documented, there is currently no central data base documenting Asia-Pacific trans* rights violations. A data base of

202 Winter (2009b); Godwin (2010).

203 Sood (2009).

204 This point is made in UNDP et al. (2009), WHO et al. (2010) and USAID /UNDP (2010).

205 The need for research drawing on multiple disciplines was noted at a transgender forum at the recent ICAAP 10 meeting in Busan.

206 Note that APNSW, UNFPA and UNAIDS (2011) identifies sex work as a major driver for the HIV epidemic in Asia, at least over the next 20 years, and involvement in sex work as a major vulnerability. The report claims that the most cost-effective interventions against HIV are likely to be those that focus on sex work, noting with regret that only 1 percent of global HIV funding goes to sex work.

207 Bavinton et al. (2011).

this sort, monitoring effects of rights violations upon people's lives, could become a valuable tool for those working in and for trans* communities region-wide. It could prove a valuable resource for those pressing for accountability and seeking change. Also valuable would be broader social sciences and multi-disciplinary research that provides a clearer picture of what life is like on the stigma-sickness slope, what aspects of stigma and prejudice, discrimination, harassment and abuse, and marginalization are most damaging to psychological health and well-being, and which have the strongest effects on HIV vulnerability. Larger and more comprehensive studies are needed on stigma, prejudice, discrimination, harassment and abuse, and on trans* people's overall health and well-being than have so far been conducted in the Asia-Pacific region, along the lines of work done in the USA,²⁰⁸ UK,²⁰⁹ Belgium,²¹⁰ Netherlands,²¹¹ and Australia and New Zealand.²¹² Research of this kind could examine the impact of laws and legal environments on trans* people in the Asia-Pacific (including on TSWs). Longitudinal research may be particularly useful, detailing the progressive effects of stigma, discrimination, harassment, abuse and social, economic and legal marginalization upon people's lives, and where possible examining the impact of *changes* in laws and law enforcement upon the lives of trans* people. One possible research focus would be to examine the effect of repealing punitive laws, or of introducing protective laws, upon the provision and uptake of HIV services.²¹³

6. **From risk to resilience.** Research is needed that goes beyond risk factors for trans* people and looks instead at protective factors and personal qualities that confer upon trans* people resilience against the effects of stigma and prejudice, discrimination, harassment and abuse, and consequent marginalization. A wide range of factors might contribute to resilience, including a supportive family and/or friends network, good levels of general and vocational education, early transition and ability to 'pass', good rights awareness, as well as capacity to maintain high levels of self-esteem and withstand 'minority stress'. Very little attention has been focused on such factors. This is unfortunate; information about resilience may help us develop programmes which help trans* people avoid the stigma-sickness slope. Such research will also counter the tendency, always present, to view trans* people as passive victims of circumstance, rather than active agents in their own lives.
7. **Empowering trans* people through CBOs and NGOs.** The importance of empowering trans* people in regard to their own health and well-being is already well known.²¹⁴ It is well accepted that trans* CBOs (and trans* related NGOs, particularly those engaging trans* people in key roles) can play a leading role in promoting trans* people's welfare.²¹⁵ Research is needed that examines ways to make trans* CBOs and relevant NGOs more effective in their work on behalf of trans* people. As a first step, it is important to map existing local, national and regional groups, perhaps in a way

208 e.g. Grant et al. (2011), as well as IOM Committee on Lesbian, Gay, Bisexual and Transgender Health Issues (2011).

209 Whittle et al. (2007).

210 Motmans et al. (2010).

211 HRW (2011).

212 See Couch et al. (2007), in regard to Australia and New Zealand, and NZHRC (2007) in regard to New Zealand..

213 See more in Godwin (2010).

214 e.g. Sood (2009); USAIDS / UNDP (2010).

215 e.g. see p35 of APNSW, UNFPA and UNAIDS (2011), and also Godwin (2010) for several examples of CBO work that has an impact on trans* people's lives.

similar to that recently done in South Asia by SAATHI,²¹⁶ and to a lesser extent in the recent ARROW Report²¹⁷ and perhaps building on recent steps taken by APTN and ILGA-Asia in this regard. Mapping should enable us to identify gaps; transgender communities left underserved by CBOs or relevant NGOs. Where CBOs and relevant NGOs exist, mapping makes it possible to identify what each group is doing, providing a baseline (along the lines of the recent SAATHI report)²¹⁸ and making possible recommendations for developing the work of trans* related CBOs and NGOs in South Asia.²¹⁹

There is a particular need for research (perhaps longitudinal) into effective ways of developing the work of CBOs at the local, national and regional level (this last level especially underdeveloped currently in the Asia-Pacific).²²⁰ Especially important are studies that document the ways in which CBOs can work with others in civil society, such as: (a) media; (b) government officials (e.g. in education, social welfare, health and law) and elected representatives (from local upwards); and (c) other agencies and organizations (community, non-governmental and governmental) working for the welfare of sexual minorities, PLHIV, women, drug users, sex workers etc. In all this, trans* people, trained in methods such as participatory evaluation and research, may prove an important research resource.²²¹

The focus of work for CBOs and relevant NGOs will necessarily vary from place to place; e.g. in terms of a focus on vocational or social activities, rights or health; in terms of general, transition or sexual health; in terms of prevention or care. Priorities will vary from community to community. Hence, it is difficult to identify a single research area that would facilitate the work of organizations region-wide. However, it seems likely that across much of the Asia-Pacific region there is a particular need to research ways by which CBOs and relevant NGOs (alone and in collaboration with partners) can (a) *promote more trans* positive attitudes in the general population and more trans*-positive practices in key personnel who come into contact with trans* people;* (b) *promote a more sensitive transgender rights culture, making existing equality legislation work better for trans* people;* (c) *promote more effective provision of key health information to members of trans* communities;* and (d) *promoting more trans* positive, competent, comprehensive and accessible healthcare*. Attention now turns to these.

8. **Promoting trans* positive attitudes and practices.** Policies and practices (even those that are initiated and perpetuated by the highest levels of government and largest institutions) are the work of people. Policies and practices are more likely to change when people's attitudes change. Good information is one of the keys to attitude change. Consequently, public education campaigns (as well as campaigns to educate key social agents such as police, judiciary, health workers, teachers etc)

216 SAATHI (2008).

217 Sood (2009).

218 SAATHI (2008).

219 The SAATHI (2008) report recommended increased involvement of trans* community involvement in administration and policy making in NGOs, more exclusive targeting on trans* people's needs (as compared with the needs of other better served groups), and a broader work focus (not only on sexual health needs but also on areas like psychosocial support, self-help, income generation, vocational training, and other educational initiatives).

220 See Sood (2009) p35.

221 IAVI-India (2008).

are important tools in the struggle for enhanced rights and healthcare for trans* people.²²² Documentation of innovative and good practice, properly disseminated, may prove useful in helping CBOs to develop effective and scaled up education campaigns.²²³ Guidelines for monitoring service providers and their staff may prove an important training tool, and perhaps can be adapted from elsewhere.²²⁴ Across the region mainstream mass media remain part of the problem rather than part of the solution, undermining respect, equality and dignity for trans* people. It is important to research and document ways of promoting a commitment to those values in TV, newspaper and magazine media, as well as across the internet.

9. Promoting transgender rights culture, making equality legislation work better.

It is important to document the ways in which key conventions, declarations, court judgements and juridical and jurisprudential reports can be used to advance the rights of trans* people across the Asia-Pacific, and to find ways in which transgender communities across the region (and their advocates) can use that information in ways that make sense in the societies in which they live. The importance of such research derives from the widely accepted view that rights-based approaches offer an effective way forward for tackling the HIV epidemic in marginalized communities. This includes sexual and gender minorities in the Asia-Pacific.²²⁵ Rights-based approaches make particularly good sense in countries that have signed international instruments (and optional protocols), which would appear to offer opportunities for advancing trans* people's rights. Key of course is the Universal Declaration of Human Rights, to which all UN members states are signatories.²²⁶ Also important are ICCPR,²²⁷ ICESCR,²²⁸ CRC,²²⁹ CRPD,²³⁰ and CEDAW.²³¹ Many Asia-Pacific countries are parties to these conventions, and yet few have so far enacted legislation to allow legal gender status recognition, or to provide effective (and enforced) protection against discrimination on the grounds of gender identity or expression.

It may be that other potentially important global tools for rights advocacy exist, including the 1994 UN Human Rights Committee decision in regard to 'Toonen v Australia',²³² commitments from the ICPD,²³³ the Yogyakarta Principles,²³⁴ the International Bill of Gender Rights,²³⁵ the ILO Recommendation Concerning HIV and AIDS and the World of Work,²³⁶ the Joint Statement on 22nd March 2011 from

222 Godwin (2010).

223 See Sood (2009) and APNSW, UNFPA and UNAIDS (2011) for examples of successful education campaigns.

224 Scottish Transgender Alliance (2009).

225 Godwin (2010); NGO Delegation (2010).

226 See <http://un.org/en/documents/udhr/>

227 See <http://www2.ohchr.org/english/law/ccpr.htm>.

228 See <http://www2.ohchr.org/english/law/cescr.htm>.

229 See <http://www2.ohchr.org/english/law/crc.htm>.

230 See <http://www.un.org/disabilities/convention/conventionfull.shtml>. Note that the CRPD adopts a social perspective on disability, and may therefore be more palatable to trans* activists than if it were to adopt a medical perspective. See Petersen (2011) for a fuller discussion of this.

231 See <http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm>.

232 Available at <http://www1.umn.edu/humanrts/undocs/html/vws488.htm>. The Toonen decision stated that the word 'sex' in the ICCPR should be interpreted as embracing sexual orientation.

233 Available at <http://www.un.org/ecosocdev/geninfo/populatin/icpd.htm>. See also p9 of Sood (2009).

234 Available at <http://www.yogyakartaprinciples.org/>.

235 Available at <http://transgenderlegal.com/ibgr.htm>.

236 Available at http://www.ilo.org/aids/lang--en/WCMS_142706/index.htm. But note that CEDAW appears to view all

UN members states on ending acts of violence and related human rights violations based on sexual orientation and gender identity²³⁷ (plus a supporting statement by a group of 17 National Human Rights Institutions); the 15th June 2011 UN Human Rights Council resolution instructing the High Commissioner for Human Rights to commission a study to document discriminatory laws and practices and acts of violence against individuals based on their sexual orientation and gender identity;²³⁸ the ACJ report to the 15th annual meeting of the Asia Pacific Forum of National Human Rights Institutions;²³⁹ declarations by professional organizations such as WPATH on issues such as de-psychopathologisation of gender variance, the medical necessity of gender affirming healthcare and other issues;²⁴⁰ as well as legal toolkits.²⁴¹

Conceivably it is possible that even those more localised human rights developments that occur elsewhere and which appear irrelevant to the Asia-Pacific context may sometimes provide useful tools for Asia-Pacific trans* activists intent on swaying public, government and judicial opinion on transgender rights issues. Examples might include the Declaration of Rights of Sex Workers in Europe;²⁴² the Council of Europe Convention on preventing and combating violence against women and domestic violence (which extends protection to trans* women);²⁴³ the Council of Europe 'Human Rights and Gender Identity' issue paper, and the recent European Parliament call for an end to the pathologisation of trans* people.²⁴⁴ Legal toolkits and training initiatives may also prove useful (see for example a training initiative of the Women's Network for Unity).²⁴⁵ Some of the best pointers to effective legal activism may be found in the Asia-Pacific region itself (e.g. recent important cases in India, Nepal and Pakistan etc).²⁴⁶ Strategies adopted in these cases (whether successful or unsuccessful) may inform the work of others in the Asia-Pacific region. It is particularly important that these strategies are documented.

10. **Getting health information out to trans* communities.** It is important to document the various means (both well-established and innovatory) by which important health information can be disseminated through trans* communities. Interesting Asia-Pacific initiatives already exist; for example a healthcare booklet (and disk) produced by APNSW.²⁴⁷ Also useful would be research aimed at identifying ways of getting information to the hard-to-reach in trans* communities – particularly the elderly and the rural (who may neither be members of community groups nor linked to the internet, and may have limited literacy), as well as trans* men (for whom there is little readily available health information at all).

sex work as a form of violence against women. See APNSW, UNFPA, & UNAIDS (2011) for more on this.

237 Available at <http://ilga.org/ilga/static/uploads/files/2011/9/27/Joint%20Statement%20on%20SOGI.pdf>.

238 Details available at <http://www.ncrw.org/news-center/in-the-news/un-human-rights-council-requests-study-discrimination-and-sexual-orientation>.

239 ACJ (2010).

240 All available at <http://www.wpath.org>.

241 ICJ (2010); EQUINET (2010).

242 International Committee on the Rights of Sex Workers in Europe (2005).

243 Available at <https://wcd.coe.int/wcd/ViewDoc.jsp?Ref=CM%282011%2949&Language=lanEnglish&Ver=final>.

244 Various news reports.

245 See APNSW, UNFPA and UNDP (2011) p18 for an example.

246 For more detail see e.g. Sood (2009) and Godwin (2010).

247 APNSW (2010). Note that the production of healthcare manuals in various Asian languages is one of the recommendations in South and Southeast Asia Resource Centre on Sexuality (2008) (see p12).

11. **Promoting trans*-positive, competent, comprehensive and accessible healthcare.** The available research shows that current healthcare provision often fails on all four counts. Research is therefore needed that documents any good practice, particularly ones that help CBOs and other key stakeholders work with healthcare providers to scale up existing services, and develop new initiatives. Documentation on healthcare approaches outside the Asia-Pacific region is already available, providing guidance that might go some way to promoting trans*-positive practices across the Asia-Pacific,²⁴⁸ as well as provision that is more competent²⁴⁹ and comprehensive.²⁵⁰ A recent WHO report on prevention and treatment of HIV and other STIs may be useful in this regard.²⁵¹ Such healthcare approaches might draw on recent research worldwide, particularly in regard to behavioural interventions in the field of HIV.²⁵² However, it is likely that these approaches need to be adapted to local contexts. For the Asia-Pacific region one-stop services may be particularly useful (addressing a broad range of transgender needs; general, transition-related and sexual health).²⁵³ Also key is research that taps trans* people's own perceptions of their health (and related) needs, and which documents the needs of the elderly, rural, and/or uneducated.

248 Transgender Law and Policy Institute (2005), Transgender Healthcare Access Project (2008).

249 Tom Waddell Health Centre Transgender Team (2006); Hembree et al. (2009); and the (at time of writing) new Standards of Care (7th version) issued by WPATH (2011).

250 Vancouver Coastal Health (undated).

251 WHO (2011).

252 Ross (2010).

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/ Appendix 1: Sample email to CBO leaders soliciting material for desk review

Dear ...,

I am writing to seek your help. You are definitely my best contact for this in

I am currently conducting a 'desk review' for United Nations Development Programme (UNDP) Asia-Pacific Regional Centre. It is entitled '**Transgender Persons, Human Rights and HIV Vulnerability in Asia and the Pacific**'. This review, to be completed by late August, will examine existing literature on laws, regulations, policies and practices that raise transgender persons' vulnerability to HIV infection.

My TransgenderASIA currently contains a bibliography which contains some relevant English-language material (<http://web.hku.hk/~sjwinter/TransgenderASIA/bibliography.htm>).

I'll refer to some of the material on that site. .

However, there is surely some material out there (not just English-language, but also other languages) which I do not know about, and which may shine a light on laws, regulations, policies and practices that have the effect (*or even intention!*) of subjecting trans* people to stigma, reducing opportunities, restricting freedoms , increasing poverty , reducing access to basic services (including health) etc and making them more vulnerable to HIV infection.

I am therefore writing to ask you if you know of any relevant material that you would like me to know about. This may include the following:

Research reports

- by community organizations,
- by NGOs,
- by university scholars,
- by research students
- etc

Laws

Legal cases

Regulations, policies and practices

- of national, regional or city governments
- of police
- of health, social welfare and education services.

If you are able to send the material to me then please do so.

If you know where I can find the material please let me know.

If the material is in a language other than English we may be able to arrange funds for translation.

In any case, please send me an answer in the next two weeks (before the end of May). That would enable us to arrange any translation (something you or your colleagues may be willing and able to help with) during the month of June.

Sam Winter, B.Sc., P.G.D.E., M.Ed., Ph.D.
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Appendix 2. Recommendations from 'Legal Environments, Human Rights and HIV responses among men who have sex with men and transgender people in Asia and the Pacific: An agenda for action'¹

Recommendations relating to the legal environment

1. Support leadership, community empowerment and advocacy to improve the legal environment and address stigma:

A range of recommendations involving

- a. government and donor engagement with CBOs to support efforts to build up the transgender community's capacity for advocacy (Recs 1.1 – 1.3),
- b. building links with judicial, parliamentary and progressive faith-based leaders who can contribute to dialogue and help move the rights discourse forward (Recs 1.4, 1.5).

2. Improved law enforcement practices and support to judiciary:

A range of recommendations involving

- a. educating political, civic and law-enforcement leaders, as well as guidelines and training for law enforcement personnel, regarding HIV and rights issues as they pertain to transpeople (Recs 2.1-2.3, 2.7,2.8);
- b. collaboration between ministers to promote law-enforcement approaches that support HIV prevention and health promotion (2.9);
- c. Putting in place effective complaint mechanisms for cases in which police exceed their authority or policing trans-people (Recs 2.4, 2.5); d. unhindered Internet use by NGOs, CBOs and transpeople for purposes of health promotion and HIV prevention (Rec 2.6).

3. Law reform

- a. the reform or the appeal of all legislation that discriminates against or punishes transpeople's identities and gender expressions, or punishes HIV service providers and sexual health educators going about their work (Recs 3.1-3.3, 3.9);

¹ Godwin, J. (2010). Legal environments, human rights and HIV responses among men who have sex with men and transgender people in Asia and the Pacific: an agenda for action. Bangkok: United Nations Development Programme. Accessible at <http://www.snap-undp.org/elibrary/Publication.aspx?ID=629>.

- b. the enactment of legislation that protects transpeople from hate crimes, vilification, discrimination, sexual assault and treatment without consent, and recognises the gender identities and relationships of transpeople regardless of whether they have undergone sex reassignment surgery (Recs 3.4 – 3.7, 3.10);
- c. the discouraging of diagnostic procedures which portray transpeople as mentally ill and undermine the legitimacy of sex reassignment procedures (Rec 3.11);
- d. The decriminalisation of sex work, and support for HIV prevention services for transgender sex workers (Rec 3.12).

4. Legal services

- a. providing legal aid for transpeople facing legal issues arising out of their gender status (Rec. 4.1); and
- b. providing legal education aimed at empowering transgender communities, and transgender education aimed at sensitising legal professionals to transpeople's circumstances (Rec.4.2)

5. Research, evidence and monitoring.

- a. the HIV research agendas that embrace rights issues, both as inputs and outcomes, and which disseminate research findings to judges, parliamentarians and human rights institutions (Recs 5.1, 5.2, 5.4));
- b. The sharing of research findings on HIV programmes, both in regard to successes and in regard to lessons learned (Rec 5.3).

6. National planning of HIV responses

- a. National HIV strategies and plans which take account of the need to decriminalise male-to-male sex, build up advocacy, and address the legal and policy environments facing transpeople (recs6.1-6.3)

7. National human rights institutions

- a. Helping to promote and protect on transpeople's rights, raise awareness of those rights and hold governments accountable in regard to police harassment, abuse and violence (Recs 7.1-7.2)

8. Donors and multilateral organizations

Diplomatic initiatives addressing the criminalisation of same-sex behaviours (Rec.8.1)

- a. Recognition and support for the work of human rights NGOs (Rec 8.2),

- b. Promote measures aimed at documenting and condemning rights abuses, setting rights standards, supporting legislative reforms and otherwise reducing rights violations against transpeople (Recs 8.3-8.6)

Recommendations relating to HIV services and the broader social environment

9. HIV prevention, treatment, care and support services

- a. developing effective comprehensive national HIV strategies and plans, and programmes and facilities for HIV prevention and care, treatment and support, as well as for sero- and behavioural surveillance, as appropriate doing so in the context of national policies on health, youth, gender, education etc (Recs.9.1-9.4, 9.6, 9.9);
- b. building up capacity for transgender CBO's engaged in HIV work (Rec. 9.5)
- c. ensuring that all sexual and reproductive health services respect sexual and gender diversity, and avoid stigma and discrimination in regard to transpeople (Recs 9.7, 9.8)
- d. recognising diversity within the transgender population, ensuring cultural appropriateness in programming, incorporating counselling for young transpeople and their families, and incorporating components for those in the transgender community who are hard-to-reach (Recs 9.10-9.13)

10. Education and media

- a. The provision of non-discriminatory sex and gender education programmes in diversity-embracing institutions (schools and colleges, including those training health care professionals), as well as public education programmes aimed at combating stigma and discrimination and utilising the media to the fullest (Recs 10.1-10.4)

11. Employment and income security

- a. Equal opportunities for economic empowerment, supported by labour unions and industry bodies (Recs 11.1,11.2)

For additional information, contact the TransgenderAsia Centre or the author of this report, Sam Winter:

The **TransgenderASIA Centre** seeks to bring together psychologists, sociologists, anthropologists, as well as medical and legal experts and others who share a desire to better understand transgenderism in Asia, as well as the circumstances in which Asian trans* people live. The website (at <http://web.hku.hk/~sjwinter/TransgenderASIA/>) aims to promote and disseminate research and understanding of, as well as contribute towards efforts to bring about social change for, Asian trans* people.

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TransgenderASIA Research, Information and Advocacy Centre:
<http://web.hku.hk/~sjwinter/TransgenderASIA/>



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