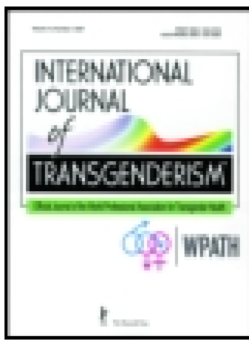

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Cultural Considerations for the World Professional Association for Transgender Health's *Standards of Care*: The Asian Perspective

Sam Winter

ABSTRACT. This article begins by portraying the nature of the Asian transgender experience, paying particular attention to transprejudice as a health issue, and the possible role of pathologization of gender variance in prompting and supporting transprejudice. It then outlines the range of transgender health care provision available in Asia. The article ends with seven recommendations for the seventh revision to the World Professional Association for Transgender Health's (WPATH) *Standards of Care* (*SOC-7*). The first four touch on comparatively broad issues that set the scene for the provision and usage of transgender health care services. I argue that *SOC-7* should (a) recognize transprejudice as a health problem, (b) depathologize gender identity variance (GIV), (c) change the language used to describe transpeople, and (d) incorporate more realistic figures for GIV prevalence. The next two recommendations focus on matters of clinical management, addressing the need for WPATH (through *SOC-7*) to better meet the needs of young GIV people worldwide who are in transition by (a) promoting health care service involvement in developing family and community support for young transpeople and providing basic health care information in various languages for all involved and (b) recognizing the need for more flexibility in terms of real-life experience (RLE) and age requirements during transgender health care. The final recommendation focuses on the need for WPATH to consult widely within the international trans-community when drawing up *SOC-7*.

KEYWORDS. Gender identity, transpeople, Asia, health care, standards of care

INTRODUCTION

This article is about transgender people (transpeople) in Asia. I am specifically concerned here with those persons who self-identify and present (or are intent on presenting) as members of a gender category other than the one matching the sex category assigned to them (usually on the basis of genital anatomy) at birth. They may be described as gender identity variant. Some may be in need of transgender health care services to aid their transition

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(e.g., hormones and, for some, surgery). They are therefore the focus of this article. I use terms such as *transgender* and *gender identity variance* (or GIV) in preference to other terms, such as *transsexual* and *gender identity disorder* (or GID), which are used as a diagnostic categories in *DSM-IV* and *ICD-10*. For convenience I refer when necessary to *transwomen* (those assigned to the male sex category at birth who identify in a non-male gender) and *transmen* (those individuals designated female at birth who identify as non-female).

The article takes as a starting point the World Professional Association for Transgender Health's (WPATH) *Standards of Care*'s stated concern for "lasting personal comfort with the gendered self" and "psychological well-being and self-fulfillment" of all gender identity variant people, including outside the developed West, and considers how the seventh revision of the association's *Standards of Care* (*SOC-7* for convenience) might better reflect those concerns. The article draws on research concerning transpeople in Asia (including my own and that of students and researchers elsewhere) and innumerable conversations and correspondence with transpeople, activists, and health care providers across Asia. It also draws on a range of documents related to transgender health care and associated standards of care. The article rests on a belief that neither transgender health nor transgender health care are simply matters of medicine and medical practice but are inextricably linked to legal, social, and psychological issues that shape the experience of transpeople. These are issues that can jeopardize (sometimes in the most direct ways imaginable) the mental and physical health of transpeople, as well as the quality of health care they enjoy. These issues should therefore, in the view of this author, concern WPATH and *SOC-7*. The article therefore also draws on several widely known declarations and statements of principle in regard to broadly applicable human rights, as well as in regard to the rights of sexual and gender minorities. All these documents are listed in Appendix A. The last of the list, not widely available otherwise, forms Appendix B.

The rest of this article falls into three sections. They are (a) an overview of the Asian transgender experience, (b) an overview of Asian transgender health care, and (c) the implications for *SOC-7* if those standards are to truly reflect the life circumstances of transpeople worldwide, as well as their aspirations worldwide for physical and mental health and well-being, and for accessible, flexible, and quality health care matched to their needs. Seven recommendations are offered in regard to *SOC-7*.

I should apologize that much in the first two sections concerns transwomen, very little on transmen. As is implied in *SOC-6* section 2, transmen are a relatively invisible community. It would be risky to assume too readily that what applies to transwomen invariably applies to transmen. Nevertheless, I believe that the seven recommendations, if implemented, would serve the broader health interests of both groups.

THE ASIAN TRANSGENDER EXPERIENCE

Asia is a vast continent, home to 60% of the world's population, perhaps a similar proportion of the world's transpeople, and the place I know best. As far as can be judged, much of the Asian transgender experience (different ways of thinking about sex, gender, and sexuality; early transitions; social and economic marginalization; limited health care; informal self-help communities; etc.) is also shared, in whole or in part, by transpeople in other non-Western cultures such as Latin America (Kulick, 1998), Oceania (Nanda, 2000b), and Africa (Jacobs & Cromwell, 1992; Murray & Roscoe, 1998).

Until recently the lives of Asian transpeople were not a popular research topic. However, the literature (print and Web based) has grown much during the last decade. The TransgenderASIA Centre carries (as of April 29, 2008) a bibliography of around 200 works (over a quarter of which are post-2002). However, the research coverage is patchy. Across Asia, transmen remain underresearched, and even for transwomen most of the available English-language research focuses on a broad band of 18 countries in South, Southeast, and East Asia (less than half the total of Asian nations yet accounting for around 95% of the items on the TransgenderASIA bibliography). These

18 countries are Turkey, Pakistan, India, Nepal, Bangladesh, Myanmar, Laos, Cambodia, Vietnam, Thailand, Malaysia, Singapore, Indonesia, the Philippines, China (including Hong Kong), Taiwan, South Korea, and Japan. Together they represent a highly diverse group (historically, culturally, economically, and politically). Nevertheless, some general observations can be made. These observations are that in a number of Asian countries, transpeople are to be found in such numbers and living in such ways as to make them highly socially visible; many of them begin cross-gender presentation and physical transition around their teens (or even before); many of them grow up and live in a social, cultural, and even linguistic context quite unlike that in which Western transpeople live; and almost all (in some way and to some extent) experience transprejudice. All of these observations have implications for health and health care.

The available Asian prevalence estimates mainly concern transwomen. It suggests that, in some cultures at least, transpeople seem far more common than in much of North America or Europe (where much of the prevalence research on GIV has been hitherto been done). There may be between 50,000 and 100,000 Malaysian transwomen (*maknyah*; around 1:75 to 1:150 birth-assigned males aged 15 and above; Jamaludin, 2001; Kaur, 2007). In India there are an estimated 500,000 Indian transwomen (*hijra*; about 1:600; Nanda, 1990). In Thailand there are perhaps 300,000 transwomen (*phuying khaam phet*; around 1:300; Winter, 2002). High prevalences are not entirely limited to South and Southeast Asia. In one town in Oman in the 1970s an estimated one in 60 birth-assigned men were living as *xanith* transwomen (Wikan, 1991).

Notably, these Asian prevalence figures are broadly of the same order as those argued for "the inherent condition of transsexualism" by Olyslager and Conway (2007, p. 23; 2008). Yet they exceed by many multiples the most commonly cited Western prevalence figures for male-to-female transsexualism; for example, around 1:30,000 (birth-assigned) adult men and 1:100,000 women in Europe (American Psychiatric Association, 1994). The discrepancy almost certainly results from the fact that Western figures represent those who approach clinics, are diagnosed as GID (or transsexual), and/or have been approved for sex reassignment surgery (SRS) or have undergone it. By contrast, Asian estimates have generally included all transwomen; pre-op (pre-operative), post-op (post-operative), and non-op (non-operative, choosing not to undergo surgery). As has been pointed out elsewhere (e.g., Olyslager & Conway, 2007, 2008), transpeople who approach clinics may represent a small minority of transpeople overall. This is most certainly the case for Asia, where large numbers of transpeople do not undergo SRS or even anticipate or express a desire to do so. In a recent Lao study, only one of 214 participating transwomen had undergone SRS (Winter & Doussantousse, 2009a). In a recent Philippines study we found that only one out of 147 participants had. Another 29% indicated they had no desire to do so (Winter, Rogando-Sasot, & King, 2007). Even in Thailand, where SRS is more easily available and affordable, only 28% of a sample of 195 Thai transwomen had undergone the operation. Another 12% had no desire to do so (Winter, 2006).

Interestingly, four Asian reports provide figures apparently based on clinic-focused counting methodologies of the sort common in Western studies; i.e., counting the number of transpeople seeking/undergoing SRS. For Taiwan, Hwu, Yeh, and Chang (1989) report a prevalence rate of 1:1030 for transmen and transwomen combined. For Iran, official statistics suggest that there are 15,000 to 20,000 transpeople nationwide (Tait, 2007). Even at 15,000, this represents around 1:3300 of the approximately 50 million people aged 15 and above. In passing, however, it should be noted that homosexuality is a serious criminal offense in Iran (even prompting capital punishment). With subsidized SRS available for those diagnosed as transsexual, as well as the opportunity to change legal gender status, it has been suggested that some people undergoing SRS may simply be homosexual men and women escaping the criminalization of their sexual preference (Stack, 2005; Tait, 2007). No such claim has been made in regard to Singapore (where homosexuality is also a criminal offense, though less energetically prosecuted in recent

years) and the estimated prevalence is 1:2900 for transwomen and 1:8300 for transmen (Tsoi, 1988).

All the above clinic-focused prevalence rates are high compared to figures from the West. The only exception to this tendency comes from the fourth study. The Hong Kong study of Ko (2003) reported figures corresponding to a prevalence rate around 1:200,000 for transmen and transwomen combined. Ko speculates whether challenging real-life experience (RLE) requirements, client unfriendly services, and the availability of more attractive surgical options overseas may all account for this unusually low figure. Later on in this article we look more closely at the transgender health care provided in Hong Kong.

In many Asian cultures it is not only the numbers of transpeople that is striking; it is also the age at which they transition (through childhood and adolescence, rather than adulthood). Indeed, in much of Southeast and East Asia early transition seems to be the norm. This impression is confirmed by community-based research on transwomen in Thailand, the Philippines, Laos, Malaysia, Singapore, Korea, and Japan and a clinic-based study in Singapore involving transwomen and transmen.

Turning first to the community-based samples, a study of 195 Thai *phuying khaam phet* revealed that half felt "not male" by age 11, half of those who were took hormones were doing so by age 16, and half of those who were cross-dressing were doing so full-time by age 18 (Winter, 2006). Broadly similar results were found in a Philippine sample of 147 *transpinay* (a Filipino word for transwomen); the corresponding mean ages were 10, 17, and 18 years (Winter et al., 2007). In a comparable Lao study involving 214 *kathoey* (a word commonly used in Laos for transwomen) the figures were 11, 17, and 13 (Winter & Doussantousse, 2008). In Malaysia, Y. Teh (2002) reported that 71% of her sample of 507 *maknyah* "thought they were female when they were children" (p. 57) and 14% were cross-dressing by age 11, 82% by age 20. In a sample of 43 Korean transwomen, Kim et al. (2006) found a mean onset of gender dysphoria by 11 years and cross-dressing by 18 years. All the studies so far cited were community-based studies (involving sampling within the respective communities of transwomen).

Turning now to the Singapore clinic-based study, Tsoi (1990) found that by age twelve, 74% of 200 transwomen in his sample had begun to identify as the other gender (80% for the 100 transmen). By age 18 this figure had swelled to 99% (99% for the transmen also). By age twelve 60% of the transwomen had begun to cross-dress (84% for the transmen). By age 18 this figure had risen to 92% (94% for the transmen). By age eighteen 38% of transwomen had started taking hormones (the figure appeared much lower for transmen).

The widespread pattern of early transition, evident in all these studies, means that those transpeople who later choose to undergo SRS, by the time they actually approach a surgeon, have likely presented in their desired gender for a lengthy period, in many cases for years. The implications in terms of any need for an RLE are obvious.

Many transpeople growing up, transitioning, and living in Asia do so in a social and cultural context unlike much of the developed West. First, the number of transpeople living in many communities means that young persons transitioning can usually find a ready source of emotional and social support, as well as practical information (including on medical matters) to guide them in their transition. Their native languages will often provide them with a widely understood name to denote their GIV. Some will have the benefit of growing up in cultures of "gender pluralism" (Peletz, 2006, p. 309), which in early modern times promoted the acceptance of gender variance and which had traditions of transpeople performing highly valued social roles; for example, as spirit mediums and healers. Currently, gender pluralism may be on the wane, with those roles under attack by forces of modernization (including urbanization and the lasting effects of colonization), to be replaced by less prestigious roles such as beauty and hair salon work, dance and mime performances for tourists, and, in many societies, begging and (for transwomen) sex work (see, e.g., Doussantousse & Keovongchith, 2005; Earth, 2006; Hossain, 2005; Nanda, 1997; Y. Teh, 2002; Winter et al., 2007).

The involvement of transwomen in sex work begs a paper all by itself. Briefly, transwomen in some premodern societies provided a sexual outlet, enabling men to bypass strict limits on access to women outside the institution of marriage; e.g., in Oman, India, Thailand, etc. (Jenkins & Kim, 2004; Nanda, 2000c; Wikan, 1991). It is possible that contemporary transwomen, deprived of some of their earlier roles, drawn into the money economy, and deprived of other employment possibilities, have increasingly pursued a role as sexual outlet in the context of sex work.The nature of their work places transgender sex workers at particular risk of sexually transmitted diseases (over and above other sex workers). Some, especially those drifting into the city with little education or few contacts, may find getting a job difficult. Driven to the fringes of society, living on the streets and on their wits, some (particularly transwomen) drift into sex work, where they risk harassment, abuse, and violence. They are left vulnerable to risks arising from the unwillingness of many customers to use condoms, as well as the increased risk that comes from being the receptive participant in anal intercourse. For those forced to work on the street, police harassment is an additional problem, one that serves to discourage the carrying of condoms and lubricant. The less attractive and older the transgender sex worker is, the less power she has to insist on a condom anyway. Migrants from the countryside, often less educated and informed than their urban counterparts, may be particularly at risk. Drug and alcohol use, quite common among those involved in sex work, can exacerbate the problem of unsafe sex. Impotence drugs used by customers add to the problem, raising the risk of anal abrasions.

Many Asian transpeople grow up in cultures that do not make the same distinctions between sex, gender, and erotic preference as is common in the developed West. The lack of any distinction is reflected in their languages. One consequence is that judgments about a person's maleness or femaleness may be made not so much on the basis of biology (as in the West) or even gender but on the basis of sexual behavior. A second consequence is a ready acceptance that a person's status as male or female may change over his or her life span. A third is that the vocabulary used to denote transpeople (who fail to conform in terms of gender) is often also that which is used to denote homosexuals (who fail to conform in terms of sexuality) and intersex people (who fail to conform in terms of aspects of biological sex). This can make it difficult for activists pressing for health care services (e.g., gender-related and sexual health care) for transpeople as distinct from other social groups. In at least two countries (Thailand and the Philippines) activists have recently been taken steps to establish names in their indigenous languages to describe that group we know as "transpeople" in a more specific way. For more detail on all these aspects of cultural context see Winter (2009).

All of the above observations carry implications for provision of transgender health care. Key among them are the following. Large numbers of young transpeople intent on transition need easy and low-cost access to competent and trans-friendly health care. These transgender health care needs may be closely linked to other health needs, including sexual health care needs, yet may be distinct from the needs of other sexual minority groups. Transpeople's health care needs may change over the course of their life span. Where their current health care needs are not easily met by established health services, they will turn to their transgender peer groups for what they need.

Contemporary Transprejudice

The term *transprejudice* (introduced by King, 2007, and in the view of the Hong Kong research group with which I am connected—see King, Winter, & Webster (2009)—a term preferable to *transphobia*) is defined as the negative valuing, stereotyping, and discriminatory treatment of individuals whose appearance and/or identity does not conform to the current social expectations or conventional conceptions of gender. Transprejudice is common across Asia, including in those cultures which were once characterized by "gender pluralism" (Peletz, 2006, p. 309). It is, in the view of this author, common even in the apparently most transaccepting societies. It is often present at all social contexts in which the transperson operates: family and school (with many gender variant children and

adolescents being coerced, punished, abused, and evicted), workplace (with many transpeople, even those who are highly educated, unable to get or keep jobs or move ahead in their careers, except where they are able and willing to conceal their GIV), in the purchase of goods and services (with many transpeople finding it difficult to get housing, access trans-friendly health services, use banking services, or even gain entry to entertainment venues). Transpeople also encounter difficulties in dealings with government and its agencies.

Many Asian governments fail to provide enforceable antidiscrimination legislation. Across Asia as a whole, human rights culture is not as well developed as in, for comparison, Europe. It is not surprising then that whereas around 80% of European countries have ratified or acceded to the International Covenant on Civil and Political Rights (ICCPR; United Nations Organisation, 1966a), only around 52% of Asia's have. Three of those that have not are among the world's most populous (China, Indonesia, and Pakistan). Even among those nations that are parties to the ICCPR and/or other instruments such as the International Covenant on Economic Social and Cultural Rights (ICESCR; United Nations Organisation, 1966b) and the Convention on the Rights of the Child (CRC; United Nations Organisation, 1989), the degree of protection for sexual and gender minority groups remains unclear. One reason is that these instruments fail to explicitly include sexual and gender minorities as vulnerable groups (Tahmindjis, 2005). In theory then, ICCPR, ICESCR, and/or CRC place upon acceding or ratifying states responsibilities to (a) ensure a range of freedoms (from school discipline damaging to dignity, degrading treatment or punishment, arbitrary arrest or detention, interference with privacy) and (b) protect key rights (to expression, marriage, work, equal opportunity for promotion, education directed to full development of personality, and adequate standard of living). In practice, however, implementation falls far short of the ideal.

Many governments refuse even transpeople (even post-op) the opportunity to change their legal status. In some countries where opportunity to change legal gender status has been offered, it has later been withdrawn. Kuwait is one example: a ruling that allowed a transwoman (who had undergone SRS in another country) to change her legal gender status was later overturned by the appeals court (BBC News, 2004). The effects of a bar on changing one's legal gender status are many, including upon rights to marry and enjoy family life. Asian research into transpeople's sexuality reveals a majority pattern of heterosexuality (i.e., erotic attraction to another gender; Kim et al., 2006; Y. Teh, 2002; Tsoi, 1990; Winter, 2006; Winter & Doussantousse, 2008; Winter et al., 2007; Winter & Vink, 2009a, 2009b; but see an exception to this pattern in Okabe et al., 2008). The consequence is that, in those societies in which transpeople cannot change their legal gender status, they cannot marry according to their erotic/romantic preference, and adoption may be very difficult indeed. In Pakistan a newly married couple were recently separated, charged, found guilty, and imprisoned on the grounds that the groom (who it turned out is a post-op transman and was known to be such by his bride) had lied by presenting as a man at the wedding (BBC News, 2007).

Across much of Asia, laws that criminalize homosexuality (defining the offense in terms of the birth-assigned sex of the persons concerned, rather than their gender) serve to marginalize heterosexual transpeople further. These laws, together with public decency laws that effectively criminalize cross-dressing, provide a pretext for abuse (violent and/or systematic) by local authorities and police against transpeople. Consider the following cases. In Kuwait recently, 14 transpeople were arrested within the space of a few weeks for cross-dressing (specifically, on the grounds that they were violating a law that criminalizes "impersonation of the other sex" and that sets custodial sentences of up to one year). They were reportedly abused both psychologically and physically by police officers during detention (Human Rights Watch, 2008). In Nepal transgender *meti* have been mocked, threatened, chased, arbitrarily detained, stripped, raped, and/or assaulted (in some cases almost to the point of death) by police in a series of incidents described by some human rights activists as a program of "sexual cleansing" (Human Rights Watch,

2006a, 2006b; Pant, 2005). In India, there have been reports of widespread police violations against *hijra* and transgender *kothi* in Karnataka state. The incidents involved harassment (including in the victims' homes), entrapment, and physical and sexual abuse, including rape (People's Union for Civil Liberties—Karnataka, 2003). In Bangladesh, abuses of this sort appear widespread, involving not only police but also *mastans* (violent gang members acting as musclemen for political parties in exchange for the parties' tolerance of their racketeering and other criminal activities; Human Rights Watch, 2003).

Together with other researchers I recently undertook a detailed examination of Asian transprejudice (Winter et al., in press). Our 30-item questionnaire examined attitudes and beliefs about transwomen and was completed by 841 undergraduate students in seven societies: five Asian (Hong Kong, the Philippines, Thailand, Singapore, Malaysia) and two Western (United States and UK). Transprejudice was evident in all seven societies, though to varying degrees.

A factor analysis was performed on the pooled data, in an effort to identify core attitudes and beliefs underlying our international data. Five factors were identified, together explaining 52.1% of variance. They were, in order of variance explained: (a) the belief that transwomen suffer from a mental illness (mental-illness); (b) the belief that transwomen are not women, should not be treated as such, and should not be afforded rights as women (reject-women); (c) rejection of contact with transwomen in a variety of social situations, including among family members and teachers (reject-social); (d) rejection of contact with transwomen within one's peer group (reject-peers), and (e) the belief that transwomen are sexually motivated to do what they do, are promiscuous, and engage in sexually deviant behavior (sexual-deviance).

A worrying feature of the findings was that these factors were correlated. Particularly strong, and fairly consistent across the seven countries involved, were the links between, on one hand, the belief that transwomen suffer from a mental illness and, on the other hand, key components of transprejudice. Within country samples those who believed that transwomen were mentally sick were also likely to resist regarding them as women and deny them rights as women, as well as reject any social contact with them. The link was also apparent at the level of countries; those countries with a culture of pathologization tended to be the most transprejudicial. The findings of this study raise the possibility that a mental disorder model of GIV may support and encourage key transprejudicial attitudes. I shall return to this point later.

Prejudiced attitudes can reasonably be expected to go hand in hand with discriminatory behaviors. In the next sections I will take four Asian societies in our seven-nation study (Malaysia, Thailand, Hong Kong, and the Philippines), detailing the types and levels of discrimination that confront transpeople there. By coincidence these countries represent examples of largely Islamic, Buddhist, Confucian, and Christian societies.

Malaysia

Malaysia is party to the Convention on the Rights of the Child (CRC) but not to the two other key international human rights instruments (the ICCPR and ICESCR), all mentioned earlier. This country was apparently the most transprejudiced Asian sample in our cross-national study (interestingly, on a par with the American sample, which was drawn in Arkansas). As might be expected from this finding, discrimination against transpeople is evident throughout Malaysian society, sometimes so systematic and encompassing that it merits the word *oppression*, an oppression perpetrated not only in the family, in schools, and in the workplace, but also by lawmakers, bureaucrats, and academics. Transpeople are unable to change legal gender status (and Muslim transpeople not even their ID cards). Indeed, the 1955 Minor Offences Act has made cross-dressing illegal and led to many arrests. A 1983 *fatwa* (religious edict) reinforces the ban on cross-dressing, as well as outlawing SRS, at least for transpeople and surgeons who are Muslim (Y. Teh, 2002). To outsiders the *fatwa* may be somewhat difficult to understand, in view of the liberal attitudes toward this sort of surgery in an otherwise much stricter Islamic society, Iran (Mehrabi, Ardebili, & Bidokht, 2006). The

subsequent absence of Muslim surgeons doing this work in Malaysia has had an effect on all transpeople living there, making SRS less easily available than hitherto. A group of academics recently published a book on the problem of effeminacy in men, proposing ways of preventing it and stamping it out when it occurs (Noraini, Jamil, Ahmad, Hazizan, & Shukran, 2005). Inspired by the same problematizing stance on gender variance, politicians in one part of the country have proposed a program of forced rehabilitation for cross-dressers ("Rehab Centre," 2007). At least one marriage has been annulled after it was found (subsequent to the marriage) that one of the spouses was a transperson (Y. Teh, 2007).

Predictably, many transwomen report difficulty getting a job. Y. Teh (2002) reported that 62% did so, adding that 54% of her sample was actively involved in sex work, though estimates elsewhere have been as high as 65% (Y. K. Teh & Khartini, 2000). Whether in sex work or not, transwomen are harassed by police and, if they are Muslims, the powerful Islamic Religious Authority. Many are arrested and charged with indecent behavior (the most common offense being cross-dressing). Those taken to police stations are often forced to strip and then to dress as male, a generally humiliating experience. Some have reported being beaten up (Y. Teh, 2002). In one particularly egregious case police are reported to have beaten a middle-aged transwoman (in full view of witnesses) on the grounds that she was cross-dressing in a public place and then later sought the names of any persons visiting the victim in hospital. The incident prompted Amnesty International to issue a call for action (Amnesty International, 2007). Oppression at this level can be expected to have an impact on transpeople's mental health. Y. Teh (2002) found that 14% of her sample had attempted suicide at least once, despite the very negative view Islam takes toward suicide (Sarfraz & Castle, 2002).

Hong Kong

Hong Kong is a party to all three international legal instruments mentioned earlier (ICCPR, ICESCR, and CRC). In our cross-national study the Hong Kong sample was the second most transprejudiced of our five Asian societies (albeit significantly less so than the Malaysian sample and on a par with Singapore). Consistent with this finding, anecdotal evidence confirms that Hong Kong transpeople encounter rejection inside and outside the family and find it difficult to get jobs. In the local language (Cantonese) they are often called *yan yiu* (literally "human monsters"; effectively "freaks"), though more respectful alternatives exist. The media, sensationalistic when covering transgender issues, employ the word *yan yiu* with little compunction. A recent formal complaint to the government-appointed Broadcast Authority was ruled groundless (letter of complaint and the Broadcast Authority's response available from this author). In 2003 a magazine reporter stalked a transwoman through an Internet chat room, discovered the place where she worked (a beauty salon), took photos of her at work, and ran a sensationalist pictorial on her (headed "The Man Who Wears a Bra"). She lost her job. The following year she committed suicide (see Emerton, 2006).

The Hong Kong government adopts an ambivalent stance toward transpeople. On one hand the Hospital Authority of Hong Kong government subsidizes SRS and the Security Bureau issues new ID cards (with changed details regarding gender status) to post-op transpeople. On the other hand, the Security Bureau also dismisses requests (even after SRS) for a change in legal gender status. The government therefore facilitates medical and social transition but forbids legal transition. The government has also recently refused to enact any legislation that would protect transpeople (or indeed members of other sexual minority groups) against discrimination. For more detail on the Hong Kong situation, see Winter and King (2009).

Thailand and the Philippines

Both Thailand and the Philippines are parties to ICCPR, ICESCR, and CRC. In our cross-national study Thailand came out as significantly less transprejudiced than Malaysia, Hong Kong, or Singapore, and the Philippines as significantly less prejudiced than them all (indeed, only

surpassed in transacceptance by the UK [London] sample). Yet in many ways the discrimination encountered by transpeople in these two Southeast Asian societies is quite similar. For that reason I discuss them as a pair.

In both countries, transwomen encounter difficulties entering the world of work, all the more because many of them are already well into gender transition by the time they try to do so. Like their Malaysian counterparts, their chances of employment are undermined by the documentation they present upon applying for a job, which states their birth-assigned sex regardless of their gender transition. Some transpeople manage to gain mainstream employment. In the Philippines, for example, where English is widely spoken, some get jobs in call centers providing support and information to callers worldwide (of course, never being seen by their customers). Notwithstanding, for most transwomen employment opportunities are limited to a variety of "trans-ghetto" jobs; jobs widely considered suited to their feminine sexuality and aesthetics. They include beauticians, hairdressers, makeup artists, cabaret performers, and entertainment and sex workers (in bars, on the Internet, or on the street). The difficulties getting a job extend even to able graduates from prestigious universities. Many are forced to conceal their gender, if they can, during working hours (presenting as best they can as male: in effect "in drag") and to revert to female outside working hours.

Winter and Vink (2009b) recently examined Thai transpeople's opportunities for employment. They found that 22% of an opportunistic sample of 225 Thai transwomen believed that being transgender had reduced their chances of getting jobs (and 29% believed that it reduced the choices of jobs available). In a similar study in the Philippines involving an opportunistic sample of 158 transwomen (Winter & Vink, 2009a) the figures were somewhat lower, at 12 and 15%, respectively. Notwithstanding that these two societies are comparatively transaccepting (relative to some of their close neighbors), it is likely that these figures grossly underestimate the problems that transpeople have getting a job. In contacting participants, the researchers relied heavily on social networks within the transgender community. It is likely that those already working were better networked and more readily drawn into our samples, whereas those who were unemployed were more less likely to be networked and less likely to learn of our study and have the chance to participate. Had the jobless been better represented in our sample, our figures for the impact of transgender upon employment may have been even more alarming.

The Thai and Filipino governments provide no effective legal protection against discrimination on the grounds of gender identity status. Indeed, they actually perpetrate some of the most debilitating discrimination. As we have seen, Thai transpeople remain legally members of their birth-assigned sex regardless of how long or successfully they have presented in another gender or how much they have modified their bodies. Indeed, transpeople (even those who are post-op) cannot even change their ID cards, or any other documentation for that matter. All the documentation they carry therefore indicates to employers, government officers, and others a legal sex contrary to their gender presentation. Transwomen (being legally men) are summoned at age 20 for military service (along with all other men of that age who have not already done military training at high school). Some, particularly those who have not yet undergone breast surgery, run the risk of being humiliated in a group physical examination. Those relieved of military service receive discharge papers (the so-called SorDor 43) carrying the words *mental disorder*. They must produce their discharge papers upon applying for any job. The documentary evidence that they have a mental disorder is highly likely to deter any potential employer from offering a job. The armed forces of Thailand have announced that the phrase *mental disorder* will be replaced in future by *belonging to the third category*. It remains uncertain whether this will affect the many SorDor 43s that have been issued in earlier years. For further information on transprejudice in Thailand see Winter (in press).

In some ways the situation facing Filipino transpeople seems somewhat better than that for their Thai counterparts. First, they are not required to perform military service (though they may be required to do military-style

activities as part of their education). Second, they have opportunities for employment in a growing English-language call center industry. Third, any Filipino transperson who is able to bear the expense of SRS, has undergone the operation, can hire a lawyer, tolerate the public attention, wait out the months or years involved, and risk an unfavorable decision has for some years been able to petition a Regional Court for issuance of a new birth certificate. In most cases courts have apparently been ready to grant these petitions. However, the costs involved in obtaining SRS and hiring a lawyer have rendered a change in legal gender status beyond the means of most transpeople. Worse, the Supreme Court of the Philippines has now overturned the earlier decision of a lower court in one of these successful cases (Supreme Court of the Philippines, 2007), leaving other cases at risk of being similarly overturned in the future. Filipino transpeople's dismay at this development has recently been heightened by a subsequent case involving a person with congenital adrenal hyperplasia who, being gender dysphoric, petitioned for a new birth certificate as male. In this case the Supreme Court overturned an unfavorable lower court decision and granted the change. The key issue, it appears, was that the Supreme Court was able to recognize a clear physical disorder underlying her gender dysphoria (something they were apparently unable to do in the case of the transwoman). In view of all this, it is not surprising that 30% of Filipina transwomen feel that society is generally rejecting toward transpeople (Winter et al., 2007).

The nature of the transwomen's circumstances in these two countries is underlined by figures on parasuicidal behavior. In the two recent Winter and Vink studies mentioned earlier (2009a, 2009b), around 16 and 22% of Filipina and Thai transwomen, respectively, reported having attempted suicide on one or more occasions.

In summary then, transprejudice (interpersonal, institutional, even legal) frames the lives of many Asian transpeople. It leads to discrimination that limits opportunity, resulting in social and economic marginalization (even exclusion) that is sometimes so debilitating and systematic that it merits the word *oppression*. We know from Western research that transprejudice (and resulting discrimination) is a health issue; that its cumulative impact can harm transpeople's health (mental and physical). We can conclude from the material so far presented (most obviously in the figures on parasuicidal behavior in comparatively transaccepting places like the Philippines and Thailand, and the reports of beatings, rape, and death elsewhere across the continent) that the same true in Asia. This then the context in which transpeople live in Asia and in which transgender health services are (or are not) provided and are (or are not) utilized by transpeople. I now turn to an outline of those services.

THE NATURE OF TRANSGENDER HEALTH CARE IN ASIA

Asian governments' commitment and wherewithal to provide health services varies greatly across Asia. For many people living in Asia general health services are scarce and/or expensive. To give some examples from Southeast Asia, government per capita annual expenditure on health in Bangladesh was US$26 in 2006 ($21 in India, $44 in Indonesia). The number of physicians per 10,000 people was as follows: three in Bangladesh (2005), six in India (2004), and one in Indonesia (2003; all figures from the World Health Organisation, 2007).

As one might expect, transgender health services in places such as these are often poorly funded. Specialist personnel and services are scarce or absent altogether. Transpeople commonly report that generalist medical personnel, particularly those in public health services, are often ill prepared for provision of transgender health care and/or by their behavior demean the transpeople seeking their care. Perhaps for these reasons, among others, parents of children experiencing GIV (including those parents who are anxious about how their children are developing) seldom appear to take their children to doctors. In an e-mail focus group of 18 transwomen across Southeast Asia convened as part of the preparation of this article, I did not find a single participant whose parents had done so. Arguably this is a good thing.

Later on in life, of course, transpeople unarguably do have health care needs. In many countries the private health sector, medically trained and otherwise, fills the gap left by inadequate government health care services, albeit in some societies (for example, Malaysia) religious factors constrain their ability to do so.

Many transpeople appear to do without doctors altogether, at least in regard to some of their daily health care needs. This is particularly true where hormones are easily available, as in much of Southeast Asia. In Laos (where Winter & Doussantousse [2008] found in a respondent-driven sample of 214 transwomen that 38% of participants were taking hormones, starting from a mean age of 17 years, and from as early as 8 years old) various products are available, costing around US$1 for a month's supply. In the Philippines (where Winter et al., 2007, found in an opportunistic sample of 147 transwomen that 69% of transwomen were taking hormones, from a mean age of 18 years, and as early as age 14), many transwomen report obtaining contraceptive drugs free at their local reproductive health centers. In Thailand (where Winter, 2006, found in an opportunistic sample of 195 transwomen that 94% were taking hormones, starting from a mean age of 16 years, and as early as 10), up to 23 products containing cross-sex hormones are available over the counter at major pharmacies. Self-medication is widespread. Transpeople commonly take cross-sex hormones without consulting or being supervised by medical personnel. Instead they rely on advice and information supplied free of charge by friends in the transgender community, who are seen as both knowledgeable about their needs and affirming in their demeanor. My own research confirms the scale of unsupervised hormone use. In three separate studies (in Laos, Thailand, and the Philippines, each with local coresearchers) I found that transpeople hardly ever consulted medical professionals about the use of cross-sex hormones, either before or while taking them. For example, in an opportunistic sample of Lao transwomen, only 2 out of 60 who reported taking hormones at some point in their lives had ever consulted a doctor about hormone use, with 4 others reporting that they had consulted other medical professionals. In contrast, around 4 out of 5 of the sample had consulted other transwomen (Winter & Doussantousse, 2009a). More recent studies of hormone use in Thailand and the Philippines have found much the same pattern of advice-seeking. Of 139 Thai transwomen in an opportunistic sample who reported taking cross-sex hormones at some point in their lives, only 43 consulted a doctor and/or nurse before doing so, with 120 consulting transgender friends. The advice-seeking after beginning hormone use was hardly more balanced; 70 consulted a doctor or nurse, yet 101 consulted other transwomen (Winter, Li, & Lertraksakun, 2009). Of 132 Filipina transwomen in an opportunistic sample who reported taking cross-sex hormones at some point in their lives, only 64 consulted a doctor and/or nurse at any point, with 115 consulting transgender friends (Winter & Alegre, 2009).

Perhaps unsurprisingly, all three studies revealed disturbing patterns of hormone (ab)use. Many participants appeared to consume whatever friends recommended. When they had money they ingested doses well above recommended levels. When they had no money, they ingested none at all. They were largely ignorant of health risks involved in prolonged hormone use, many failing to take the most obvious precautions against ill effects (such as desisting from smoking). Not surprisingly, many of those who took hormones eventually stopped because of health complications. In the Lao study, around half had stopped taking hormones within 6 years of beginning to use them, with 9 out of 10 citing health problems. The Thai and Philippine studies yielded similar figures. See also Y. Teh (2002), who reported in a study of Malaysian *maknyah* a resistance to consulting doctors (especially government doctors). Predictably, a recent Thai study (believed to be the only Asian study of its kind) revealed that transpeople taking hormones had a lower overall quality of life than those who did not (Suja, Sutanyawatchai, & Siri, 2005).

As one might expect, it is in the area of surgery that the private health sector has made major inroads into transgender health care. In Thailand, for example, a wide variety of surgeries is available, at a price. A telephone survey of the prices charged by 13 of the best-known surgeons on July 3, 2007, revealed the following

approximate price ranges (for Thai patients): trachial shave: 12,000–30,000 baht; augmentation mammoplasty: 60,000–150,000 baht (Nuttawut Udomsak, personal communication, April 28, 2008; exchange rate as of July 7, 2007, US$1 = 31.44 baht). It is likely that prices much lower than these are available. In the same survey, SRS cost 120,000 to 450,000 baht. More recent figures indicate as little as 50,000 baht (about US$1580 at April 2008 exchange rates), and breast implants from 40,000 baht (US$1260). Even in terms of average Thai income these prices are comparatively low, around 10 weeks and 8 weeks of average income, respectively. It is not surprising then that Winter (2006) found, in an opportunistic sample of 195 Thai transwomen, that 40% of Thai transwomen had undergone breast surgery (mean age 23 years), 39% a nose operation, 18% a chin operation, and 8% a trachial shave. Some made use of injected silicone, especially to the hips and buttocks. Around 28% had undergone SRS (mean age 24 years, the youngest age 16 year). But note that 12% were non-op and intended to remain so.

The more entrepreneurial (and most able) surgeons provide services for overseas patients. Diagnostic and documentary requirements for SRS are somewhat unclear. Some surgeons providing services for foreign patients refer to *SOC-6* on their Web sites. In practice, many surgeons appear more accommodating, setting aside the requirement for a report from a mental health professional in the case of patients already living in their preferred gender and/or who appear to have been taking hormones for a lengthy time period. A consultant psychologist who worked with a Thai surgeon informed me "... it is up to the surgeon whether to grant or not grant SRS on a case-by-case basis. What [name of surgeon] did in cases of foreigners who had no paperwork but wanted SRS, he asked them to lift their shirt and show their breasts. If they had a slight breast growth, he took this to be the effect of hormones and granted SRS. Presumably, he did the same for Thai patients, too" (Anonymous, personal communication, June 18, 2007). Similarly, "bottom line here is that if they present themselves as feminine enough to use women's public toilets, they will be accepted for surgery regardless of other criteria they may fail once they are in Thailand" (same informant, personal communication, June 12, 2007). This more accommodating attitude seems particularly common where Thai patients are concerned. One Thai surgeon told me, "Thai transsexuals come out since they were young and pass quite good several years before they have enough budget for surgery. Anyone who meet them usually believe that they should be in another sex role" (Anonymous, personal communication, June 18, 2007).

The accommodating Thai approach to surgery (at least in regard to the involvement of mental health professionals) stands in stark contrast to the provision of surgery for transpeople in much of the West. It may prompt alarm among many Western clinicians. I should note then that in my own work with Thai transpeople over the last 9 years I have seldom heard transgender patients complain about the work of surgeons, except that the best surgeons are expensive (in fact cheap by Western private health care standards). Post-op regrets about surgery appear no more common than in the West, though there is a need for formal research in this area.

Private surgery is, of course, available elsewhere in Asia. A recent paper concerning the Philippines quoted at least US$2100 for breast implants and US$6300 for SRS (Winter et al., 2007). More current figures indicate that charges have risen, with breast implant surgery apparently now costing at least US$2800 and SRS surgery at least US$7100 (Sass Rogando-Sasot, E-mail to author, April 30, 2008).These figures represent 10 months and 26 months of average Philippines income, respectively. Such costs may play a role in the decision of some transpeople to undergo the operation in Thailand or the intention of others (29% according to Winter et al., 2007) not to undergo the operation at all.

Across Asia, including in the Philippines and even in Thailand, the costs of orthodox surgery are prohibitively high for many transpeople. Many turn to cheap alternatives: injected silicone (a procedure particularly common in the Philippines) and simple castration (until recently reportedly available at some 16,000 clinics in Thailand at as little as US$125, but now banned by the Medical Council of Thailand; "Thai Health Ministry," 2008).

In India, SRS as understood in Western countries is hardly available to many transpeople at all. Instead, many members of *hijra* (and related) communities undergo a crude and hazardous procedure involving both castration and penectomy but not construction of a vagina (Nanda, 2000a). Few of those performing the operations have any recognized medical qualification. Nanda (2000a) provides a vivid description of the operation:

> The surgery is (ideally) performed by a *hijra*, called a "midwife". The client is seated in front of a picture of the goddess [Bahuchara Mata] and repeats Bahuchara's name over and over, which induces a trancelike state. The midwife then severs all or part of the genitals (penis and testicles) from the body with two diagonal cuts with a sharp knife. The blood from the operation, which is considered part of the male identity, is allowed to flow freely; this rids the person of their maleness. The resulting wound is healed by traditional medical practices and a small hole is left open for urination. (p. 33)

In Malaysia, since 1983 SRS involving Muslim patients or surgeons has been banned on religious grounds (Y. Teh, 2002). The Muslim population is of course the majority in Malaysia and would otherwise be expected to provide most of the patients and surgeons. A couple of non-Muslim surgeons still reportedly continue to work, but the pool of non-Muslim transpeople upon whom they can work is small, and so they are reportedly inexperienced. Transpeople wanting SRS who can afford to go overseas do so (with consequent erosion of possibilities for pre-op and post-op care).

Hong Kong is a rare exception in the overwhelmingly private provision of transgender health care in Asia; it is almost fully subsidized by government. Notably, there is an attempt to follow *SOC-6* strictly. In the view of this author, however, the result is an unfortunate demonstration of what can happen when each of these things is done without adequate funding. Between 1986 and 2005 Hong Kong had a centralized gender clinic, led by a psychiatrist, modeled on the Clark Institute in Toronto, and reliant upon the time specialists were able to set aside for work with transgender patients. Within the transgender community, patient complaints about quality of services were common. In 2005, the government, with little warning, restructured services into a set of regional clinics (again each headed by a psychiatrist). Predictably, after such a long period of centralized care, some of the health care workers now providing services have had little experience of working with transpeople, leading to some dismay among patients. Apart from long waiting periods for first and subsequent appointments, they have complained about demeaning, incomplete, inappropriate, and/or inexperienced health care. The experiences reported by A. (a transwoman who recently underwent SRS) are fairly typical. She reports that she first saw a gender clinic psychiatrist in 2002, at which time the psychiatrist recognized that she was experiencing GIV, even asking her when she would like surgery. From then on, however, she reports that progress was slow. Her first hormones, at a dosage she felt was too low for her needs, were prescribed 28 months after the first consultation. Another 7 months later, and after she showed her doctor an article in a leading endocrinological journal, he doubled her dosage. Her surgery in May 2007 came over 5½ years after the first consultation. During her long contact with the gender team she had seen her psychiatrist on average every 3 or 4 months. She had also seen a clinical psychologist, social worker, geneticist, and surgeon during this period (plus a legal adviser, whose services were not subsidized). However, she had not seen an endocrinologist or gynecologist at all. Faced with the delays, frustrations, and gaps in government health care, an indeterminate number of transpeople have turned to other health care sources that bypass the government health system. In Hong Kong contraceptives are available over the counter, and a myriad of hormones are available through the Internet. A wide range of surgeries are available in nearby Thailand.

In summary, even in those parts of Asia in which large numbers of transpeople live (many more than is implied by the prevalence figures in *SOC-6* section 2), governments are not deeply involved in the provision of transgender health

care. Where they are the results are often not impressive. Public health services are often seen by transpeople as either ill prepared or uncaring in regard to their needs. Across much of Asia the private health sector has stepped in to fill the transgender health care gap, especially in the case of surgery. Transpeople, many of them in their teens and early 20s, transition in a way quite unlike that apparently currently envisaged by *SOC-6*. Transpeople often take hormones, sometimes from an early age (in some cases much earlier than the 16 years anticipated in section 5), perhaps unknown to parents (contrary to section 5) and, despite the risks involved, without medical consultation or supervision (contrary to section 8). In some countries those transpeople who require surgery, including SRS, do so without meeting the criteria of *SOC-6* (especially section 10), sometimes younger that the ages (of 18, section 5; or majority, section 8) needed for *SOC-6* eligibility, and particularly without seeing mental health professionals (for diagnosis or any of the other duties listed in section 4) and without undergoing an RLE (section 9). Indeed, in some countries surgery seems available more or less on demand, with SRS apparently offered without many of the eligibility criteria listed in section 12. Where SRS is not easily available, and savings allow, many transpeople travel overseas for the operation (with implications for continuity of care, particularly follow-up as described in section 13). Where orthodox surgery proves too expensive, alternatives such as silicone injection, castration, and penectomy are sometimes available, often through a parallel private sector, sometimes involving practitioners of dubious qualification, and probably at some risk to the patients involved.

Implications for SOC-7

In light of all the above, it may be argued that *SOC-6* is ill matched (or even irrelevant) to the broader transgender health care needs of the Asian (perhaps global) trans-community. Even in the developed West *SOC* provisions have a history of being ignored (e.g., Petersen & Dickey, 1995). Transpeople increasingly see themselves as representing diversity rather than disorder (James, 2004). They seem increasingly critical of the "management of gender identity disorders" they feel they get through *SOC-6* (Meyer et al., 2001, §1 ¶1). Internet sharing (within and between communities) of information about (and access to) global health care services (e.g., SRS) and products (e.g., hormones) is increasing. Surgeons outside the developed West are marketing themselves internationally, and the health care that Western transpeople enjoy for their (carefully diagnosed) GID remains largely uninsured (with notable exceptions in some European countries and the State of Minnesota in the United States). For all these reasons it seems entirely possible that Western transpeople will increasingly sidestep *SOC* in the future, the result being their increasing irrelevance, even in the developed West.

Interestingly, of those countries with which I am familiar, Thailand (with relatively open access and relatively uncontrolled transgender health care unhindered by *SOC-6*) anecdotally appears to yield the transpeople generally best satisfied with transgender health care available to them. Notably, satisfaction seems much higher than in Hong Kong, in which there is *SOC-6*–focused (indeed government-subsidized) health care. True, the Thai system is imperfect. Thai transpeople use (arguably abuse) hormones without medical monitoring. Injected silicone is a cause for concern. Some surgeons may not be as able as others. But one gains the impression that Thai transpeople would be wary of facing the health care challenges that transpeople encounter in Hong Kong (or, for that matter, any other places professing adherence to *SOC-6*). In any case, as indicated earlier, Thailand (and much of Asia indeed) has few of the specialists that *SOC-6* adherence would require, and their involvement in transgender health care would, without funding by government or insurance companies, add prohibitively to the cost of health care.

What then does all this mean for *SOC-7*? To make the standards more relevant, radical revisions may be necessary. The current *SOC* aims, as stated in *SOC-6*, are "to articulate WPATH's professional consensus about the psychiatric, psychological, medical and surgical

management of gender identity disorders" (Meyer et al., 2001, §1 ¶1). The underlying philosophy appears from the outset to be about management of pathology rather than a broad-ranging health care focused enhancement of transpeople's mental, emotional, and physical well-being.

I have seven recommendations. The first four touch on touch on comparatively broad issues, issues that set the scene for the provision and utilisation of transgender health care. They address the need for *SOC-7* to (a) recognize transprejudice as a global health problem, (b) depathologize GIV, (c) amend the language used to describe transpeople, and (d) incorporate more realistic figures for GIV prevalence. The next two recommendations focus on matters of clinical management, addressing the need for *SOC-7* to better meet the needs of young transitioning transpeople by (a) promoting health care service involvement in developing family and community support for young transpeople and providing basic health care information in various languages for all involved and (b) recognizing the need for more flexibility in terms of RLE and age requirements during transgender health care. The last recommendation focuses on the need for WPATH to consult widely within the international trans-community when drawing up *SOC-7*.

Recognizing Transprejudice as a Global Health Problem

In Asia, as we saw earlier, and worldwide (and in some cultures more than others) transpeople face transprejudice and discrimination. These experiences serve to (a) promote minority stress and push transpeople to the margins of society; (b) damage subjective well-being and mental health (through low self-esteem, social anxiety, social isolation, depression, helplessness, and hopelessness); and (c) damage physical health and well-being, both directly (when prejudice is expressed through violence) and indirectly (when it prompts transpeople to engage in risky and harmful behaviors, sexual, drug-related, and suicidal). In addition, transprejudicial health policies and practices (at the level of the health system and of individual practitioners) discourage use by transpeople of whatever health services exist and in some cases lead to the removal of those services altogether. In my view, therefore, *SOC-7* needs to address the matter of transprejudice, recognizing it as a global health issue.

Recommendation 1

SOC-7 should include material recognizing the relationships between transprejudice, transgender health, and health care, specifically:

1. The impact transprejudice and discrimination can have upon transpeople's health;
2. The importance of extending to transpeople the rights to respect, equality, and dignity enjoyed by the general population;
3. The potential of social and legal initiatives (e.g., public education and legislative protection) in reducing transprejudice and discrimination;
4. The role health professionals can play in public education aiming to reduce transprejudice; and
5. The importance of identifying transprejudicial health care policies and practices resulting in unresponsive, inaccessible, expensive, or otherwise poor services for transpeople and improving what is provided.

Note here that the American Medical Association (AMA, 2007) has recently adopted a policy that explicitly states its opposition to discrimination against transpeople (whether within the association or in broader society).

Recognizing the Need to Depathologize GIV

SOC-6 (from its title ". . . Gender Identity Disorder . . . " onwards) is replete in the language of psychiatric pathology, language in conflict with the perceptions of many transpeople in the developing world who see their GIV as a difference (not a disorder). Many in the developing world note the irony of a supposed mental disorder, for which the most effective intervention is medical (endocrinological and surgical) support. The

same irony is detected in the West, even in the medical establishment (e.g., Monstrey, 2009).

In a section 3 paragraph entitled "Are Gender Identity Disorders Mental Disorders?" *SOC-6* notes (following *DSM-IV* and *ICD-10*) that the answer is affirmative, when and if "significant adaptive disadvantage" or "mental suffering" results from the patterns of behavior involved (Meyer et al., 2001, §3 ¶10). Yet throughout Asia hundreds of thousands of transpeople seem to live without inherent adaptive disadvantage or mental suffering. Like their (often less fortunate) Western brothers and sisters, disadvantage and suffering often result from the reactions of others (particularly those most significant in their lives and over significant parts of their lives) in regard to their GIV.

Note the research quoted earlier (Winter et al., in press) that indicates a link (in several Asian countries as well as the United States and UK) between, on one hand, the psychiatric pathologization of GIV (the belief that transpeople suffer from a mental disorder) and, on the other, key transprejudicial attitudes. Given the widely accepted impact that transprejudice can have upon mental and emotional well-being, these findings raise a disturbing possibility: that a mental disorder model of GIV may, by promoting and supporting transprejudice, contribute to mental pathology among transpeople; in short, that pathologization is pathogenic (see also Winter, 2007). True, *DSM-IV* diagnosis of GID, or *ICD-10* diagnosis of transsexual etc. may indeed have resulted (in some parts of the developed world) in improved health care (even sometimes subsidized). But, transpeople worldwide may be paying a heavy price for the benefits enjoyed by few. Arguably, the case for depathologization is as clear for GIV as it was some years ago for homosexuality. Note the case for depathologization made by Monstrey (2009).

Ironically, the recently released Royal College of Psychiatrists (2006) draft *Good Practice Guidelines for the Assessment and Treatment of Gender Dysphoria* (RCP-*DGPG*) show a way forward. Section 2.1 states that transsexualism and GID are clinical labels for "atypical gender development," adding that:

> The experience of this dissonance between the sex appearance, and the personal sense of being male or female, is termed gender dysphoria. The diagnosis should not be taken as an indication of mental illness. Instead, the phenomenon is most constructively viewed as a rare but nonetheless valid variation in the human condition, which is considered unremarkable in some cultures.

Again, in *DGPG* section 3.1.1:

> . . . the terms disorder and disease in this context are widely perceived by transpeople as offensive and stigmatizing. The use of these terms should therefore be avoided in clinical practice.

It is this sort of thinking that can lead the *SOC* from a culture of medical management of pathology to one of broad-based health care informed by legal, social, and psychological (as well as medical) considerations that support diversity.

In view of the above considerations, the following is recommended.

Recommendation 2

SOC-7 should include material to the effect that:

1. GIV is an aspect of human diversity, a condition involving a discordance, a dissonance, between socially ascribed sex and personally experienced gender identity.
2. GIV is not of itself pathological; rather, it is a state/condition likely to benefit from health care support.
3. Terms such as *gender identity disorder* (explicitly the language of pathology) and *transsexualism* (which in *ICD-10* is used to denote pathology) are nowadays inappropriate to describe GIV. Rather, the condition is better denoted as GIV (gender identity variance).
4. GIV people may indeed experience poor mental health (depression, social anxiety, etc.). But insofar as these typically result from long-term experience of other

people's intolerance toward GIV (compounded by the GIV person's concern to avoid further such experiences), any diagnosis should focus on the mental health problems that may accompany the diversity rather than upon the diversity itself. There is a clear parallel with the case of homosexuals who are depressed about their sexuality, whom many health care workers nowadays would hope to be diagnosed and treated for their depression rather than for their sexual orientation.

At this important time, with the process of revision for a future *DSM-V* already under way, statements such as these, coming from WPATH and enshrined in the *SOC-7*, have the potential to be particularly influential.

Recognizing a Need to Change the Language Used to Describe Transpeople

SOC-6 describes "two primary populations with GID"—"biological males and biological females" (section 1). The terminology here seems to ignore growing evidence for brain sexing during early (perhaps fetal) development and for a biological basis for GIV. The proposition that biological sex has at least five components (chromosomal, gonadal, hormonal, genital, and brain) implies that (a) transwomen may be (at least in part) biologically female, (b) transmen may be biologically male, and (c) GIV is a subtype of intersexualism.

For transpeople, there may be more practical consequences of language insensitive to their identity. Specifically, the terminology used in *SOC-6* (*biological males* and *biological females*) may serve to encourage other terms objectionable to transpeople; for example, *male transsexual* (for a transwoman) and *female transsexual* (for a transman). Terms such as these are offensive because they deny transpeople's self-identification. They also encourage the view that transpeople are, in presenting as members of another sex, actually engaged in deceit and pretence, a view that, as Bettcher (2007) has argued, promotes and excuses transprejudice.

Recommendation 3

SOC-7 should embrace terms that are more community sensitive (and arguably more scientifically correct) in referring to transpeople; for example, terms such as *transwoman*, *transgender woman*, *female-identifying transperson*, etc. (to describe that population currently described in *SOC-6* section 1, as *biological males*).

Incorporating More Realistic Figures for GIV Prevalence

SOC-6 (section 2) currently quotes Western prevalence figures for those at the "transsexual end of the spectrum" (i.e., candidates for SRS). *SOC-6* admits that the prevalence of GID may be higher, though figures are not cited. This article provides such figures, and they are indeed much higher than those commonly used in discussions of GIV. The low prevalence indicated by *SOC-6* conveys the impression that GIV is an extremely rare condition that primary health care workers will seldom encounter in their practice. The risk is that health service budget holders and planners will allocate resources for transgender health care inadequate to the task in hand.

Recommendation 4

SOC-7 should incorporate additional, more broadly based (and arguably more realistic) data on the prevalence of GIV, incorporating figures (clinic and community based) from Asia (and from elsewhere where figures are available), as well as referring to the calculations of prevalence of inherent transexualism presented in Olyslager and Conway (2007, 2008).

Interestingly, the RCP-*DGPG* incorporates some higher prevalence figures than *SOC-6*, although they are UK based (*DGPG* 4.1).

Better Meeting the Needs of Young GIV People Worldwide Who Are in Transition

De Vries and Cohen-Kettenis (in press) note the increasing numbers of young GIV people approaching clinics in the West and the need for *SOC-7* to take account of this trend. As indicated earlier, early transition is common outside the West. Large numbers of transpeople (at least across Southeast Asia) transition during

late childhood/adolescence, perhaps undergoing SRS (if they do so) in their teenage years or early adulthood. Hormone use can start as early as age 10, and SRS can happen as early as age 15. Transgender community members guide and support each others' transitions, offering advice on matters such as hormone use. Medical practitioners are seldom consulted: their services are often seen as ill-informed (or uncaring) regarding transgender health care needs, limited in availability and scope, or costly (especially where specialist services are involved).

Recommendation 5

Recognizing the comparatively marginal role that orthodox medical practitioners play in transgender health care needs of many young transpeople worldwide (for example in regard to the use of hormones), WPATH should incorporate the following in *SOC-7*:

1. Material that recognizes the important role that informal transgender communities (and self-help organizations where they exist) play in peer support and mentoring for their community members and the roles that health care workers, where they exist, might play in enhancing community support (in particular, providing communities and self-help groups with accurate but easily understandable—i.e., non-technical—information about health care issues; e.g., hormones, injected silicone use, and surgery).
2. Material that recognizes the important role played by families in the psychological health and well-being of young transpeople and the need for health care services, where they exist, to promote informed and affirming family responses to young transgender family members.
3. In addition, WPATH, the organization that more than any other is concerned with promoting more effective transgender health care services worldwide, should incorporate material in the *SOC-7* designed to provide the material described in item 1 above. WPATH should take steps (perhaps through its global membership) to translate such material into major languages (especially those languages in which such material may not currently be easily available) and to post it on the WPATH Web site.

(Interestingly, some of the matters raised above are already touched upon the RCP-*DGPG* in paragraphs 17.2, 21, and 22.)

I now turn, while on the subject of young transpeople's needs, to eligibility criteria for surgery. *SOC-6* advocates adherence to eligibility criteria for (a) hormones (including a mandatory 3 months minimum previous RLE or psychotherapy (section 7; the same requirements implied for breast surgery in section 11) and (b) SRS (including at least 12 months of "successful continuous" RLE). The 12 months' RLE criterion for SRS seems rather inflexible. In a section 12 paragraph entitled "Can Surgery Be Provided Without Hormones and the Real-Life Experience?" *SOC-6*, though allowing for SRS without hormones, seems to restate the requirement for a RLE. RLE (at least successful RLE as specified in section 12) appears to involve continuous full-time cross-gender presentation (with no time credited for periodic gender presentation reversions). It also implies ongoing involvement and monitoring by a health care professional; for example, note in section 9 that the professional should discuss the consequences of RLE before beginning.

All this could pose difficulties for young transpeople living in countries with few specialist transgender health support services, who have already lived in their desired gender role for years before approaching surgeons and, despite the *SOC-6* pronouncement that SRS "is not a right that must be granted on request," may feel it should be their right (especially because they have the money to pay).

Conceivably, the young transperson requesting surgery may be under 18. *SOC-6* section 6 states without any qualification, that "any surgical intervention should not be carried out prior to adulthood, or prior to a real-life experience of at least two years in the gender role of the sex with which the adolescent identifies." It may be assumed that this means any surgery whatsoever. One might ask whether there is any

health-related reason why surgery on persons under 18 should be proscribed in this way. Monstrey's article (2009) implies that there is not.

As Brownstein (2009) points out, the guiding principle of medical practice is "first do no harm." If *SOC-7* are to provide a proper venue for resolving disagreements between patients and doctors about treatment, then it is important that they balance patient and clinician needs better than they do now.

Interestingly, the RCP-*DGPG* displays a more flexible approach to RLE and age requirements than is seen in *SOC-6*, including (in *DGPG* 19.5) a "time-already-served" approach to previous cross-gender presentation. Notice too what the *DGPG* has to say about age requirements for irreversible interventions with clients under 18: that "each case should be decided on its own merits and not automatically ruled out on the basis of age alone." The attention of clinicians in the UK is drawn to "development in other countries of treatment services for adolescents, which recognized the intense distress experienced at that age if treatment is not available" (*DGPG* 12.1).

Recommendation 6

WPATH should, through *SOC-7*, revise and clarify the RLE and age requirements for surgery, so that neither can be interpreted as constituting, for any transpeople anywhere in the world, an unreasonable barrier preventing "lasting personal comfort with the gendered self," "psychological well-being," and "self-fulfillment" (announced in section 1 as the aims of the *SOC-6*).

Involving the International Trans-Community in Developing SOC-7

The recommendations made so far stem from a view that *SOC-6* has largely failed to address the broader health needs of transpeople worldwide; i.e., to enjoy good mental, emotional, and physical health, living productive and dignified lives as valued members of their respective societies, without being marginalized, pathologized, or (to the extent that they need medical support) experiencing health care unresponsive or insensitive to their needs. The last recommendation therefore seeks to ensure an international and client focus for *SOC-7*.

Recommendation 7

In drawing up *SOC-7* WPATH should strive to consult to the fullest extent practical the international trans-community, seeking to identify transgender health needs and aspirations for transgender health care worldwide (not only in North America and Europe but around the world).

The above recommendations are offered in the context of *SOC-6*'s stated overarching treatment goal of "lasting personal comfort with the gendered self in order to maximize psychological well-being and self-fulfilment." They are offered in the belief that the association needs to think much more broadly and internationally about transgender health and well-being (looking not just at medical management but also at the cultural, sociological, legal, and social psychological factors that impact on transpeople's lives, health, and well-being). In the view of this author it is only with this shift in perspective that the *SOC-7* will truly reflect the aspirations of transpeople in the developing world (as elsewhere) for mental, emotional, and physical well-being, as well as for accessible, flexible, and quality health care matched to their needs.

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APPENDIX A

Health Care, Health Rights, and More General Rights Documents Upon Which This Article Draws

1. Health Law Standards of Care for Transsexualism (TransgenderCare, n.d.).
2. Access to Health Services for Transsexual People (Collins & Sheehan, 2004).
3. The Royal College of Psychiatrists (2006) draft *Good Practice Guidelines*.
4. The 1995 International Bill of Gender Rights. Retrieved January 22, 2009, from http://www.pfc.org.uk/node/275
5. The March 2007 Yokyakarta Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity. Retrieved January 22, 2009, from http://www.yogyakartaprinciples.org/
6. The International Covenant on Civil and Political Rights (ICCPR; United Nations Organisation, 1966a). Retrieved March 12, 2009, from http://www2.ochr.org/English/law/ccpr.htm
7. The International Covenant on Economic, Social and Cultural Rights (ICESCR; United Nations Organisation, 1966b). Retrieved March 12, 2009, from http://www2.ochr.org/English/law/cescr.htm
8. The United Nations Convention on the Rights of the Child (UNCRC; United Nations Organisation, 1989). Retrieved March 12, 2009, from http://www.unhchr.ch/html/menu3/b/k2crc.htm
9. Principles Regarding Health Care for Transpeople. Compiled at the International Lesbian and Gay Association 2006 World Conference (Transgender Pre-Conference Meeting, Health Care Subgroup, Geneva 27 March 2006; see Appendix B).

APPENDIX B

Principles Regarding Health Care for Transpeople (Here Called Gender Variant People)

ILGA 2006 World Conference. Transgender Pre-Conference Meeting. Health Care Subgroup, Geneva March 27, 2006

Members: Tamara Adrian, Aidan Dunn, Mariela Castro Espin, Nina Trige Andersen, Bernard Reed, Jane Thomas, Sam Winter, Barbara Graner, Dina Levias, Andrea Stefanie, Audrey Faveau

1. All people have the right to freedom of gender identity and expression (the right to gender variance).
2. All should have the freedom to exercise that right without psychiatric pathologization or imposition of other people's moral judgments (without being judged as either mad or bad).
3. Those gender variant people who seek medical support should be able to access it not only for matters related to their gender variance but for general health issues.
4. Those who seek a medical evaluation in connection with their gender variance should be able to get it from a multidisciplinary team. In view of the fact that gender variance is not a mental disorder, the team should not be led by a psychiatrist.
5. Evaluation should be aimed at identifying a condition (along the lines of pregnancy) rather than a disorder/disease.
6. Diagnostic criteria should be clear, including to the gender variant clients.
7. Beyond evaluation, the role of a medical team should be in supporting the person's expression of gender variance (not on treatment or "cure"; again, along the lines of what happens with pregnancy).
8. Just as many of the HIV/AIDS problems that the gender variant people experience have arisen out of their position at the margins of society, so too HIV/AIDS support services have often marginalized gender variant people by portraying them as MSM. This must all change.
9. Gender variant people should have the right to change their legal gender status without having first to be made sterile or, for that matter, undergoing any other form of medical treatment (hormonal or surgical).