TRANSGENDER LIFESTYLES AND HIV/AIDS RISK

NATIONAL TRANSGENDER HIV/AIDS NEEDS ASSESSMENT PROJECT

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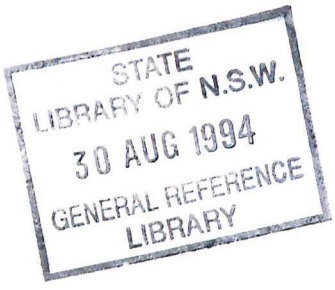

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I. BACKGROUNDS

1. INTRODUCTION

The National Transgender HIV/AIDS Needs Assessment Project was commissioned by the Commonwealth Department of Human Services and Health, in July 1992 for completion by mid-February 1993, and a steering committee of four, comprising representatives from the Australian Federation of AIDS Organisations (AFAO), Department of Human Services and Health, Australian National Council on AIDS (ANCA) and the transgender community was formed in August. But internal problems arose preventing the project from progressing much beyond the blueprint stage, and it was subsequently offered to the present co-ordinator in the School of Sociology, University of New South Wales, in February 1993, who accepted it and organised a team of fieldworkers by the end of April.

This report describes the study we have carried out on people across Australia with transgender issues, henceforth referred to as "transgenders", or "tranys" in the abbreviated form[1]* Our sample population are people of either sex who have crossed over, or intend to cross over permanently (otherwise known as "gender crossers"), into the opposite gender. We have not included people who don the clothing or other accoutrements usually associated with the opposite gender temporarily (otherwise known as "cross dressers") for whatever purpose. As a study population transgenders have been overlooked for far too long, especially with regard to AIDS education and prevention. This project represents the first real advance into research in this area in Australia and it emerged as an idea after some preliminary observations on the sexual and drug-related behaviours of transgenders by service providers in the inner city area of Sydney, and as a result of at least one previous study of transgenders at risk of HIV infection (Alan *et al* 1990).

The aims of the project were to determine the health and welfare needs of transgenders with respect to current services and assess what is required to prevent the spread of HIV/AIDS across their community. This would be achieved through a data-collecting process that would highlight problematic areas for HIV infection. A pamphlet would be produced based on the evidence of the findings derived from the study and this would be distributed across the transgender community and amongst service providers appropriate to the needs of this community. Time, however, was against the pamphlet and its production was dropped as an objective of the project. The research segment of the project was maintained and this document is a report on that effort, its findings and the culmination of eight months fieldwork.

The areas highlighted for research in the original brief of the project were: 1) an estimate of the population of transgenders across Australia; 2) their levels of education and job skills; 3) their past and present sources of income; 4) information on gender-crossing and sex reassignment; 5) various health issues, HIV risk and prevention, and information on existing services; 6) legal aspects; 7) housing; and 8) other relevant issues. We have met with these requirements through the distribution of a self-administered questionnaire addressing these issues to transgenders in all states of Australia.

Since this is a national study our work on this project took our fieldworkers to many parts of Australia, including visits to commercial street beats and brothels, social venues and "drag shows", a major service centre for transgenders in Sydney, the north, south and central coast, far west and riverina areas of New South Wales, the Gold Coast, Brisbane, Canberra, Melbourne and Adelaide, where questionnaires were distributed for return by mail or completed in our presence. Questionnaires were also sent to points of distribution in Perth and Hobart. Ads were placed in two rural newspapers in New South Wales and Polare, a magazine for transgenders, inviting participation in the research, and the Gender Centre posted out questionnaires to all people on their mailing list. Our fieldwork, which commenced at the end of April 1993, was finalised by the end of October in the same year.

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* This replaces the older more familiar terms "transsexual" and "transvestite". The reason for this is discussed on page 9

We found a great deal of enthusiasm for the study amongst trannies, some even telephoning us or writing to us asking if they could participate. The reason for this is probably due to a dearth of research on transgenders in Australia which involved the people concerned, as well as tranys recognising the value of this study as an essential contributor to a wider social understanding of their needs, as well as this leading to positive changes in social, economic health and legal aspects pertinent to their lives.

The sample in our study is dominated by respondents who changed gender from an assigned male designate at birth to the preferred female (ie. male-to-female), but a respectable number of female-to-male transgenders also took part, enabling us to make certain observations concerning this group. Participants were predominantly white Australians of all ages representing both major social classes in more or less equal proportions. Our findings highlight a persistent social discrimination against our trany sample, seen most clearly in a decline in both income and quality of occupation following their gender change, as well as constant negative reactions to this change from family, friends, neighbours, other groups, service providers and just about every section of society. As a consequence the receipt of welfare benefits amongst the participants was extremely high, many of them had not experienced a "meaningful relationship" with another human being for years, and a large number were constantly moving accommodation. It is a cruel irony for many trannies to have achieved their life-long goal of finding inner peace in their preferred gender only to be faced with their society's sudden hostility towards this change in status. It has left many of our respondents shattered, bitter and angry, as the barrage of unsolicited comments scrawled across many of the questionnaires testifies.

This reactive social, economic and legal treatment of transgenders manifests in a range of negative trany behaviours that lead to self-destructive outcomes. Our findings reflect this in the sample's high incidences of drug use, unsafe sex practices, sexually transmissible diseases and various problems of health and well-being. There was a remarkably high incidence of anal sex and other sexual behaviours that imply trannies generally subservient position in even the most casual of liaisons. A large proportion worked in prostitution, with street sex work predominating amongst Sydney tranys, which indicates that safe working environments for transgender sex workers are not as readily available as for say, female and male sex workers. Another factor indicating the stressful lives experienced by many tranys is high levels of sexual and physical violence, as seen in the excessive assaults committed upon the participants. The picture is a grim one but emphasises the urgency in meeting the needs of transgenders in social, economic, legal and health areas of their lives.

This report is divided into three major sections: 1) background information; 2) findings and an analysis of data; 3) concluding remarks. The first section consists of four subsections (or chapters), including this *Introduction*. The second subsection is a review and critique of past research on transgenders both overseas and in Australia, emphasising their shortcomings as well as their importance relative to other studies in this area. These earlier studies support the necessity for research of the kind we have conducted across Australia. The third subsection explains the importance of terminology for a proper social and political description of the people in this study. The new terminology brings an accurate and fresh insight into the transgender subculture. The last subsection is a description of social milieux of transgenders as we have observed across Australia. What is most fascinating about this aspect of the study is the variety of ways these milieux have developed from one urban centre to another, and how these urban milieux differ from the situation in rural areas.

The second section deals with the technical details of the study itself. In the first subsection the empirical method employed for the research is described, along with an explanation of the sample used in this study. The second to fifth subsections are concerned with the survey findings and an analysis of the data, beginning with a description of the demographic findings in the sample's response to our survey, followed by an analysis of the sexual information data, then the data on health matters, and lastly the data on transgender issues. Together these provide an excellent insight into a subculture of people about whom very little is known and many myths exist. The overall findings of the study should revolutionise the present popular perception of transgenders.

The final section summarises the analytical findings of the study and makes recommendations for the social, economic, legal and health needs of transgenders. It also includes a subsection on the importance of HIV/AIDS to trannies, especially where they are practicing the kinds of unsafe behaviours highlighted by the survey data. The discussion in this subsection leads to an examination of HIV prevention issues in the transgender community, and included in the recommendations in the last subsection are those concerned with this essential aspect of trany health and survival. Based on our findings we conclude that transgender health, including HIV/AIDS transmission, is immutably bound up with the negative social, legal and economic reactions of Australian society to transgenders which leads to widespread low self-esteem among transgenders, and to the kinds of social norms and values in the trany community which very often result in the sort of self-destructive behaviours that we observed and are evident from our findings.

The report took 24 days to write and was presented to AFAO at the end of January 1994. It was obviously insufficient time for all the issues arising from our study to be given the fullest consideration. The entire project took us at the University of NSW 135 days to complete within the scheduled period, which meant we were under considerable pressure to meet the schedule right from the start. With more time at our disposal this report could have been much more comprehensive than it is.

In any case it is our hope that this study will prove to be a watershed for a number of future projects looking into specific issues of transgenders.

During our research we were assisted by a great many people. We would therefore like to acknowledge the assistance given to us by the following:

in New South Wales:
Transgender Liberation Coalition
The Gender Centre (formerly Tiresias House)
Les Girls
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the trany street girls
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the girls at 3 Faces
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ACSA
the girls at Mars Bar
Deb of SWIPE

and, of course, the transgender community across Australia, without whose participation the project would not have even got off the ground.

We would also like to thank Ricki Coglan for the cover design.

2. TRANSGENDER RESEARCH IN THE PAST

Research into the present day situation of transgenders has been limited and sporadic. Most of it has been clinical research carried out by medical investigators. The works of the early sexologists first brought scientific attention to what today we describe as transgender. Drawing on the pioneering efforts of the "father of sexology", Krafft-Ebing and another pioneer sexologist, Iwan Bloch, Mangus Hirschfeld (1910/1991) concentrated on the phenomenon of cross-dressing, coining the word "transvestite" in the process. His investigation of a group of men with this persuasion led to the discovery that most "transvestites" were for all intents and purposes heterosexuals. But it was his contemporary Havelock Ellis who first brought attention to variations in "transvestism" by claiming that certain male cross-dressers, rather than simply focus on female attire, psychologically and socially identified as females (Ellis 1906/1936). He therefore proposed a new term, "eonism", to include these as well as the more common fetishically inclined cross-dressers. However, it wasn't until the event of the well-publicised "sex change" case of Christine Jorgensen (Hamburger *et al 1953)* that the scientific fraternity began to make clear distinctions between cross-dressing and gender-crossing. Harry Benjamin took the term "transsexual" from an obscure paper by David Cauldwell (1949) and in his book (1966) asserted "transsexualism" was an entirely separate psychological phenomenon to "transvestism". Research into "transsexualism" was thenceforth dominated by a medical perspective, which inspired the international trend of surgically "curing" what became described as "gender dysphoria" with genital reconstruction (commonly referred to as "sex change"). This medical model of "transsexualism" and a rapid growth in clinical studies of both "transsexuals" and "transvestites" followed Benjamin and the early "sex changes". In the search for a theoretical explanation of "transsexualism" the neo-Freudian Robert Stoller (1968) concluded that its crucial formation depended on a boy's failure to resolve the Oedipal phase by separating from mother. Among the more prominent clinical empiricists, Richard Green (1969) investigated pre-pubescent boys with cross-gender symptoms and concluded that "transsexualism" manifests in early childhood, even prior to the Oedipal phase, as young as one and a half years in at least one case, Bentler (1976) found that amongst his group of male-to-female patients about a third each were heterosexually, homosexually and asexually oriented, and would continue to be sexually attracted to women, men and neither sex post-operatively, respectively, and Wardell Pomeroy (1969) found his sample of male-to-female transgenders to have been isolated in childhood, dependent on fantasising to develop a self identification, and possessing a low libido.

Differences in opinions on "transsexualism" began to appear amongst medical researchers by the early 1970s. Meyer and Hoopes (1974) first questioned the terms "transsexualism" and "transvestism" as appropriate to individual needs of people crossing gender, while Meyer and Reter (1979) criticised the medical process under which transgenders passed in reaching their goal of ultimate gender reassignment by surveying 100 pre- and post-operative patients and demonstrating that their lifestyles, self-perceptions and social experiences were not significantly differentiated in the two groups. Person and Ovesey (1978) investigated those persons labelled "transvestites" in medical scenarios and concluded that cross-dressing is not necessarily stimulated by the libido, but it could have a childhood history which may or may not develop into post-pubescent sexual stimuli. In contravention to prevailing psychoanalytical theories on cross-dressing they consider "transvestism" closely related to "transsexualism", or, variations on a transgender theme.

Transgender issues have aroused the interest of much fewer social researchers than medical and clinical researchers, although a considerable body of literature on the cross-cultural phenomenon of transgender from ethnographic research exists (eg. Czaplicka 1914; Devereux 1937; Hassrick 1965; Hill 1935; Hoebel 1960; Levy 1973; Lurie 1953; Parsons 1916; Simms 1903; Wikan 1978), demonstrating the widespread incidence of gender-crossing across societies in every corner of the globe. Evidence from early Sumerian scripts, Herodotus in the 5th century BC, and Plutarch (Bullough 1993:23-44) also attest to cross-dressing and gender crossing as very ancient social behaviours.

One of the earliest sociological treatises on the subject of transgender is that of Thomas Kando (1973), who studied 17 male-to-female transgenders who had undergone surgery at a Minnesota gender clinic. He concluded that gender change was more essential to his subjects than the "sex change" and the latter was sought to achieve the former more successfully. He also observed that these transgenders were more conservative in their views on gender roles than non-transgenders, and they act out their "reassigned" gender with much greater conformity to social norms. Another sociologist who became interested in transgenders in the 1970s was Edward Levine (1975), who attempted to understand the different roles, social phases, that they pass through, eg. incipient transgender in childhood, homosexual behaviour in adolescence, a "drag queen" identity in early adulthood, and "transsexual" after "sex change" surgery. About the same time Deborah Fienbloom (1976) carried out participant observation research on a group of American "transvestites", whom she found to be model citizens either as men or dressed as women, and intolerant of homosexuality, paedophilia, sado-masochism and other forms of sexual deviancy, which, she claims, is an attempt to divert possible attention from their own compulsion to cross-dress.

Among the social theorists who have attempted to understand transgenders, Janice Raymond (1979) offered a feminist-separatist theory of male-to-female "transsexuals", whom she claimed were manipulated by the male medical establishment in accordance with socially constructed feminine norms, and as "constructed" women were a threat to the women's movement through conforming to these feminine norms or, in some cases, even infiltration. Dave King (Plummer 1981) traces the historical development of the medical discourses on gender deviance, especially in distinguishing sex and gender, and argues that the concept of transsexualism was only made possible by dividing a generalised field of gender-inappropriate behaviours into separate fields of sexual perversion (fetishistic-transvestism) and gender perversion (transsexualism). Epstein & Straub's (1991) collection of essays by historians, academics and cultural theorists examine the historical and current construction of gender ambiguity and its implications. While there is no singular theme, most of the contributions lend weight to the view that the major significance lies not within the phenomenon itself but in the way that the phenomenon sheds light on the socially-constructed nature of gender, sex, maleness and femaleness themselves. The most recent theorist in this field is Marjorie Garber (1992), who argues that there can be no culture without the transvestite (understood as a figure of gender ambiguity as opposed to the clinical definition). Using feminist, psychoanalytical and cultural theory, she reinterprets the historical phenomenon of cross dressing as an essential feature found at many levels in our gender binary society, without which gender itself could not exist in its current construction.

Very little empirical social research on transgenders has been done in Australia. Perkins' (1983) participant observation of the transgender subculture in Kings Cross revealed a community of male-to-female "transsexuals" for whom the only occupations available were as female impersonators in 'straight' and gay drag shows, as strippers, as sex workers or as "bar-girls" hoping to become mistresses to male bar patrons or, when this failed, surviving by lifting their wallets. Distinct social milieux developed within these various occupational environments and a subgroup hierarchy based on "respectability", on "passing" and on income formed the essential infrastructure of the subculture. In Alan *et al's* (1990) basically clinical study of 77 male-to-female transgenders who attended the Albion Street AIDS Clinic it was found that 83% of the sample had been involved in sex work, 43% had used drugs intravenously, and 20% were seropositive to HIV. Perkins (1991) surveyed 53 Sydney transgenders of both sexes who contacted the transgender accommodation unit Tiresias House in 1984 and found that nearly half had worked as prostitutes, 37% had used illegal drugs, almost a half had been arrested at some time, and 28% had spent time in gaol. Although two-thirds of this sample had achieved the School Certificate, including 11% who held a trade certificate and 4% with a tertiary degree, more than 80% were unemployed. Half of the sample had attempted suicide.

Researching transgenders has been conducted since the turn of the century, but most of this has been medical and clinical research which concentrates on "curing" the phenomenon of cross-dressing and crossing gender, or explaining them as unique forms of social and sexual deviance. Until recently little has been done to understand the social interactions involving transgenders. This was best achieved through participant observation, which reveals a subcultural world of social outcasts who have developed unique means of survival in a society

hostile to the concept of crossing gender. But, as some of the more recent social theorists, as well as ethnographers and ancient historians, demonstrate, gender crossing and cross dressing are not such isolated cultural phenomena as society is led to believe. Yet, as the recent surveys of transgenders in Sydney have found, the social ostracism of gender crossers has led to a series of negative social outcomes that have resulted in these people's low self esteem, powerlessness and vulnerability to HIV infection, and other potentially lethal risks. Our study tends to support the findings of these surveys.

3. THE PROBLEM OF DEFINITION AND IDENTITY

In identifying and defining target groups, the tension between inclusion and specificity is a familiar problem to researchers and all interested in social policy. If the target group is narrowly specified, then one risks excluding from the sample base people who really ought to be included. On the other hand, if too many people are included in the sample, one might lose sight of the core issues. For the purposes of this study the target population was loosely seen as that group of people who current (social) gender status was at variance with the sex originally assigned. While, at first glance, it might be thought identifying, defining and developing an appropriate terminology ought to be straightforward, this is not the case. There are, in fact, a number of factors that complicate the issue.

There are a myriad of terms used to describe the target group or portions thereof. These terms can have meanings that vary over time, from group to group, or even from State to State in Australia - "transgender" refers to social status in NSW while "transgenderist" in Queensland describes someone who has changed their social gender without surgical intervention. One group may use a term positively while another may use the same term pejoratively - 'transsexual' is used proudly by certain groups, while others point to its unpleasant psychiatric connotations. The way in which a particular term may be understood will also vary from one intellectual discipline to another; the term 'identity' has very different meanings for sociologists and psychiatrists. There are also considerable gaps between the everyday uses of particular terms, the way that various groupings within the target population uses the same terms and the meanings that professionals may attach to these terms ie. between clinical, social attribution and self-definitions.

Before one can consider the appropriate terminology to identify and define the target group, perhaps it is best to briefly review the range of terms traditionally employed.

Gender: While many people might think that the term 'gender' has a self-evident meaning, there exists a considerable literature (and controversy) over its meaning. Socially the term is often used interchangeably with 'sex', whereas academically, sex refers to a biological status (ie. the physiological attributes of maleness or femaleness) and gender refers to social status (ie. masculine or feminine roles). For the purposes of this report, we will use the term 'gender' to refer to the social significations of one's sense of self as masculine or feminine ie. the social, psychological and behavioural aspects of masculinity and femininity. There is no assumption that a person's sex and their gender are necessarily congruent.

Transsexual: The term 'transsexual' refers to a specific psychiatric classification listed in the Diagnostic and Statistical Manual, 3rd Edition (DSM III) published by the American Psychiatric Association. Over the years a number of diagnostic criteria have been proposed to define transsexualism. These criteria seem to have in common the following markers:

1. a persistent discomfort and sense of inappropriateness about one's assigned sex;
2. a persistent preoccupation for at least two years with shedding one's primary and secondary sex characteristics and acquiring the characteristics of the other sex; and,
3. that the person has reached puberty.

Within medicine, transsexualism is regarded as a symptom of gender dysphoria syndrome, a range of psychiatrically defined conditions that refer to a series of what are said to be gender-inappropriate behaviours and identities. It should also be borne in mind that, over the years, the medical definition of 'transsexualism' has undergone significant changes, and that these changes may be expected to continue as research continues.

In common usage, this term is used quite inappropriately to refer to anyone who expresses gender ambiguity consistently, often incorrectly assuming or implying surgical intervention. Those groups of people who might variously be referred to as transsexual attach a multiplicity of meanings to the term ranging from strict interpretations of the medical definition to anyone

who has changed, or is changing their social gender permanently with or without surgical intervention.

Genital Realignment (or Reconstruction) Surgery: (Often referred to inaccurately as 'sex-change' surgery or misleadingly as 'sex-' or 'gender-reassignment surgery'). This is a medical procedure first developed to align the genitals of those born with ambiguous sex characteristics (hermaphrodites, intersexes etc.) with one of the two socially acceptable biological genders. During this century, this procedure has been increasingly applied to those who are diagnosed as primary gender dysphoric (or transsexual). Standard pre-conditions for this procedure are: (a) psychiatric diagnosis as transsexual by two psychiatrists, including differential diagnosis to eliminate other mental illnesses; (b) psychosocial adjustment by living in the desired gender role for at least two years prior to surgery; and (c) endocrinological assessment and the administration of cross-gender hormones. Genital realignment surgery may take place with or without other interventions, such as cosmetic surgery or electrolysis.

Transvestism: Transvestism is another psychiatric classification used to describe a compulsion to dress in the clothes of the alternative gender. This compulsion may be permanent or transitory, and while not necessarily sexually-motivated, when associated with sexual arousal and pleasure it is referred to (psychiatrically) as transvestic fetishism. The medical literature recognises a significant degree of cross-over between the categories of transsexual and transvestite. Many psychiatrists insist that transvestism is male-specific ie. that all transvestites are biologically male and the female transvestism does not exist.

In common usage, transvestite is used to describe behaviours ranging from anyone who cross-dresses (for whatever reason) to those who have changed their social gender permanently without surgical intervention. In common usage, it is often the case that this term implies a degree of sexual 'perversion' and thus often carries a pejorative connotation. The application of the term transvestite often does not discriminate between permanent and part-time adoption of the dress of the alternative gender.

Cross-dressing: Beyond the psychiatric definitions, there are a range of people who might adopt the dress of the alternative gender for a variety of reasons. These include professional impersonators (often called "drag queens/kings"), male/female sex workers who cross-dress for work purposes only, and members of the gay and lesbian communities (who, in common with many others, often use the term 'drag queen' to refer to all people who cross-dress, regardless of their lifestyle, motivation or degree of permanence). Many of those people who have changed their gender permanently, particularly those who have undergone surgery tend to regard and use the labels 'transvestite', 'cross-dresser' and 'drag queen' with considerable distaste.

Sexual Preferences: There does not appear to be any consistent connection between the categories described above and the common categories of sexual preference (ie hetero-, homo-, bi- and a-sexuality). Moreover many, but far from all, of the target group describe their sexual preferences using their social gender, as opposed to their biological gender as a basis for self-categorisation. Thus a person who may be biologically male, live as a woman and be sexually attracted to males could identify as heterosexual, whereas others might feel that person's sexual behaviour would more accurately be described as homosexual. But, they might also regard a similar person who has undergone genital realignment surgery as heterosexual. In terms of social identification, the target population would include people who live in and identify with the 'straight' community and people who live in and identify with the gay and lesbian community, as well as those with no particular nor fixed socio-sexual identity.

From the above it can be seen that the target population has no fixed characteristics that allow us to describe it unproblematically. A member of the target population may be of any biological sex (which some would claim can be varied), of any social gender (which can vary within a person over time), of any sexual preference (which can also vary within a person), may (or may not) fall within any of the categories listed, and, even if they do, this categorisation may itself vary over time.

Indeed, the very idea of applying clinical definitions and categorisations to social groupings as a basis for social policy is increasingly questioned. A review of the history of medical categorisation of, and interventions into homosexuals' or women's sexualities would suggest that such an approach be treated, at best, with a considerable degree of caution. Other reasons to pause before adopting the medical terminology include its narrow basis (it focuses only on the medical literature, it is primarily concerned with 'transsexualism' as a diagnostic entity and assumes all gender-inappropriate behaviours to be psychiatric disorders) and a sex-bias in that literature - biological females who wish to change their gender tend to be ignored.

Perhaps it is worth noting that most of these terms and categories have at their core a notion of personal identity ie. they seek to classify and describe a personality type. It might be argued that the inherently subjective nature of this approach lends itself to the way in which these terms overlap, confuse and offer differing meanings to different people and groups, and makes the task of finding a criterion or criteria of commonality and a terminology that identifies all without marginalising any a difficult proposition. This would seem to suggest that an identity-based approach to the target population might prove to be inadequate. Indeed, if anything, the target population seems to be characterised by its diversity.

Bearing in mind that in the increasing consensus from international HIV/AIDS studies it is the behaviour, rather than the identity, of the person involved, that is the critical factor in preventing the spread of HIV, it might be more appropriate to focus on the behaviour of the target population as a means of identifying and defining it accurately and flexibly.

What seems to emerge from the above is that, at the level of behaviour, a degree of commonality that is useful and significant can be established. All of the target population can be said to live outside the gender norms of our society, ie. their behaviour, either on a permanent or casual basis, would ordinarily be described as gender-inappropriate. As this 'gender-inappropriate' behaviour itself occurs across a range that is not necessarily fixed nor comprehensible within the binary gender system a more flexible notion of a gender continuum may be more useful in dealing with this population. All of which lends itself to the view that the traditional terminology is inappropriate for the purposes of this study.

In the last few years, an attempt to develop a new and inclusive language to describe the target group has emerged from within that community. In Sydney, a group called the Transgender Liberation Coalition (TLC) has proposed using the term 'transgender' to describe the series of behaviours that fall outside the gender norms of our society and are one of the distinguishing characteristics of the target group. TLC argues that there is no single identity within the target population, that the group is characterised by diversity, and it's only commonality is that all members of the target group share a common history of living outside societal norms and being marginalised for so doing. It emphasises that the issues the target population faces are primarily social rather than medical and proposes socially-based approaches to deal with these issues. TLC prioritises self-determination and self-definition by the target group. It uses the term 'transgender' to describe a series of behaviours or a social status. While the use of this term is not uncontroversial, it does seem to avoid the shortcomings of the traditional terminology, and possesses the added benefit of emerging from the community itself rather than being imposed on it by outsiders.

As this approach seems flexible enough to describe the entire range of the target population without either giving privilege to or marginalising any sub-section of it, we have decided, for the purposes of this study, to adopt the term 'transgender' and to use it in the way that TLC advocates, ie. to refer specifically to behaviours and social status; it does not carry any connotation or implication of identity or personality type.

We will therefore refer to the target population as the "transgender community" and to the individuals within that community as "transgenders", or as transgender men and transgender women according to their social gender. For the purposes of data collection, we have targeted any individual who permanently lives in or has the intention to permanently live in the opposite gender.

4. SUB-CULTURES AND REGIONAL VARIATIONS

In Australia the existence of sub-cultures that we might agree to describe loosely as transgender sub-cultures is despite a long history, a relatively recent discovery. For years they seem to have existed on the fringe of both mainstream and the emerging gay cultures, occupying an anomalous position within and between both. The political changes that have occurred with the emergence of gay and lesbian liberation at the end of the 1960s seemed to have by-passed the transgender communities. In this chapter, we hope to provide some anecdotal and observational impressions of the emerging transgender sub-cultures in the various States visited by us on this project, and to highlight both the commonalities and the diversity of transgender sub-cultures across Australia.

In common with many other minority sub-cultures, transgender sub-cultures are usually found within major population centres. Amongst the reasons for this we might list: (i) the relatively low number of transgenders, (ii) their historical investment in anonymity, (iii) the possibility of finding work in the sex and entertainment industries (industries that, historically and currently, have provided the best prospects for employment and the highest public profile for transgender people), (iv) the greater degree of acceptance (or possibly nonchalance) amongst inner-city folk, (v) and the variety of services available to inner-city residents (eg. choices in medical service providers, beauticians, clothing suppliers etc.) which might not be available in less densely-populated areas, or who might refuse their services to transgender people.

New South Wales: For many reasons, Sydney has become the transgender 'capital' of Australia. Amongst them we might note that Sydney has the highest transgender population; it is the traditional centre that transgender men and women, alienated or exiled from their places of upbringing, have tended to gravitate to; its thriving inner-city culture offers possibilities of both invisibility and acceptance; it possesses large entertainment and sex industries; there is a large and increasingly powerful gay community and a corresponding acceptance of the diversity of human sexual expression. One consequence of this is that Sydney's transgender population includes a high proportion of Maoris, Islanders, Asians and other migrants. While this adds a cosmopolitan flavour to the community, it makes the task of producing lifestyle- and culturally-relevant safe living materials more complex.

Sydney's transgender population is characterised by its diversity. Perhaps its diversity can best be illustrated by observing that Sydney is a site where, within the transgender sub-culture, the following can co-exist: the most freely-available genital reconstruction services (which critics argue tend to normalise gender deviance), the emergence of the counter-discourse of transgender and associated theoretical models such as gender fluidity, pan-gender, male lesbians and so on, and the organisation by a transgender man of the Mr. and Ms Wicked competitions, contests that celebrate radical sex/gender (eg. S & M) perversity.

Sydney's transgender population is spread across all walks of life, and includes academics, journalists, entrepreneurs, factory workers, sex workers, the unemployed, and a host of others amongst its ranks. Its members may live invisible lives in the suburbs, where no-one is aware of their history, or flamboyant lifestyles in the inner-city, where entertainers and sex workers make a living precisely because of the circumstances of their personal histories, or indeed, any conceivable mixture in between these two extremes. It should be noted that most of the population is concentrated in the inner-city suburbs.

Just as is the case for transgenders, their lovers may come from any walk of life and transgenders and their lovers may be found in just about any conceivable combination. Just one example: there was an enduring relationship between a transgender man, a transgender woman and a dominant woman. This original variation of the age-old *menage a trois* was cemented together by S & M sexual practices.

There are a number of community-based organisations that offer representation and/or support to the transgender community. The organisation with the highest profile, Transgender Liberation Coalition (TLC), is an advocacy group that concentrates on social and political

changes and is currently focussing on obtaining anti-discrimination legislation for transgenders, HIV/AIDS issues and running the Trany Anti-Violence Project, which documents incidents of violence, abuse, harassment and discrimination against transgenders. A branch of TLC called Transgender Outreach Coff's Harbour (TOUCH) operates in the mid-North Coast region. Boys Will Be Boys, a social/support group for transgender men, is based in Sydney and publishes a newsletter for its members across the country. The Seahorse Club, which boasts almost 300 members on its books, is a social/support group that mainly addresses the needs of people who vary their gender expression on a part-time basis.

Despite their woeful inadequacy, the level of publicly-funded services directed at the transgender community in Sydney is the highest in the country. The Gender Centre (formerly known as Tiresias House) is an accommodation and counselling centre for transgenders that has been operating, with varying degrees of effectiveness, for more than a decade. The Sex Workers' Outreach Project (SWOP) has a part-time transgender officer. The Kirkton Road Centre (KRC), a medical clinic, health and counselling centre which targets inner-city sex workers and injecting drug users, has a sizeable transgender clientele. There were mixed feelings from transgenders about some of these organisations, and both the range and quality of services they provide. The Gender Centre is the best known of these organisations to transgenders and it was often a major topic of conversation in our visits to trany venues, clubs, brothels and the streets. Some thought it most useful as a counselling service and had benefited positively from it. But others thought it too bureaucratized and had lost its "grass roots" character. It should be borne in mind that many tranys have developed a resistance to bureaucratic organisation as most, in one way or another, have experienced insensitivity towards gender crossing from bureaucrats and resent the impersonal style of dealing with them as "clients". This has resulted in a suspicion of paperwork and its tendency to record personal information most tranys would prefer to forget.

Relations with the gay and lesbians communities in NSW are variable. A considerable section of both the transgender population and the gay and lesbian communities would like to see, and is working towards, integration. It must be said that appreciable levels of tranyphobia and homophobia are impeding this process. Over the last year in particular, this movement towards integration has been gaining momentum and there are some signs of an emerging political coalition between the hitherto separate communities.

Sex work plays an important role in the Sydney transgender community, particularly amongst women. There are a number of transgender-specific brothels and parlours in the inner-city, while in the suburbs, a number of women who have undergone surgery work in female brothels. The traditional location for transgender street sex work, William Street, is still functioning, though regular workers complain bitterly about the effects of the recession and HIV/AIDS on their earnings. Because of its well-known status and proximity to the Kings Cross nightlife area, William Street is also the site of virtually systematic abuse and violence against women workers, which the police seem either unable or unwilling to prevent. Police intervention focuses instead on enforcing often draconian prostitution laws.

While many transgenders live self-sufficient and satisfying lifestyles, the stresses and level of marginalisation can have severe effects, resulting in a chaotic lifestyle often involving transient sex work, injecting drug use and indiscriminate sexual behaviour. One story, recounted to us by the person's social worker illustrates this perfectly. A woman had an infection in the genitals but was unwilling to visit a doctor because it would have meant exposing her male genitals. It took three months of patient persuasion before she would agree to seek medical help, and then only on condition that the social worker accompany her. At the waiting room, the social worker recognised and said hello to a friend. During the minute that the social worker's back was turned, the client disappeared. It took ten minutes of frantic searching before the client was found. During that ten minutes, the client had left the clinic, scored a hit of heroin, and found a client for sex work. She was re-discovered in the ladies toilets of the clinic, in the company of her sex work client and with the needle still in her elbow.

This particular woman's aversion to accessing health services is not uncommon amongst the transgender community who regularly report ignorance, discrimination and ridicule by these service providers. In Orange, an incident occurred where a man was discovered to be a

female-to-male transgender during an emergency medical procedure. The story spread quickly all over town resulting in embarrassment, ridicule and ostracisation of the transgender concerned. A local sexual health worker who, with the best of intentions, wished to help found himself unable to do so because of the unavailability of any relevant protocols, information, or advice centres. It was as though transgenders did not exist.

The range of venues that cater to the transgender population, as part of a larger clientele, is larger in Sydney than in any other city. Perhaps the most well-known is the Taxi Club (also known as the Grosvenor Club) in the inner-city. Open virtually 24 hours a day, part club, part disco, part drinking hole, part gambling den, the Taxi Club is a long-established (and rather run-down) part of the scene that possibly owes its pre-eminence to its cheap prices and long opening hours. Other transgenders of both sexes frequent the Bottoms Up Bar in Kings Cross and muse about the appropriateness of the venue's name. In the gay areas of Oxford St and Newtown, there is a series of venues that hold drag shows attracting transgender audiences and, of course, Les Girls is a perennial part of the scene, offering jobs and a social space for women. There does not appear to be any specific venue for the men, who tend to socialise mainly in the lesbian community.

Transgenders are scattered across the width and breath of NSW. In Newcastle, there is a designated street in Islington where street workers can ply their trade. On the North Coast there is an informal network of women based around the Nimbin area. Those men and women who live in country areas battle with isolation and loneliness to get by, often living in terror lest their history becomes known and where their history is known, encounter some of the most virulent hostility experienced amongst any group that encounters hostility on a daily basis.

Queensland: The abiding impression we took with us after our visit to Brisbane was one of friendliness and camaraderie. The scene in Brisbane is considerably smaller than that of Sydney, and far more concentrated in the Fortitude Valley and New Farm areas of the inner-city. There are a few nightclubs and bars that host drag shows, with Options being the club of choice for most local transgenders when they socialise. We were warned by local men and women to arrive and leave these venues by taxi as attacks and bashings were a frequent occurrence.

The community organisation, Australian Transgenderist Support Association Queensland (ATSA) appears to enjoy the most unequivocal support from the community it represents (it should be noted that ATSA uses the term 'transgenderist' to describe those people who have changed their social gender permanently without medical intervention). ATSA's meetings are regular and well-attended, attracting up to 30 members of the community at any one time. ATSA operates as both an advocacy and peer support group, produces a regular newsletter and maintains a 24-hour phone help line. ATSA members go on regular outreach visits to regional centres and isolated transgenders, but ATSA is restricted from offering this service state-wide by lack of funding. Relations with local gays and lesbians appear to be warm, possibly reflecting a feeling of solidarity in a state where feelings of hostility and violence towards sexual minorities are said to run highest. There is also a small branch of Boys Will Be Boys, whose members tend to socialise in the same venues as the women.

Street workers operate within the New Farm area, encountering harassment from passers by and the police, who are zealous in enforcing Queensland's prostitution laws. As male prostitution has not been decriminalised, and as female prostitution is subject to severe legal impediments, there are no parlours or brothels from which these workers can operate in relative safety. Taken together with the ambiguous position of Queensland's transgenders under that state's Anti-Discrimination laws, it seems reasonable to infer that, in a legal sense at least, the desired aim is that Queensland's transgenders should remain invisible.

Victoria: The transgender scene in Melbourne is perhaps the most diffuse of all those visited by us. There does not appear to be any distinct centre or venue, such as those in Brisbane and Sydney. Venues that are frequented by transgenders vary from gay bars and clubs through the Hellfire Club to straight nightclubs. In our observation, none of these venues attracted more than a handful of transgenders on any one night.

There is some low-key street work done in the St. Kilda area, but the actual location varies. According to the Prostitute Collective of Victoria, it may take the form of streetwalking (with risks of police and kerbcrawler harassment) or hanging around specific street corners (with the same risk of police harassment but lesser risks from kerbcrawlers). Brothels in Victoria are licensed and there a few parlours in the Inner-city that employ transgender women workers. The conditions in these establishments seem as good as any in the country.

One interview done in a South Yarra parlour will stay in our researchers' memories forever. Advised by other women at the parlour to come back the next night to interview Karen (not her real name) because she was, in the opinion of the other women, "a real old-style trany, you'll love her". And the researchers were not disappointed or misled. She took three hours to complete the questionnaire, every question becoming the trigger for one of Karen's stories, which were both hilarious and truly evocative of transgender life. From a bottle hidden in a paper bag in her handbag would come liberal measures of brandy, accompanied by a dash of Coke (which the most junior of the boy workers was summarily despatched to the shops to buy - Karen was not one to have her commands questioned by minions, she simply presumed such total compliance that all other options were automatically closed). These were drunk out of coffee cups with much clinking thereof and toasts of "There's the look sister" and the like. It was one of those little moments that bring fond smiles on every recall.

Community organisations in Victoria seem to have a chequered history and we heard frequent complaints about individuals who imposed their own personal agenda on the community, thereby alienating others from the organisations. We attended one meeting (which was, as it happened, destined to be the last meeting of that particular group) at a church hall. This meeting was totally dominated by one woman who was attempting to use the group to recruit members for her particular Church. The Elaine Barry Project, a support group for transsexuals and transvestites was derided by almost everyone we spoke to for its strict dress and behaviour codes, which people felt were outdated. There is a small branch of Boys Will Be Boys. On a brighter note, an activist group similar to TLC is in the process of being formed. People involved in this process confirmed their intention to concentrate on social issues and to open its membership to the entire transgender community.

The only medical service specifically for transgenders is the Gender Identity Clinic at Monash University, which is the only clinic of its type currently in operation in Australia. Just about every woman we spoke to in Melbourne mentioned the Clinic in one context or another. Whether the remarks were positive or negative, we felt that the common sub-text of all these remarks revolved around issues of power. Indeed the Clinic seems to spread its shadow over every aspect of transgender existence in Melbourne. This may account for the fractured nature of the transgender community there, as we were informed that the Clinic takes a dim view of community solidarity outside of support for those undergoing the genital realignment process. Many criticised it for the almost farcical levels it went to produce "stereotypical" women, a notable example of which was the Clinic's insistence that a woman, who was blind from birth, attend a training course in cosmetics as part of her reassignment process!

Perhaps as another consequence of this influence, Victorian transgenders are slightly more conservative than those we met in other parts of the country and the old-style labels of "transsexual" and "transvestite" tend to be accorded more weight in Victoria.

There is no legislative protection for transgenders in Victoria at the moment. It is as yet unclear whether moves to amend the Equal Opportunity Act will include action in relation to the needs of transgender men and women.

Relations with gays and lesbians tend to be less productive than the rest of the country, again reflecting the influence of the Clinic (which disapproves of co-operation between transgenders and gays and lesbians) and a general conservatism on both sides. Nevertheless, it was reported to us that approx. 3% of the more than 3,000 inquiries last year to the Gay Help and Advice line, a telephone help and referral service, related to transgender issues.

South Australia: Our stay in Adelaide was brief and our impressions are therefore fleeting. The scene is very low-key. Up to recently, there was only a single venue, the Mars Bar, which

women shared with a much larger gay male clientele. However a branch of the Les Girls nightclub was opening as we visited.

South Australia is unique in that it is the only state in Australia that has Equal Opportunity laws that cover transgenders (the ACT and the Northern Territory also have similar laws). It is unclear whether the South Australian law also covers those transgenders who have decided not to undergo surgery. South Australia also has laws enabling those who have undergone surgery to alter their birth certificates. Unfortunately, as these laws apply only to those people who were (a) born in South Australia and (b) had their surgery performed in South Australia (and no operations are currently performed in South Australia), it cannot be said that this particular legal change has delivered wholesale benefits to the community.

The only community organisation is the Carousel Club, formed under the auspices of the AIDS Council of South Australia (ACSA). This is primarily a peer support group, with an HIV/AIDS awareness and education focus. A number of individuals are quite active on transgender issues. Relations with the gay and lesbian community seem cordial, with one prominent woman being Secretary of ACSA. South Australians seemed to have an easy acceptance of the transgender philosophy. Our researchers was unable to find any serious demarcations being drawn by transgenders there, unlike the situation in Melbourne.

The sex work situation is possibly more regressive in Adelaide than in any centre we visited. Sex work is illegal and a heavy police crackdown on sex workers was going on during our visit there. The local police chief attracted media headlines when he announced his intention to stamp out prostitution in Adelaide (sic). There seemed to be neither street work nor parlour work. The only available option for transgender sex workers was escort work which seemed rather risky as it included visiting clients' homes. A number of women worked from home but the level of police activity meant that we could only speak to one sex worker during our stay there - the rest had gone underground. That particular worker told us that the police had already phoned her to say that she was going to be arrested as "she'd been working for far too long without getting arrested". In a note of consideration not usually associated with Vice Squads, the police had told her that they would telephone her to say when they were coming to arrest her. Whether this was done out of courtesy or to avoid arresting her clients (anyone on a premises where prostitution is taking place is liable to arrest in South Australia) was unclear.

Western Australia and Tasmania: Although we did not visit these states, some information has reached us via the national grapevine. It seems that transgenders in Western Australia are greatly divided and conflicts are common, particularly among those in the sex industry. Groups tend to form and fall apart with regularity.

In Tasmania, transgenders are largely invisible, even in Hobart, due to regressive attitudes across the state. A small group called Metamorphosis was formed recently but seems intent on maintaining a low profile.

Conclusion: In conclusion, the lasting impressions we carry with us about the transgender sub-cultures are both positive and negative. Positive in the immense diversity of transgenders and their sub-cultures - a diversity of people, of self-images and identities, ambitions, dreams, ways of living and surviving against tremendous adversity, personal histories, and belief systems. Negative in the immensity of the obstacles transgenders face in merely getting by from day to day - routine and systematic exclusion, discrimination, abuse, ridicule, ostracisation, both physical and sexual violence, all of which are exacerbated by the ever present possibility of HIV/AIDS infection. Many transgenders avoid leaving their homes as much as possible because of these ever present problems.

This seems to suggest that the question: 'What motivates people to endure such hardship in order to live in their preferred gender?' has not yet been adequately answered. Our study has attempted to address some of these issues which will, hopefully, one day be redressed by appropriate legal, social and health policies and changes in societal attitudes.

II. THE SURVEY

5. METHODOLOGY AND SAMPLING

Social research into any marginalised community presents a number of obstacles. In the case of the transgender community, these problems are magnified by a number of factors specific to the community itself. Many transgenders have an enormous investment in invisibility and are loathe to reveal their history and status to anyone, even to their lovers. For example, some transgender female sex workers were encountered while researching another project (*Health Care and Prevention Practices Among Private Female Prostitutes in New South Wales 1993-94*, funded by NH&MRC) but we could not ask them to participate in this project unless they first revealed their transgender status to us. Others live their lives 'hidden in the suburbs', avoiding all contact with the community and its organisations for fear of exposure. These factors combine to make access to a representative range of transgenders a rather difficult proposition for an outsider.

The level of distrust and hostility often found in such marginalised populations as gays, prostitutes, illegal drug users and others is more pronounced in the transgender community. Previous contact with various researchers and media have resulted in negative outcomes which include, from a transgender perspective, being presented as medical oddities, treated as guinea pigs or being exposed in sensational media reporting. Distrust of authority (and anything perceived as connected with authority) and distaste for paperwork are commonly reported among marginalised populations, but again, have a higher significance amongst transgenders. Many transgenders reported histories of discrimination and ridicule when in contact with the authorities, whether they be police, government departments or welfare organisations. One woman told us that "tranys feel discriminated against every time they fill in an official form", for such forms invariably ask people to list their sex. As with many other marginalised groups, transgenders have their own folklore, own argot and esoteric information. This tends to maintain and reinforce the gap between the public image that transgenders (and others who claim to speak on their behalf) sometimes present to the public and the everyday realities that are usually not apparent to the wider community and only discussed with other transgenders. All of this effectively denies outsiders an insight into some of the transgender community's problems, mores, dispositions and experiences. Issues of confidentiality are rated highly by transgenders.

Commonly, the experiences of transgenders in our society are so far removed from the everyday experiences of most of the general population that many are reluctant to discuss their lives and lifestyles with outsiders for fear of ridicule and rejection. For example, there are some transgenders who only go out at night and therefore researchers have to seek them during these hours in order to access this section of the transgender community. Compounding this problem of reticence are the findings of previous researchers into the area, who have concentrated on medical/clinical issues, or depersonalised issues of gender. These factors combine to cause many transgenders to be sceptical of the merits of contributing to research studies. Issues of credibility are also important to them.

It was felt that by employing researchers who come from and are well-known within the transgender community this offered the best prospects for a successful resolution to the above problems. Utilising this option provided other benefits to the project. Because the researchers were familiar with the vast range of problems experienced by the transgender community on an everyday basis, they helped develop a questionnaire that inquired about issues relevant to the lives of the people being studied. As a direct consequence of this, our survey has identified and made a number of significant findings in areas that have not yet been adequately explored by other researchers (eg. sexual assault and violence, HIV risk factors). Given more time and resources, it might have been possible to research and analyse these areas more comprehensively.

Moreover, the researchers familiarity with the street language of transgenders meant that the research instrument could be constructed in a manner that was easily understood by the many and diverse groupings within the transgender community. The researchers' knowledge of the informal national transgender network led to accessing community organisations such as TLC

and ATSA, whose support bases made a significant contribution to the study. The range of personal and community contacts greatly facilitated the efficiency and depth of the research.

The large number of completed questionnaires seems to confirm the wisdom of this choice. At the outset, we would have been satisfied to have a total of about 50 completed questionnaires. In fact we received 146, or almost three times our initial target. In general, the critical feedback from the community indicated that transgenders were happy to at last respond to a survey that they saw as relevant to their needs and issues, and coming from a source that was seen as credible and reliable .

One criticism levelled at our project might be the composition of our respondents, which is heavily weighted in favour of Sydney tranys, especially since we have referred to the study as national. The bias towards Sydney was, however, unavoidable for a number of reasons. Firstly, our office was located in Sydney and all of us were more familiar with the Sydney "scene". Secondly, the trany subculture in Sydney was much more open, and apparent even to the most casual observer. Thirdly, as many as half the transgenders in Australia lived and worked in Sydney. It should be borne in mind, though, that the trany population in Sydney reflects this city's cosmopolitan aspect, and as such, is, in many ways, an ideal setting for a national perspective. Lastly, of course, there were the constraints of time and finance, which enabled us only brief visits to other centres. We regret the lower attention paid to other cities, and would dearly have liked to have had a more egalitarian approach. But, given our limitations we feel we have provided as broadly based a research project on transgenders as can be expected.

A self-administered coded questionnaire was chosen as a research tool because it taps the largest possible sample of the transgender population quickly and effectively across the greatest geographical area. The questionnaire was designed in four parts (see appendix I), ie. questions on demography, sexual issues and practices, health issues and transgender issues. The total number of questions were 40, mostly providing for optional answers, although many of these were divided into a number of parts some of which also offered answers to open ended questions. The questionnaire was randomly distributed across the transgender population via personal contacts and responses to advertisements, as described below.

Fieldworkers distributed the questionnaire nationally through many outlets. We visited transgender organisations, bars, clubs, brothels, trany sex workers' street locations, and sex workers' organisations such as SWOP (Sex Workers Outreach Project in NSW), PCV (Prostitutes Collective of Victoria), SQWISI (Self-Health for Queensland Workers in the Sex Industry) and PASA (Prostitutes Association Of South Australia), trany welfare organisations such as the Gender Centre (formerly Tiresias House), involved medical and psychiatric professionals, sexual health clinics and needle exchange services in metropolitan New South Wales, country and coastal areas and in Adelaide, Melbourne and Brisbane, as well as the Gold Coast.

Advertisements were placed in the local lesbian and gay press, such as *Capital Q* and the *Sydney Star Observer* requesting those interested in responding to the survey to contact us at the University of New South Wales. When visiting Brisbane, Adelaide and Melbourne and pursuing postal contacts in Tasmania and Western Australia, the lesbian and gay press was also consulted with regard to valuable leads for the distribution of the survey, such as social organisations for tranys and ATSA in Queensland. Public access radio stations such as Triple Z in Queensland were successfully approached for interviews and publicising the survey among listeners. Advertisements were also placed in regional newspapers in order to reach transgenders in country areas where gay bars and other possible meeting places did not exist or were located in private homes, well hidden from the health workers we contacted. Sexual health is a relatively new category in country centres and the workers occupying these recently created positions seemed unfamiliar with transgenders and their issues.

Anecdotal information like this, gathered during the period of data collection supported and rounded out the picture that was starting to present itself in the statistics of a degree of ignorance on the part of professionals with regard to dealing with transgenders during periods of great distress, with the result that transgenders tended to avoid them. It is believed by the

researchers that qualitative work in the form of follow-up interviews would contribute greatly to a deeper understanding of the implications of the social and health issues raised by the survey.

One hundred and forty-six completed questionnaires were returned by our closing date of 3rd December 1993 and their data entered into a Vax SPSS system for computer analysis.

Population figures: Until very recently, gender related data has only been routinely collected on the two legally recognised sexes - male and female. The Australian Bureau of Statistics does not collect data about transgender status in the national census, and neither does the Registrar of Births, Deaths and Marriages, and most population data available from social research studies and service agencies lack any reference to transgender status. Even if this type of data were collected it is highly unlikely that they would accurately reflect the numbers of this target group. Most people with transgender issues have a large investment in remaining hidden and, given the option of indicating a transgender status, are unlikely to self-report.

According to Ross 1: 24,000 males and 1:150,000 females in Australia are, or are likely to be, "transsexual" (Ross *et al.*, 1981). Since 8,254,200 males and 8,277,700 females (Australian Bureau of Statistics 1988) reside in Australia, this means that approximately 400 transgenders of both sexes were said to exist in 1988. However, evidence from several other sources supports a 1993 population "guesstimate" in excess of 2500. Following is a discussion of the factors that were taken into consideration.

Although approximately eight per cent of the population experience the psychiatric diagnosis of "gender identity conflict" issues at some stage in their lifetime, and that between two and four per cent of the adult male population experience "intermittent or continuous gender identity conflict or transgender fantasies" (Alan *et al* 1990), this cannot directly be correlated with the experiences of transgenders. Taking NSW as an example, given that the adult male population of in this state is currently estimated at approximately 2,000,000, this estimate of prevalence gives a population anywhere between 40,000 and 80,000 adult males living in NSW who experience "intermittent or continuous gender identity conflict or transgender fantasies".

Female-to-male transgenders have received less attention in estimating their incidence than their male-to-female counterparts. Hamburger (1953) received 465 letters from individuals requesting a "sex change" following the publicity of Christine Jorgensen, about a third of whom were females. Pauly (1965) claimed that there was one biological female transgender to every three or four biological males, Benjamin (1966) thought that the ratio of female to male transgenders was 1:8, while Stoller (1968) deduced that it was more like 1:4. Walinder (1975), Money (Raymond 1979:24), and Lothstein (1983) all reported the incidence of gender crossing in both sexes to be about equal.

The prevalence of psychiatrically diagnosed "transsexualism" in Australia has been reported at very different rates - 7.4 per million (Ross et al 1981), 0.2 % (2,000 per million) adult males by Professor Steinbeck (Alan *et al* 1990), 33 per million for male-to-female and 10 per million for female-to-male (Kaplan and Sadock 1991), and 20 per million in Australia by Dr Herbert Bower (Alan *et al* 1990). These estimates give a range of population of people with "transsexualism" in New South Wales, for example, from 42 to 5,700. It was reported by Alan *et al* (1990) that estimates of the population of people with "transsexualism" in NSW vary between 50 and 2,000. This report also suggests that the lower figure was highly unlikely given that a single Sydney surgeon had reported performing genital realignment surgery on 80 clients between 1987 and 1990, and that a retrospective study of client records at the Albion Street Centre revealed 77 "transsexual" clients in the period between 1985 and 1989, all of whom were biologically male at birth. This study does not reveal whether or not these clients self identified as being "transsexual" or whether the gender identity of the client was assigned by a service provider. It also makes no reference to whether or not the population were psychiatrically diagnosed as being "transsexual". Since only 13 % were known to have obtained genital realignment surgery it would be more accurate to describe the population as people with transgender issues (Alan, *et al* 1990).

Another factor affecting an estimate of the population of people with transgender issues is the high level of interstate and international movement of this population. It is not evenly spread

geographically and New South Wales has a disproportionately higher concentration, especially in the inner city areas of Sydney and other metropolitan regional centres such as Newcastle, Wollongong, Lismore and Albury. In Australia only Sydney and Melbourne have well established specialist services providing medical and surgical interventions associated with the medical "gender reassignment" process. But, the services in Sydney are popularly regarded as being superior by those who seek genital reconstruction and there is reputed to be a more liberal disposition among both service providers and the general community. Because of the easy availability of these services, transgenders come to Sydney from many countries in the South Pacific, including New Zealand, as well as from other states in Australia. Those from non-English speaking backgrounds and other cultures commonly include Maori, Pacific Islanders and Aboriginal Australians. Of the 100 homeless clients with transgender issues offered accommodation by Tiresias House between July 1989 and June 1992, 8% were Aboriginal and 10% were Maoris or Pacific Islanders (Tiresias House 1992).

If we accept the highest above estimate of 2500 for the NSW population of transgenders, and given the higher proportion of tranys in this state, a national estimate of at least 5000 would seem reasonable. Therefore, our sample of 146 represents about 3% of this estimate of the Australian transgender population. Considering that this sample was acquired on a random distribution basis we feel that it is representative of transgenders in Australia.

6. SURVEY RESULTS: DEMOGRAPHY

This chapter examines the demographic background of our sample of 146 transgenders. The data acquired in this area of inquiry can serve to establish a basic typology for the sample. For example, our trany sample may be grouped according to youth and middle aged, male and female, inner-urban and suburban, urban and rural, basic education and post-school education, blue collar and white collar employees, pre-gender and post-gender reassignment, and so on. When data on experiential variables in subsequent chapters are entered in accordance with the demographic typology, we may, for example, discover that the youthful tranys have a more active sex life than their middle aged counterparts and this may place them at greater risk for HIV, or, we might find that inner-urban tranys' greater exposure to the drug scene places them at greater risk of sharing needles than outer suburban and rural tranys. What these examples demonstrate are the importance demographic figures play in social research into a marginalised group such as transgenders. More importantly, what these will very likely indicate to the socially conscious reader is the extent of social heterogeneity or homogeneity in the Australian transgender population.

Gender, Age and Residence: Despite our observations on the equitable populations of female and male transgenders in chapter 5 our survey was weighted heavily in favour of male-to-female tranys, as figures 1 and 2 clearly indicate.

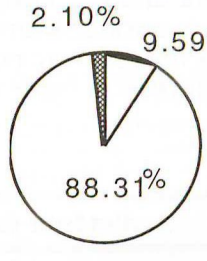

Figure 1: Gender at birth

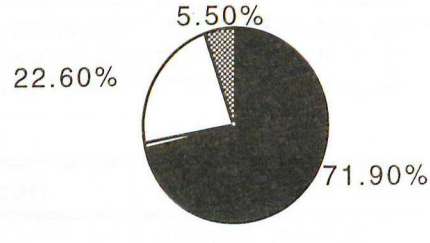

Figure 2: Current Gender

Key: Black=Female; White=Male: Grey=Not Known

These figures do not show that a complete reversal of gender took place in the sample. That is, only 105 (ie. 71.9% of the sample) of the 129 tranys born into the male gender (ie. 88.4% of the sample) considered themselves to have made a complete change over into the female gender. Although this portion represents the vast majority, a significant number continued to regard themselves as male. A handful of those who recorded their natal gender failed to do so for their current gender, and may reflect some tranys who are genuinely uncertain which gender they presently represent, despite any superficial expressions of femininity or masculinity. For these latter two groups there is a serious discrepancy in their perceptions of self, which may reflect a belief in biological rather than social criteria for determining gender. They may, therefore, consider that their gender crossing was a true perversion of nature.

Crossing gender is widely thought of as an activity of mostly young people exploring or experimenting with various sexual identities, while at the same time gender crossing among older people is assumed to be much less frequent and an extreme form of perversion. In other words, it is popularly considered to be two phenomena. But, as table 6.1 below illuminates, whilst nearly three-quarters of the sample were between 20 and 40 years of age, almost a quarter were over 40, and the average age for the group was the early 30s. The implication here is that gender crossing usually occurs after adolescent sexual experimentation and is maintained throughout most of the transgender's adult life. In fact, the findings for the actual age of gender crossing in chapter 9 supports this, since nearly 40% of the sample did so in their 20s.

Age Group	Frequency (N=146)	Percent (of 146)
Under 15	0	0
6 - 20	3	2.1
1 - 25	23	15.8
26 - 30	37	25.3
31 - 35	24	16.4
36 - 40	23	15.8
41 - 45	17	11.6
46 - 50	11	7.5
51 - 60	6	4.1
61 and over	2	1.4

Table 6.1: Age groups of transgenders

As pointed out in chapter 5 our sample was not as nationally egalitarian as we would have liked. However, as table 6.2 illustrates, there was a fairly wide distribution of transgenders from across the country. Over half were Sydney residents, whilst over a quarter came from all the other capitals, except Darwin. However, the Sydney bias in these figures may not be quite as unrealistic as a first glance might suggest. Nevertheless, the impression here is probably a good indication of trends rather than a strictly accurate picture.

Region of residence	Frequency (N=146)	Percent (of 146)
Sydney: City & Inner Suburbs	2	1.4
Sydney: Eastern Suburbs	43	29.5
Sydney: Northern Suburbs	11	7.5
Sydney: Western Suburbs	7	4.8
Sydney: Southern Suburbs	15	10.3
New South Wales Country	15	10.3
Canberra	1	0.7
Melbourne	17	11.6
Victorian Country	3	2.1
Brisbane	15	10.3
Queensland Country	1	0.7
Adelaide	7	4.8
Perth	4	2.7
Hobart	2	1.4
Not known	1	0.7

Table 6.2: Region of residence of transgenders

There is a definite trend here for tranys to be located in urban rather than rural settings. Although this may have much to do with our research being concentrated in the cities, it is also true to state that a disproportionate number of tranys are located in urban settings. Given the greater resistance towards gender crossing in rural areas, and the existence of trany subcultures in the cities, this is not surprising. As we noted in chapter 5, advertisements were placed in local country newspapers seeking to contact rural tranys, but the response was negligible. On the other hand, in more cosmopolitan rural centres, such as Coffs Harbour, where a trany organisation has been established, the response was above our expectations.

Accommodation: Type of accommodation can be used as an index of a person's social and economic stability. For example, we may assume that living in a refuge or in a shared accommodation arrangement, and the extent of moving from one accommodation to another, are indicative of individual social instability, while living in government housing is indicative of individual economic instability. Table 6.3 below indicates their current accommodation reported by the sample.

Accommodation	Frequency (N=146)	Percent (of 146)
Homeless	0	0
Refuge	11	7.5
Boarding house	2	1.4
Hotel	1	0.7
Share accommodation	18	12.3
Other short term accommodation	1	0.7
Rented flat	58	39.4
Living with parents	5	3.4
Living with friends	10	6.8
Housing Commission dwelling	11	7.5
Buying own home	6	4.1
Own home freehold	22	15.1

Table 6.3: Accommodation of transgenders

The number found to be purchasing or owning homes is considerably lower than the national census (owners 36% and buyers 37% in 1986), according to an Australian Bureau of Statistics' (ABS) report (1992:314). This report also indicates that about a fifth of the general population rented housing from private sources and over 5% did so from government sources. As you can see in the above figures considerably more tranys rented from both private and government sources than the national population. Since transgenders are much more dependent on others for their accommodation, due to their lower economic status seen in the levels of unemployment and dependence on welfare benefits reported in chapter 9, this adds to the general powerlessness experienced by most tranys. This is reflected in the high mobility seen in figure 3, much of which is due to negative reactions to transgenders by both other tenants and lessors.

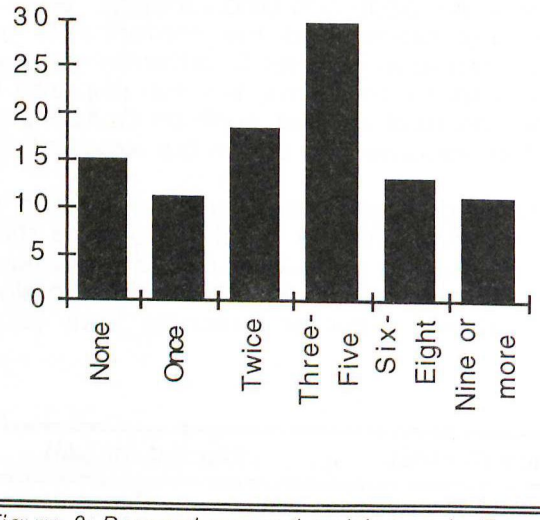

Figure 3: Percent moved residence in 5 yrs

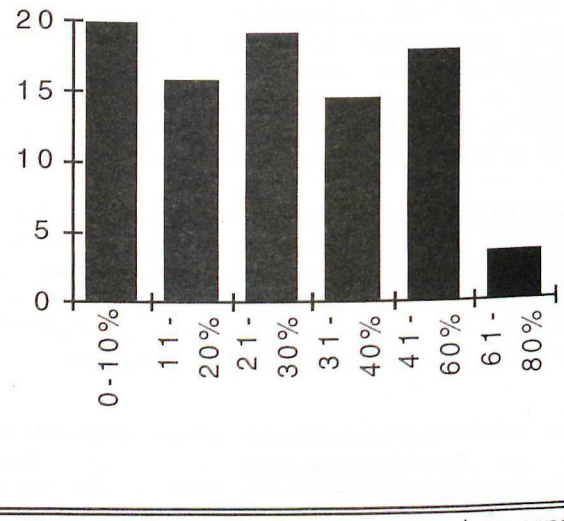

Figure 4: Percent of income spent on rent

In the past five years only about a quarter of the sample moved residence once or not at all, while as many moved from one accommodation to another six or more times in the same period. The inference here is that residential instability exists in large numbers of the transgender population, much of it due either to harassment or to economic circumstances.

Figure 4 shows the portion of weekly income spent on rent. The ABS (1992:323) indicates that the average expenditure on renting private accommodation is over a fifth of the weekly income, whilst renting government accommodation costs the average person about 17% of their income. Given that trany incomes are generally much lower than the general population (see chapter 9) and that only 15% of the sample lived in a refuge or government-supplied accommodation, yet over a third of them paid less than a fifth of their incomes on rent, the implication here is that a substantial number of tranys are living in substandard privately rented accommodation, which is evidence of the extreme level of poverty existing in the trany community. On the other hand, a considerable portion of the sample owned their homes or paid high rents. Most of these represent older tranys who had established a comfortable lifestyle prior to changing gender.

Education and Employment: The sample was employed in many occupations, as seen in table 6.4, in which three periods of work experiences are compared: before crossing gender; after crossing gender; and, currently.

In nearly every type of occupation there is a decline from before to after the gender crossing by between 25% and 50% reduction in work experiences. The exceptions to this trend are in sex work and pornography, which are often the only options left many tranys when they cross the gender line. The reason for this trend is very likely discrimination against transgenders. For many employers it seems inconceivable that someone who has crossed from a male to female role should want to continue working in their traditional male job. In most cases dismissal is the only outcome. But in many cases this is not an outright dismissal in direct response to the gender change; it is more indirect, such as objections from female staff to a male-to-female trany using the women's lavatory, or a "consideration" for the sensibilities of the company's clients, or any number of other trivial complaints that are founded in anxieties about switching sex roles. More often, however, some even more indirect reason for the dismissal is given, such as a sudden decline in quality of work, or a fictitious retrenchment of staff. What seems to be obvious in all of this is that the act of crossing gender is considered much more detrimental to the job than any loss of an employee's essential work skills.

Type of occupation	Before change N=146		After change N=146		Current employment N=146	
	Fr	%	Fr	%	Fr	%
Own business	27	18.5	15	10.3	12	8.2
Factory work	40	27.4	11	7.5	1	0.7
Service industry	38	26.0	15	10.3	6	4.1
Transit industry	9	6.2	4	2.7	3	2.1
Beautician/Hairdresser	15	10.3	7	4.8	2	1.4
Sales work	47	32.2	8	5.5	3	2.1
Porn actress/Stripping	10	6.8	13	8.9	3	2.1
Sex work	38	26.0	33	22.6	31	21.2
Theatre	21	14.4	18	12.3	8	5.5
House work	21	14.4	12	8.2	11	7.5
Skilled trade	31	21.2	10	6.8	4	2.7
Welfare/Health work	18	12.3	17	11.6	10	6.8
Domestic work	13	8.9	11	7.5	1	0.7
Nursing	16	11.0	12	8.2	6	4.1
Teaching	11	7.5	6	4.1	2	1.4
Office Work	34	23.3	16	11.0	6	4.1
Arts	18	12.3	9	6.2	5	3.4
Administration	21	14.4	7	7.8	5	3.4
Other professional	12	8.2	11	7.5	11	7.5
Other work	24	16.4	1	0.7	26	17.8

Table 6.4: Work experiences of transgenders

When we compare tranys' high educational achievements against this declining employment one cannot help but feel an unfortunate loss for human potential as a result of employers' anxieties over gender crossing. Figure 5 below shows the sample's educational levels, which are considerably higher than the national population of 40% attaining schooling below the highest secondary level, 13% attaining highest secondary school level, 19% with a certificate or diploma, 13% with trade qualifications and 9% with a tertiary degree (ABS 1992:147).

Family And Social Class Background: Figure 6 below indicates the marital status of the sample, showing over half having never married, with 16% in a de facto relationship, 6% married, 12% divorced and 10% separated. Since a gender-crossed male-to-female trany cannot legally marry a man, nor a female-to-male marry a woman, the 6% who recorded being married were in transitionary stages of crossing and were still married to their original spouse, or remained married despite one of the partners having crossed gender. The large number in the sample who have never married nor living in a de facto relationship suggests a high level of permanent unattachment in the trany community.

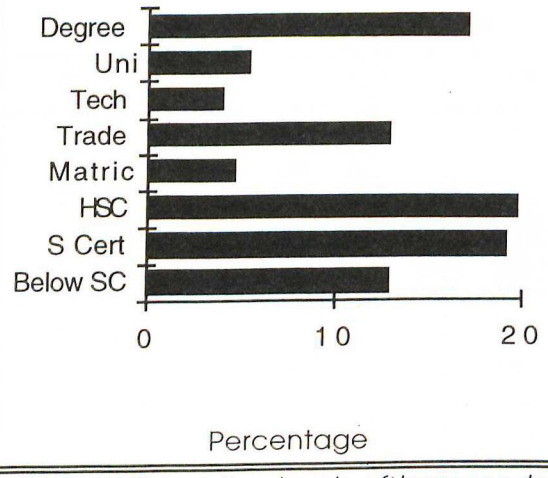

Figure 5: Education levels of transgenders

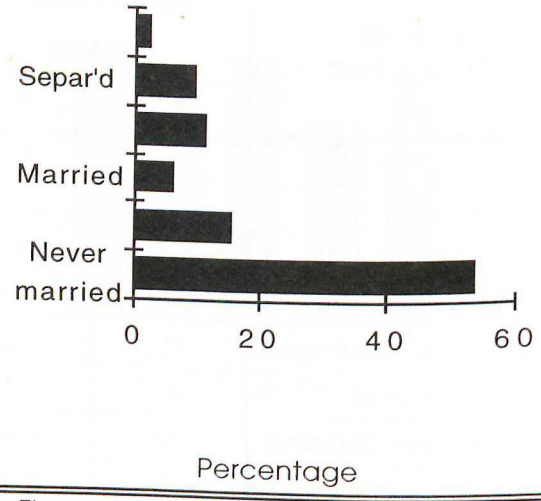

Figure 6: Marital status of transgenders

The ethnicity of transgenders is indicated in table 6.5. Apart from white Australian parentage, large numbers of the sample were exclusively or of mixed Anglo-Celtic origin. The Anglo-Celtic origins in the sample is much higher than the national situation of 60% (ABS 1992:14). Since Australia attracts Maori and other Polynesian tranys the high proportion of the sample with New Zealand parentage is not surprising.

Geographic/Ethnic Area	Frequency (N=146)	Percent (of 146)
White Australia	76	52.1
Aboriginal Australia	1	0.7
New Zealand	12	8.2
Polynesia	1	0.7
Melanesia/Micronesia	0	0
South East Asia	3	2.1
East Asia	1	0.7
Southern Asia	2	1.4
Africa	1	0.7
Middle East	0	0
Eastern Europe	2	1.4
Southern Europe	5	3.4
Northern Europe	3	2.1
British Isles	18	12.3
North America	0	0
Latin America	1	0.7
Mixed with Anglo-Celtic	16	11.0
Mixed: other	3	2.1

Table 6.5: Ethnic parentage of transgenders

Social class can be determined by such variables as occupation, education and residential area. Although over a third of the sample indicated they lived in middle class areas in Sydney (see table 6.2), this is not a good index of class because of the many tranys from across Australia and overseas who gravitate to the inner city and eastern suburbs where an open transgender subculture exists. As we have seen (table 6.4), the sample's occupation prior to gender change indicates a strong trend towards an economic middle class with 97% having worked in white collar and professional jobs. But following a rapid decline in work experiences after the gender change, with only 36% having been employed in these occupations, a dramatic descent in economic class is most apparent. Perhaps a more stable index of class is education, and, as we have seen (figure 5), with a higher than average number of tranys seeking higher education the indication here is for above average embourgeoisment. Another important criteria for social class is parents' occupation. The sample's parents' occupations are seen in table 6.6.

Occupation	Mother (N=146)		Father (N=146)	
	Fr	%	Fr	%
Home duties	60	41.0	1	0.7
Farmer	5	3.4	9	6.2
Own business	11	7.5	26	17.8
Professional	14	9.6	16	11.0
Manager	1	0.7	6	4.1
Executive	1	0.7	3	2.1
Clerk/Secretary	10	6.8	3	2.1
Labourer	3	2.1	11	7.5
Factory worker	6	4.1	10	6.8
Trades person	5	3.4	26	17.8
Transport worker	1	0.7	4	2.7
Service industry worker	5	3.4	4	2.7
Sex industry worker	3	2.1	0	0
Unemployed/Not employed	1	0.7	1	0.7
Other employment	17	11.6	19	13.6
Unknown	3	2.1	7	4.8

Table 6.6: Occupations of parents of transgenders

If we take the white collar occupations for both parents, ie. professional, manager, executive and clerk/secretary, we find that 18% of the sample's mothers and 19% of their fathers were engaged in these occupations, compared to 10% and 35%, respectively, employed in the blue collar occupations of labourer, factory worker, trades person and transport worker. Considering father's occupation as the key index to the economic class of the family, this means that there was a greater trend towards a proletarian background for the sample. This was the reverse of the national average of 48% white collar and 37% blue collar (ABS 1992:174). However, as we have seen, the sample's pre-gender change work experiences tended towards white collar occupations, or, in other words the sample had experienced a process of embourgeoisment before their gender change.

Religion can also serve as a guide to class, eg. a Catholic inheritance may indicate a working class ancestry, and an Anglican a middle class ancestry. However, taken by itself religion is an unreliable index of class at best. Table 6.7, below, indicates the sample's inherited and current religious beliefs. Very clearly, there was a marked retreat from inherited to current, or preferred, religious beliefs. Since most of the inherited beliefs were associated with orthodox religions and as most of these religions are opposed to gender crossing, it is not surprising to find such a trend in our sample.

Religion	Inherited (N=146)		Current (N=146)	
	Fr	%	Fr	%
Church of England	51	34.9	16	11.0
Catholic	45	30.8	22	15.1
Other Protestant	15	10.3	3	2.1
Orthodox (Greek or Russian)	1	0.7	1	0.7
Other Christian	15	10.3	17	11.6
Islam	0	0	0	0
Buddhism	1	0.7	5	3.4
Hinduism	0	0	2	1.4
Jewish	2	1.4	1	0.7
Other religions	3	2.1	24	16.4
Agnosticism	2	1.4	24	16.4
Atheism	4	2.7	23	15.8
Unknown	7	4.8	13	8.9

Table 6.7: Religious beliefs of transgenders

To return to the question of social class, if we take education, both own and parents' occupations, and inherited religion together, what we will find is that most tranys were raised in working class families but elevated to middle class through education and earliest work experiences, only to descend in social status following their gender crossing.

Conclusion: In summary, this chapter presents a demographic profile of a transgender sample which may reflect the social background of tranys in general, although there is an under-representation of transgender men. If our findings in other respects are representative of the transgender population, then tranys tend to be of all ages, gravitate to inner urban areas from outer suburban and rural regions, are likely to rent rather than purchase their own homes, have a higher than average education, have declined in employment potential since their gender change, more often do not have permanent attachments with others, are nearly always of an Anglo-Celtic ethnicity, and are of mixed social class backgrounds, although in cases of working class parentage there is a tendency to embourgeoisment before crossing gender.

7. SURVEY RESULTS: SEXUAL ISSUES AND PRACTICES

The purpose of this chapter is to examine the sexual health and practices of the target population, to try to establish the level of transgender dependency on the sex industry, and to identify sex-related HIV risk behaviours within the target population, and the factors that contribute and reinforce such behaviours.

This survey is the first to attempt to investigate this area in some detail. While it has been established that some transgenders engage in a variety of high-risk HIV behaviours and practices (Alan et al, 1991), this research has emphasised that its results, a retrospective analysis of Albion Street Clinic clients, possibly did not reflect a representative sample of transgenders. A detailed investigation of the extent of high-risk behaviours for HIV and the factors that may be seen as contributing to high-risk behaviours among Australian transgenders was needed.

It is generally accepted within the field of HIV/AIDS studies and experience that the more marginalised a community is, the greater the probability of high-risk behaviours and consequent seroconversion. One relevant example is the Vancouver study that found 50% HIV seroprevalence amongst a population of transgender street workers, a group highly marginalised for their gender expression, their sex work, their intravenous drug use and ethnicity (Rekart et al 1993). Central to the marginalisation of the transgender community is the common perception that transgender behaviour carries a large sexual component.

Therefore, this chapter focuses on issues of sexuality, sexual practices with lovers, acquaintances and others, frequency and duration of relationships, reliance on sex work, length of time in the sex industry, kinds of services offered to sex industry clients, use of safe sex materials, both in and beyond sex work, details of sexual abuse and violence, levels of infection by sexually transmitted diseases and sources of these infections. It was hoped that research into these questions would enable conclusions to be drawn as to the extent of HIV risk behaviours, the factors that perpetuate such behaviours among Australian transgenders and help identify possible remedies to improve levels of HIV awareness, education and prevention among the target population.

Sexual Practices: Sexual identity has been identified as a primary avenue for HIV education and prevention. We sought to establish the ways in which transgender men and women identify sexually, both before and after their gender changes. The results indicate a broad range of sexual identities among transgenders both before and after gender change, with changes in sexual identity often occurring pursuant to changes in gender representation. Table 7.1 records the responses prior to changing gender. Three intriguing findings emerge from these responses; (i) the level of those identifying as homosexual before gender change (Homo and Gay total 34.7%); (ii) the somewhat surprisingly high level of bisexuality (17.8%), and (iii) the rather unexpectedly even distribution between hetero (24.7%), homo and gay (34.7%) bisexual (17.8%) and asexual (14.4%). It is unclear whether this level of asexuality reflects a sexual disposition or an involuntary lack of sexual contact.

Sexuality	Frequency (n=146)	Percent (of 146)
Hetero	36	24.7
Homo	41	28.1
Bisexual	26	17.8
Asexual	21	14.4
Gay	9	6.2
Not clear	13	8.9

Table 7.1: Transgenders' sexual identities prior to gender change

Table 7.2 below lists the respondents' sexual identities after their gender changes. A sharp rise in the numbers identifying as heterosexual (36.3%, up to almost 50%) is evident, with a corresponding fall in the numbers identifying as gay or homosexual (down to 10.5% from 34.3%). Bisexulality increases slightly while asexuality falls by almost a third. Nonetheless, the variety of transgender sexual identities remains evident.

Sexuality	Frequency (n=146)	Percent of 146
Heterosexual	53	36.3
Homosexual	10	6.8
Bisexual	29	19.9
Asexual	14	9.6
Gay	4	2.7
Transsexual	1	0.7
Not clear	35	24.0

Table 7.2: Transgenders' sexual identity after gender change

Another notable feature is the large number who declined to respond to this question (almost a quarter of the sample, almost three times as many as those who did not respond to the same question in table 7.1 above). One explanation for this might be that transgenders treat the issue of sexual identity as secondary to those of gender. These figures must be treated with a degree of caution as transgender people may sometimes understand these terms to have rather different meanings than the everyday understandings of the terms. Foe example, would the sexual behaviour of a female transgender who has undergone genital realignment surgery and who has sex with males be best described as heterosexual or homosexual? Would the person in question necessarily agree with whatever designation is thought appropriate? Nonetheless, these figures seem to confirm that transgenders have a fairly wide range of sexual identities, and that most transgenders differentiate between sexual and gender identity. This has implications for the design and implementation of HIV education and prevention strategies and materials.

Sex Partner	Frequency (n=146)	Percent (of 146)
No one	56	38.4
Causal acquaintances	22	15.1
Casual lovers	17	11.6
Regular lovers	41	28.1
De Facto husband/wife	33	22.6
Other	8	5.5

Table 7.3: Transgenders' regular sex partners

Duration	Frequency (N=146)	Percent (of 146)
Less than three months	13	8.9
3 - 6 months	8	5.5
6 - 12 months	12	8.2
1 - 2 years	15	10.3
2 - 3 years	17	11.6
3 - 5 years	20	13.7
5 - 10 years	12	8.2
More than 10 years	23	14.8
Not clear	26	17.8

Table 7.4: Duration of transgenders' longest relationship

Table 7.3 above lists the respondents' types of regular sex partners. What is immediately obvious is the large number who have no regular sex partner (38.4%). While it is not clear whether this is by choice or circumstance, the apparent difficulties transgenders encounter when forming and maintaining lasting relationships (see also Tables 7.4 above and 7.5 below) may be relevant here. However, our findings indicate that the number of sexually active transgenders in the sample was 113.

Approximately half the sample had regular lovers or *de facto* partners (transgenders are unable to legally marry as members of their chosen gender). Perhaps significantly, about a quarter of the sample described their partners as casual lovers or acquaintances suggesting a level of casualness or, perhaps, promiscuity.

In table 7.4. the sample detailed the duration of their longest relationship. Almost a quarter had no experience of a relationship that lasted over one year, while another quarter had relationships that endured for five or more years.

Period	Frequency (N=146)	Percent (of 146)
Less then three months ago	37	25.3
3 - 6 months ago	7	4.8
6 - 12 months ago	10	6.8
1 - 2 years ago	13	8.9
2 - 3 years ago	9	6.2
3 - 5 years ago	13	8.9
5 - 10 years ago	11	7.5
Over 10 years ago	20	13.7
Not clear	26	17.8

Table 7.5: The last time transgenders had a meaningful relationship

In table 7.5, respondents listed the last time they had a meaningful relationship. About one in five had not had a meaningful relationship in the last five years or more. While the relationship between sexual activity and emotional relationships is far from linear, the high number who

failed to respond to these two questions (tables 7.4 and 7.5) may echo the large number of transgenders who are not sexually active. All in all, these figures generate an impression of a significant level of loneliness among the transgender population.

The salient features that emerge from the above would seem to be: (i) a high level of sexual abstinence; (ii) a large variety of sexual identities among the sexually active; (iii) a significant section of the target population that encounters difficulties in forming lasting relationships; and (iv) a significant section that encounters loneliness.

Table 7.6 details the kinds of sex that the sexually active tranys and their partners practiced. Bearing in mind the level of sexual abstinence by transgenders, it seems more sensible to tabulate these responses against those transgenders who reported being sexually active. The total number of sexually active transgenders was found by counting those who responded to questions about the use of condoms and other safe sex items in tables 7.8 and 7.9. In both cases, the total was found to be 113.

Sexual activity	Frequency (N=113)	Percent (of 113)
Oral sex	95	84.1
Anal sex	64	56.6
Vaginal sex	48	42.7
Group sex	7	6.2
B & D/S & M	17	15.0
Fantasy	30	26.5
Other	15	7.5

Table 7.6: Sexual practices of sexually active transgenders

The total of 276 responses in this table indicates a high level and range of sexual activity among this particular group, with an average of just under 2.5 different sexual practices listed for each sexually active trany. High ratings are recorded for all nominated sexual practices, underlining the diversity of transgender sexual behaviours. The most popular sexual practice was oral sex, a relatively low-risk behaviour. Less than 5% of the sample thought that protected oral sex could result in HIV transmission, while well over half thought unprotected oral sex could end in HIV infection. (see Chapter 8)

The high level of vaginal sex reported exceeds the 38 genitally reconstructed women by 10. Vaginal sex was also reported by a few transgender men and by some genitally intact women. While it is not precisely clear what practices were in fact occurring (eg. if vaginal penetration occurred, was it digital, penile or by some other means, such as toys?), this figure alerts us to the dangers of assuming sexual practices slavishly follow assumptions that people are tempted to make about tranys and reinforces the need for sensitivity and an open-minded approach in this area. Nearly 85% of the sample thought that unprotected vaginal sex could result in HIV transmission while almost 5% thought that protected vaginal sex could end in HIV infection.

The level of anal sex practiced by well over half the sexually active transgenders appears lower than that which might be expected. All sub-sections of the sample reported anal sex practices, though the popularity of this practice varied, with 43% of the women reporting anal sex and only 13% of the men, while two-thirds of the sex workers reported practicing it (among them three-quarters of the street workers) and only a quarter of the non-sex workers. Even a quarter of the genitally reconstructed women reported anal sex with their partners. Over 90% of the sample was aware that unprotected anal sex could result in HIV transmission, while less than 5% thought that protected anal sex could do so.

The high levels of participation in what might loosely be termed minority sexual activities (eg. bondage & discipline, group sex, etc.) strengthens the view that HIV awareness materials for this target group should be sensitive to the variety of sexual practices tranys indulge in.

It seems clear from these figures that most transgenders engage in sex behaviours that could allow transmission of HIV if safe sex practices are not adhered to.

Levels of safe sex practices : In light of the above, it seems imperative to gauge the extent of safe sex practices among transgender men and women. The kinds of safe sex items used by sexually active transgenders are listed in table 7.7, the frequency with which condoms were used is listed in table 7.8, and the frequency with which safe sex materials other than condoms were used is listed in table 7.9.

Item	Frequency (N=113)	Percent (of 113)
Condoms	80	70.8
Latex Gloves	5	4.4
Dental Dams	6	5.3
Other safe sex items	2	1.8

Table 7.7: Sex items used by sexually-active transgenders

Frequency of use	Frequency (N=113)	Percent (of 113)
Always	47	41.6
Most of the time	17	15.0
Some of the time	12	10.6
Rarely	6	5.3
Never	31	27.4

Table 7.8: Frequency of condom use by sexually-active transgenders

Among the women, 55% reported using condoms with their partners, but only 30.5% said they 'always' used condoms, while 15.2% reporting using condoms 'most of the time'. 8.6% reported using them 'some of the time' and 3.8% used them 'rarely'. An alarming 19% reported 'never' using condoms. Among the nine sexually active men, four never used condoms, one did some of the time and four did so most of the time.

Of the 24 sexually active genitally reconstructed transgenders, only five used condoms always, eight used them 'most of the time', and three used them 'some of the time'. One reported 'rare' usage of condoms and seven never used them.

Less than half of the sample who were sexually active always used condoms with their lovers. More than half had sex without using condoms and over a quarter never used condoms with their lovers. Recalling that only half of our sample were in long-term relationships or had regular lovers, this would seem to indicate a disturbing level of unsafe sexual behaviour.

Urgent measures to modify this behaviour pattern appear to be needed.

Frequency of use	Frequency (N=113)	Percent (of 113)
Always	23	20.4
Most of the time	8	7.1
Some of the time	10	8.8
Rarely	9	8.0
Never	54	47.8
Not clear	9	8.0

Table 7.9: Frequency of use of safe sex items other than condoms by sexually-active transgenders

While these figures seem on the low side, the actual numbers of transgenders engaged in sexual practices where the use of safe sex items other than condoms is necessary is also low. However, given that: (i) there are only 15 transgender men in the study; (ii) that one in five of the total sample identified as bisexual; (iii) that many of those who identified as homosexual/gay would have pursued female-to-female sexual practices; and (iv) the popularity of oral sex among sexually active transgenders, the level of dental dam and latex glove utilisation seems to be low.

These figures occurred despite a reasonable level of awareness about HIV transmission through unsafe sexual behaviours. They are a cause for concern and require a prompt and effective response.

Sex Work: Of the 146 respondents in our study, 66, or 45%, reported having spent some time engaged in sex work. This level of participation in sex work is probably unparalleled among minority groups, sexual or otherwise. It is also widely recognised that workers in the sex industry have particular issues in relation to HIV/AIDS. Therefore it seems appropriate that transgender sex workers be considered as a separate category. Throughout this sub-section on sex work we will use the participation number of 66 cited above, rather than the total sample of 146. As a guide, comparative figures for females employed in the sex industry show a participation level of only around 0.06% of the total female population (Perkins 1991b:17). Our findings indicate a transgender participation of nearly 50%.

Table 7.10 lists the kind of sex work transgender prostitutes had engaged in.

Type of sex work	Frequency (N=66)	Percent (of 66)
Street work	46	69.7
Parlour	46	69.7
Private	40	60.6
Escort	31	47.0
Other	6	9.1

Table 7.10 : Types of sex work engaged in by transgenders

What emerges strongly from these figures is confirmation of the enormous reliance on street work amongst transgender sex workers. Comparative levels for female sex workers suggest that only about 10% engage in street work (Perkins 1991b:17). This reliance on street work exposes transgender prostitutes to particular pressures in relation to HIV/AIDS. Personal safety

dangers, sometimes difficult and often abusive clients, the ever-present threat of violence from passers-by or disenchanted clients, access to injecting drug sub-cultures, client pressure and financial inducements to engage in unsafe sex, often coinciding with financial crises, and low-esteem deriving from their extremely marginalised status all combine to increase the potential for high-risk behaviours.

Generally these pressures can be reduced by working in the more agreeable environments of parlours, but there is a corresponding drop in financial return per client. Most transgender parlours operate compulsory safe sex policies and their fixed locations and more regular hours make them easier to access for HIV awareness and education.

Private sex workers and most escorts are, in a sense, freelancers, who manage to combine working indoors with greater financial benefits that often come with independence, especially for the older worker. Their low-profile (because of possible legal complications and complaints from neighbours) and their isolation make private workers vulnerable to threats and inducements from clients to engage in unsafe sex, while they may also encounter difficulties in accessing safe sex materials.

Efficient outreach services aware of and tailored to the varying needs of the various sectors of the sex industry would seem to be of importance here. Recent Sydney research indicates that as many as 20% of transgender sex workers surveyed were unaware of the existence of the Sex Workers Outreach Project (SWOP) (Sharp & Lovejoy, 1992).

Length of time spent in the industry appears to be one way of estimating a prostitute's ability to negotiate safe sex with clients. We asked sex workers to list their time in the industry and their responses are seen in Table 7.11.

Time span	Frequency (N=66)	Percent (of 66)
Less than 3 months	7	10.6
3 - 6 months	6	9.1
6 - 12 months	5	7.6
1 - 2 years	10	15.1
2 - 5 years	6	9.1
More than 5 years	32	48.4

Table 7.11: Length of time transgenders spent in the sex industry

Approximately 10% of the workers had spent less than three months in the industry, while about 17% had spent less than a year. These figures suggest a constant flow of new entrants into the industry. Despite this high turnover, our findings suggest that significant numbers find permanent employment in the industry. It seems reasonable to suggest that these 'newcomers' will have the least ability of all sex workers to negotiate safe sex with clients.

The figure for those transgender prostitutes who spent five or more years in the sex industry is striking. Almost half of all those engaged in sex work or about a fifth of the entire sample had spent many years in the sex industry , which confirms the above observation that many transgender sex workers are permanently engaged in sex work. A further fifth of the sample were involved in the industry in differing degrees. Of the long-term workers, 87.5% had done street work.

Designing appropriate HIV prevention and awareness strategies for sex workers requires both a knowledge of and a sensitivity to the services the sex workers provide. We asked transgender prostitutes to detail the services they provided. Table 7.12 below lists the results.

Service	Frequency (N=66)	Percent (of 66)
Massage only	30	45.4
Hand relief only	34	51.5
Full French	46	69.7
French and sex	41	62.1
Sex only	25	37.9
Anal sex	43	65.2
Kissing	28	42.4
Doubles/threesomes	31	47.0
Lesbian acts	17	25.8
Light dominance	30	45.4
Heavy dominance	19	28.8
Light submission	19	28.8
Heavy submission	11	16.6
Cross-dressing	33	50.0
Other fantasy	26	39.4
Stripping	28	42.4
Buck's parties	9	13.6
Sexual surrogate (therapy)	7	10.6

Table 7.12: Services provided by transgender sex workers

A broad range of services were provided, with oral and anal sex being the most common. Given the strong possibility of HIV transmission when these practices are unprotected, data on safe sex practices among transgender sex workers would seem to be important. Tables 7.13, 7.14 and 7.15 below list their responses and comparative figures for non-sex workers.

Nearly 10% of transgender sex workers reported not using condoms. Of those who did use condoms, only three-quarters used them always. It is alarming that almost 5% of the sample engaged in sex work reported rarely or never having used condoms. Levels of using safe sex items other than condoms during sex work are low.

About three-quarters of the street workers reported offering anal sex to their clients, with a similar percentage offering oral sex. Of these street prostitutes, 36 reported using condoms always, three used them 'most of the time', four using them 'some of the time', and three did not respond.

After ten years of the HIV pandemic, it is disappointing to record this type of response. There seems to be a clear need for improvement in this area.

Item	Frequency (N=66)	Percent (of 66)
Condoms	60	90.9
Latex Gloves	15	22.7
Dental dams	18	27.2
Other items	1	1.6

Table 7.13: Use of safe sex items by transgender sex workers

Frequency of use	Frequency (N=66)	Percent (of 66)
Always	50	75.7
Most of the time	5	7.6
Some of the time	4	6.1
Rarely	1	1.6
Never	2	3.2
Not clear	4	6.1

Table 7.14: Frequency of Condom use by transgender sex workers

Frequency of use	Frequency (N=66)	Percent (of 66)
Always	25	37.8
Most of the time	1	1.6
Some of the time	11	16.6
Rarely	4	6.1
Never	9	13.6
Not clear	16	24.2

Table 7.15: Frequency of other safe sex item use by transgender sex workers

Sexual assault and violence: Sexual assault and violence, whether in childhood or in adulthood, may lead to low self-esteem and self-destructive behaviours. The incidence of sexual assault and violence against transgenders has, as far as we researchers are aware, never been quantified before, and our findings indicate the existence of a major area of previously unrecognised sexual abuse and violence. As the tendency seems to be for those survivors of sexual abuse and violence to engage in unsafe behaviours, they are of relevance to HIV prevention. We asked transgenders to list the assaults they had experienced by: (i) type of experience; and (ii) age at which the experience occurred. Our findings are detailed in tables 17.16 and 17.17.

Type of assault	Frequency (N=157)	Percent (of 157)
Rape (Single)	49	33.6
Rape (Pack)	18	12.3
Incest	18	12.3
Sex with other relative	29	19.9
Sex with family friend ('uncle' etc.)	15	10.3
Other sexual assault	28	19.2

Table 7.16: Sexual assaults reported by transgenders

Age	Frequency (N=157)	Percent (of 157)
Under 5	8	5.5
5 - 7 years	13	8.9
8 - 10 years	14	9.6
11 - 13 years	26	17.8
14 - 16 years	22	15.1
17 - 19 years	22	15.1
20 - 25 years	22	15.1
26 - 30 years	11	7.5
31 - 40 years	8	5.5
Over 40 years	3	2.1

Table 7.17: Age at which sexual assault on transgenders occurred

A total of 157 incidents were reported by 71 members of the sample group. A third reported a rape by a lone assailant, while one in eight reported pack rape. About a fifth reported other types of sexual assault. The reported level of child sexual assault (incest, sex with relative/family friend) was over 40%. It is surprising that 40 years of intensive research into transgenders has not discovered this before. This seems to confirm the remarks made in Chapter 2 concerning the lack of social research into the phenomenon of transgender people, and the misplaced focus of much of the research that has taken place.

A distinct pattern of abuse emerges from these figures. From a level of 5.5% of transgenders attacked before they have reached the age of five, the rate climbs steadily and then doubles for ages 11 - 13. This seems to be the peak, from 14 years of age on it drops slightly, maintaining a constant level for years 14 - 25 before starting to drop off slowly.

No significant trends could be established by breaking down the figures for sexual assault and violence into original gender, current gender or operative status. When the figures were considered in terms of sex workers and non-sex workers, it became apparent that transgender survivors of sexual violence were concentrated in the sex worker category. See tables 7.18 and 7.19 for details.

Sexual Assault	Sex workers		Non sex workers	
	Fr (N=66)	% (of 66)	Fr (N=80)	% (of 80)
Rape (single)	28	42.4	21	26.3
Rape (pack)	13	19.7	5	6.3
Incest	13	19.7	5	6.3
Sex with other relative	23	34.9	6	7.5
Sex with family friend	15	22.7	0	0
Other sexual assault	17	25.8	11	13.8

Table 7.18: Sexual assaults reported by transgenders

Age	Sex workers		Non sex workers	
	Fr (N=66)	% (of 66)	Fr (N=80)	% (of 80)
Under 5 years	6	9.1	2	2.5
5 - 7 years	5	7.7	8	10.0
8 - 10 years	11	16.7	2	2.5
11 - 13 years	18	27.3	8	10.0
14 - 16 years	12	18.2	10	12.5
17 - 19 years	13	19.7	9	11.3
20 - 25 years	14	21.2	8	10.0
26 - 30 years	9	13.6	2	2.5
31 - 40 years	5	7.7	3	3.8
Over 40 years	1	1.5	3	3.8

Table 7.19: Age at which sexual assault occurred on transgenders

It is clear from this that among transgenders, sex workers are far more likely to have been sexually assaulted than non-sex workers, and that among the sex workers, street workers are far more likely to have been assaulted than non-street workers, as can be seen on tables 7.20 and 7.21 below. Yet these figures require cautious consideration if they are to be of any use.

These findings strongly indicate that: (i) sexual violence is mostly concentrated in street prostitution; and (ii) those currently engaged in this area of sex work are most likely to have been abused as children. This suggests a life-long pattern of abuse.

Type of assault	All sex workers		Street sex workers	
	Fr (N=66)	% (of 66)	Fr (N=46)	% (of 46)
Rape (single)	28	42.4	19	41.3
Rape (pack)	13	19.7	11	23.9
Incest	13	19.7	9	19.6
Sex with other relative	23	34.8	17	37.0
Sex with family friend	15	22.7	12	26.1
Other sexual assault	17	25.8	10	21.7

Table 7.20: Sexual assaults reported by transgender sex workers

Age	All sex workers		Street sex workers	
	Fr (N=66)	% (of 66)	Fr (N=46)	% (of 46)
Under 5	6	9.1	2	6.5
5 - 7 years	5	7.7	5	10.9
8 - 10 years	11	16.7	8	17.4
11 - 13 years	18	27.3	14	30.4
14 - 16 years	12	18.2	7	15.2
17 - 19 years	13	19.7	10	23.7
20 - 25 years	14	21.2	8	17.4
26 - 30 years	9	13.6	9	19.6
31 - 40 years	5	7.6	4	8.7
Over 40 years	1	1.5	0	0

Table 7.21: Age at which sexual assault occurred on transgender sex workers

In our view it would not be appropriate, however, to interpret these findings as supportive of the views advanced by James (1979) and Silbert (1982) that child sexual abuse pre-disposes a person to prostitution in later life. Such an argument cannot account for the numbers of street workers who have not been assaulted, nor the numbers of non-sex workers who have. Highlighting a single causal factor as pre-disposing people towards prostitution ignores, especially with transgenders, the myriad of other factors (eg. discrimination, economic survival, accessing social networks of other transgenders, to name a few) that might be of relevance. Ultimately, such a argument relies on a pejorative, almost moralistic, view of prostitution that would be rejected by many of the women who engage in this work.

It seems more appropriate to conclude that sexual abuse during childhood could, in certain circumstances, dispose the adult towards situations (of which street prostitution is only one of a host of possible examples) in which the pattern of abuse is likely to be repeated. Whatever view is adopted, this finding seems to have clear implications in terms of HIV/AIDS, for the

existing street outreach and educational programs that are aimed at transgender prostitutes do not, as far as we can ascertain, include components that deal with surviving sexual violence. This is an area that requires attention.

Looking at the broader picture on sexual assault relative to the victim's later social outcome, we made a disturbing discovery. Clearly those who had been victimised were more likely to not only enter prostitution but also to attempt suicide, inject drugs and receive various welfare benefits. Table 7.22 highlights these findings by comparing the percentages of victims with these above negative outcomes against those without them.

Type of assault	Unemploym't		Invalid Ben.		Sickness Ben.		Suicide att.		Inject drugs	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Rape (single)	37.4	27.3	54.2	29.5	45.9	24.7	48.1	25.0	51.4	28.1
Rape (pack)	14.3	9.1	20.8	10.7	19.7	7.1	16.7	9.8	29.7	7.3
Incest	12.1	12.7	20.8	10.7	18.0	8.2	16.7	9.8	18.9	8.3
Sex with other relative	25.3	10.9	25.0	18.9	29.5	12.9	24.1	17.4	27.0	17.7
Sex with family friend	9.9	10.9	16.7	9.0	16.4	5.9	9.3	10.9	21.6	7.3
Other sexual assault	15.4	25.5	33.3	16.4	18.0	20.0	31.5	12.0	10.8	22.9

Type of assault	Street prost		Parlour prost		Private prost		Escort work		Other prost	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Rape (single)	41.3	30.0	45.7	28.0	52.5	26.4	51.6	28.7	16.7	34.3
Rape (pack)	23.9	7.0	21.7	8.0	27.5	6.6	22.6	9.6	33.3	11.4
Incest	19.6	9.0	19.6	9.0	20.0	9.4	25.8	8.7	0	12.9
Sex with other relative	37.0	12.0	41.3	10.0	42.5	11.3	45.2	13.0	50.0	18.6
Sex with family friend	26.1	3.0	26.1	3.0	27.5	3.8	25.8	6.1	0	10.7
Other sex assault	21.7	18.0	21.7	18.0	32.5	14.2	29.0	16.5	50.0	17.0

Table 7.22: Percentages of sexual assault victims with negative outcomes vs those with none

Clearly these findings indicate that transgenders who have been victimised by sexual assault, incest and related abuses are more likely to encounter negative social experiences later in life. But, as we pointed out in relation to sex work, where economic factors play at least as important a role in predetermining a trany to prostitution, so receiving welfare benefits can be the result of multi-factors. Indeed, as the unemployment benefit figures show, recipients of the dole are just as likely to be victims of discrimination as sexual assault. The figures on attempted suicide and drug injecting are not so easily explained away, and these may well be outcomes of individuals who were unconsciously, or even consciously, trying to blot out the memory of an unbearable past experience, such as sexual assault.

Significantly, the greatest disparity between those victims with negative outcomes and those without is seen in the most violent sexual assault, pack rape. On top of her/his gender crossing the transgender who is also a rape victim, welfare beneficiary, intravenous drug user, suicidal and sex worker faces enormous social contempt and discrimination at all levels. It is little wonder to find that those transgenders most at risk of HIV infection are those with the greatest number of these negative social experiences.

In addition, these findings ought to be considered against a background where transgenders report that discrimination from the police is one of the most common forms of discrimination

they encounter, and discrimination from doctors and medical service providers is also commonly reported (see Chapter 9). Anecdotal evidence gathered by we researchers suggests that most assaults are not reported to the police and that those assaults reported are dealt with in a manner that transgenders find almost universally unsatisfactory.

There are no transgender-specific rape, assault or incest recovery services in Australia. Transgenders report varying welcomes at existing female-oriented services. There is clearly a need to develop transgender-sensitive recovery services. In terms of HIV, the reinforcement of negative self-image and low levels of esteem by both the assaults and the non-attention of the relevant services to the needs of assaulted transgenders, is of concern. These figures are alarming and require immediate attention by the relevant authorities.

There is also the unresolved question as to what motivates such assaults. While it is perfectly likely that quite different motivations exist for childhood and adult assaults, there is simply no adequate data on the matter. Consequently, we cannot make any firm findings about the nature of violence against transgenders. It is not possible to determine whether, for example, the assaults that have been found to occur on transgenders are motivated by misogyny, homophobia, a mixture of the two, or an entirely different phenomenon. Nor is it possible, within the scope of this study, to determine, or even shed any light on, the total levels of violence against transgenders. Further research is needed to clarify the issues surrounding assault and violence (both sexual and otherwise) against transgenders.

Conclusions: Our findings indicate that, in the area of sexual behaviour, the transgender population is characterised by its diversity. Less than half of our sample identified as heterosexual suggesting that there is no singular transgender sexual identity or practice. Many transgenders practice sexual activities that are high risk in terms of HIV/AIDS, when unprotected. This knowledge can be integrated into transgender-specific HIV/AIDS awareness and prevention programs.

Reliance on sex work is, for many transgenders, a fact of life and one that is unlikely to change without a concerted effort to re-integrate transgenders into mainstream society. The need for universal adherence to safe sex practices within the sex industry is self-evident. Currently, practices among transgender sex workers fall well short of this goal.

A major area of sexual abuse and violence has been identified. Those abused and assaulted are likely to be living in circumstances that maximise the possibility of repeat assaults and abuse. Those abused and assaulted have no transgender-specific support services to enable recovery and existing services are not considered transgender-friendly. This situation requires urgent remedies.

The level of safe sex practice requires improvement. Despite reasonable awareness of safe sex practices, these are not being internalised by sections of the transgender population. It is likely that the cause of this failure to internalise safe sex practices will be located in the hostility that many sections of society express towards transgenders.

8. SURVEY RESULTS: HEALTH ISSUES

In this chapter we will investigate the various health issues and factors relating to health and welfare in the transgender population. Data on these issues should indicate to what degree and in what areas of health tranys are potentially at risk of infection with HIV and STDs. Also, we will look at other health matters that may be important to transgenders, and gauge the extent and source of knowledge on HIV and other diseases. And, finally, the transgender sample is given the opportunity to express how they feel existing health services might be improved.

Sexually Transmissible Diseases: Most of the sample had been infected by one or more of these kinds of infections. Table 8.1 indicates which diseases were most prevalent.

Disease	Frequency (N=146)	Percent (of 146)
Syphilis	8	5.5
Gonorrhoea	20	13.7
Chlamydia	5	3.4
Trichomonas	2	1.4
Non-Specific Urethritis (NSU)	15	10.3
Pelvic Inflammatory Disease (PID)	1	0.7
Gardnarella	1	0.7
Genital Herpes	4	2.7
Genital Warts	8	5.4
Pubic Lice	33	22.6
Thrush	25	17.1
Hepatitis B	17	11.6
Hepatitis C	8	5.5
HIV	1	0.7
AIDS	0	0
AIDS Related Illness	0	0
Other	0	0
Never had any of the above	59	40.4

Table 8.1: Sexually transmissible diseases contracted by transgenders

The highest incidences of infections are with pubic lice and thrush, both of which are little more than annoying irritants which can be cured easily, and can also be contracted non-sexually. More worrying are the high incidents of gonorrhoea and hepatitis B, the latter being notable for its transmission by contaminated needles and no doubt due to the high level of intravenous drug use by the sample. While, on the one hand, we found over 40% of the sample never having been infected by an STD, on the other, 44% contracted a disease directly attributable to sexual contact. This is due, no doubt, to the frequency of unsafe sexual practices pointed out in the previous chapter. As a comparison it might be worthwhile mentioning a recent study on the sexual health of female prostitutes in New South Wales, in which 16% had had gonorrhoea, 2% syphilis, 20% chlamydia, 13% trichomonas, 8% NSU, 9% PID, 13% herpes, 16%

warts, and 8% hepatitis B (Lovejoy et al 1991). The transgenders were only slightly less infected, but with such potentially lethal diseases as syphilis and hepatitis B they were considerably more so. Also, whilst none of the prostitutes had contracted HIV, one of the transgenders was infected by this virus. As we will see in chapter 10 this solitary case is by no means representative of tranys with HIV.

In figure 10 below are shown the sources of infection of the 87 tranys who reported being infected with an STD. The clients of the 66 tranys who were involved in prostitution made up little more than a fifth of these sources, while spouses, permanent and casual lovers and brief sexual acquaintances together made up almost three-quarters. This strongly indicates that sex work is not the major contributor of STDs often assumed by the general public. It also indicates that regular sex partners (permanent lovers and spouses), who comprise a third of the infectious sources, are no more a guarantee against infection than temporary liaisons (casual lovers and one night stands), who comprise over 40%.

Figure 11 indicates the frequency of recurring infections. Nearly a half of the infected tranys never caught a disease more than once, while a few were either highly contagious or, more likely, practiced a great deal of unsafe sex (see chapter 7).

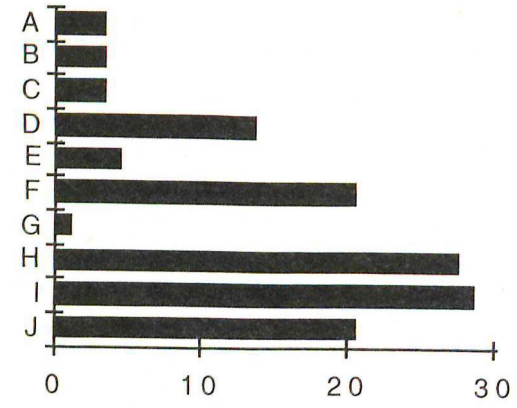

Figure 10: Source of STD infections (N=87)

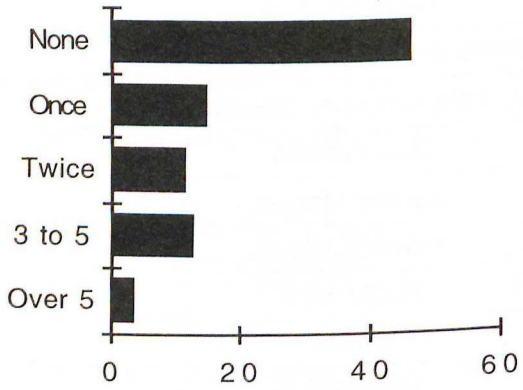

Figure 11: Number of diseases had more than once (N=87)

Key: A=drugs; B=children; C=rapist; D=casual lover; E=spouse; F=not through sex G=incest; H=one night stand; I=permanent lover; J=client of sex workers

Drug Usage: Our study reveals that tranys consumed large quantities of drugs, legally and otherwise. Table 8.2 compares drugs taken in the past with those used at present.

In every case drug consumption has decreased from the past into the present. This is an encouraging sign that tranys are increasingly finding ways of coping with the general social resistance towards gender crossing by means other than through drug insensitivity. Even smoking, which was considerably higher in our sample than the national average (ABS 1992:101), has now been reduced to well below it. All the "hard drugs", such as cocaine, heroin and speed, were also in much higher use than in the general population. For example, whilst 15% of our sample has used heroin, only 2% of the general population had ever tried it (Dept Health, Housing & Community Services 1992:32). Similar figures exist for cocaine (19% v 3%) and speed (32% v 8%). But, as the present figures clearly indicate trany consumption is now much closer to the national usage. Drinking also follows much the same trend. Whereas the proportion of "heavy" or daily trany drinkers in the past was well over a third of the sample, the

national average was 14% for men and 8% for women (ibid:12), whilst the present daily consumers of alcohol in the sample compares favourably with this average.

Drug	In the past (N=146)		At present (N= 146)	
	Fr	%	Fr	%
More than 30 cigarettes a day	48	32.9	25	17.1
11 - 30 cigarettes a day	40	27.4	35	24.0
Less than 10 cigarettes a day	13	8.9	10	6.8
Non-smoker	34	23.3	55	37.7
Prescribed tranquillisers	42	28.8	21	14.4
Prescribed anti-depressants	33	22.6	17	11.6
Prescribed barbiturates	22	15.1	10	6.8
Prescribed amphetamines	15	10.3	7	4.8
Other prescribed pills	46	31.5	41	28.1
Marijuana	78	53.4	58	39.7
Ecstasy/MDA/Special K etc	45	30.8	20	13.7
LSD/Acid/Trips etc	22	15.1	19	13.0
Amyl nitrate	40	27.4	20	13.7
Speed	47	32.2	24	16.4
Methadone	5	3.4	1	0.7
Heroin	22	15.1	7	4.8
Cocaine	28	19.2	8	5.5
Crack/Ice	6	4.1	2	1.4
More than four drinks a day	43	29.5	8	5.5
More than one drink a day	12	8.2	10	6.8
More than a few drinks a week	37	25.3	28	19.2
At least one drink a week	9	6.2	24	16.4
Less than one drink a week	14	9.6	30	20.5
Never drink	12	8.2	24	16.4
Other	6	4.1	2	1.4

Table 8.2: Drugs used by transgenders

The implications for AIDS in these drug figures is obvious. Intoxicated or "stoned" transgenders are likely to practice unsafe sex much more readily than their sober counterparts. But, it is in the use of intravenous drugs where the problem is most acute. Forty four (30%) of the sample indicated having ever used drugs intravenously. Of these only three claimed to have shared a needle with another person within the past three months, whilst over three-quarters of the needle users had never shared a needle. Table 8.3 shows these findings.

Period	Frequency (N=44)	Percent (of 44)
Within last 24 hours	1	2.3
Within the last week	2	4.5
Within the last year	0	0
Within last five years	5	11.4
Less often	7	15.9
Never shared	29	65.9

Table 8.3: Last time transgender needle users shared a needle

Whilst intravenous drug use amongst transgenders is considerably higher than the rest of the population, it appears that two-thirds of them have avoided the risks inherent with sharing needles. In this respect they resemble the pattern seen in the figures on condom usage in chapter 7. But, since most of the needle sharers have not shared a needle with another person for more than a year the risk of HIV infection is minimal. However, we have no way of determining the HIV status of all 15 tranys who have ever shared a needle, and unless they themselves have undergone tests recently they too may not be aware of it. But, if we assume that like many concerned needle users they have sought HIV screening then at least one has been infected and possibly four, including the three users who have shared needles up to a week before they took part in this study.

Problem	Frequency (N=146)	Percent (of 146)
Stress	91	62.3
Chronic fatigue syndrome	16	11.0
Emotional problems	51	34.9
Bad diet	49	33.6
Infections other than STDs	3	8.9
Depression	65	44.5
Isolation	36	24.7
Physical problems	21	14.4
Lack of exercise	43	29.5
Loss of sexual pleasure	43	29.5
Other	12	8.2
None	6	4.1

Table 8.4: Other health problems of transgenders

Other Health Problems: Table 8.4 above shows a list of general health problems, apart from STD infections and drugs, experienced by the tranys in our sample. Certain problems, such as chronic fatigue and loss of sexual pleasure, are related to street sex working, although the latter is also not uncommon with postoperative tranys. A street lifestyle is not particularly healthy in that bad diet and infections other than STDs are often associated with it. However, those problems experienced by a third to two-thirds of our sample, such as stress, emotionality and depression are probably closely related to the societal attitudes towards gender crossing.

The stressful lives most tranys are forced to endure due to family rejection, public ridicule, loss of friends, official and legal insensitivity, and many other everyday social responses discussed more fully in chapter 9 have a detrimental effect on the individual's health. Some will respond to their stress and depression by isolating themselves from the rest of society, while others will end it by taking their own lives. These psychological conditions which are idiosyncratic with most people and easily overcome by changes in lifestyle or personal attitudes, are often insurmountable with transgenders and because their causes are external they may only be overcome with changes in widespread social attitudes. One need only compare the dispirited condition of most tranys in western society, where they have the lowest status, to the confidence and contentment of transgenders in, say, traditional Navajo (Hill 1935) or Cheyenne (Hoebel 1960) societies, where they have the highest status, to appreciate the causal effects of general health problems in our sample.

Health And Medical Services: With such high levels of health problems indicated above and earlier in this chapter, as well as a dependence on the medical profession by those seeking hormonal and surgical treatment (see also chapter 9), it is not surprising to find a heavy use of health and medical services by the transgender population. Table 8.5 lists the medical services used by our sample and the reasons for using these services is seen in table 8.6.

The frequency of visits to these medical services is shown in table 8.7.

From these tables it can be seen that hormonal and genital realignment treatments dominated the medical visits of many transgenders. Visits to an endocrinologist and psychiatrist in relation to this can be as frequent as monthly. Apart from these, STD and HIV check-ups, mostly by the sex workers, are also undertaken regularly, as frequent as weekly in the case of STD screening. Of interest is the finding that nearly a third of the sample sought general counselling, which obviously relates to the high levels of stress, emotionality and depression suffered by many in our sample. The high number seeking medication with prescribed drugs may partly reflect this as well.

Since tranys are heavy users of medical and health services it was assumed that they would be ideal critics of these services. Therefore, we asked the sample to suggest how these services might be improved. The results are seen in table 8.8.

Service	Frequency (N=146)	Percent (of 146)
General practitioner	131	89.7
Sexual health clinic	28	19.2
Community health centre	14	9.6
Community nurse	2	1.4
Psychologist	20	13.7
Psychiatrist	54	37.0
Endocrinologist	59	40.4
Plastic surgeon	35	24.0
Urologist	7	4.8
Alternative therapist	11	7.5
Other	4	2.7

Table 8.5: Medical services used by transgenders

Reason	Frequency (N=146)	Percent (of 146)
STD check-up	39	26.7
HIV treatment	6	4.1
HIV check-up	39	26.7
Genital realignment (sex change)	56	38.4
Psychiatric assessment	43	31.5
General counselling	46	31.5
Dependency problems	6	4.1
Methadone treatment	2	1.4
Prescription drugs	61	41.8
Hormones	113	77.4
Cosmetic surgery	24	16.4
Other therapy	5	3.4
Other	11	7.5

Table 8.6: Transgenders' reasons for using medical services

Frequency of visits	Frequency (N=146)	Percent (of 146)
Once a week	16	11.0
Once a fortnight	25	17.1
Once every three weeks	14	9.6
Once a month	25	17.1
Every two to six months	38	26.0
Every six months to one year	16	11.0
Less often than yearly	5	3.4
Never	1	0.7
Unknown	6	4.1

Table 8.7: Frequency transgenders visit medical services

There are a number of areas which the sample felt needed improving, most notably those concerned with improving interracial relations and attitudes towards sex workers and transgenders. The issue of attitudes towards tranys relates back to the general health problems due to discrimination discussed earlier in this chapter (and more fully in chapter 9). This is reflected in nearly three-quarters of the sample requesting greater sensitivity to trany issues from the health professionals, as well as two-thirds suggesting the employment of more tranys in the health services. For the street people the health services can reach their operative maximum with more outreach services and more flexible hours, such as those offered by Kirkton Road Centre in Kings Cross.

Improvement	Frequency (N=146)	Percent (of 146)
More outreach services	62	42.5
More flexible hours in services	55	37.7
Separate needle exchange & sexual health	28	19.2
Improved efficiency in handling check-ups	39	26.7
More multi-racial staff	35	24.0
More tranys in the health services	94	64.4
Condoms more readily available	41	28.1
More sensitivity to trany issues	107	73.3
Improved attitudes towards sex workers	53	36.3
Other	11	7.5

Table 8.8: Suggestions by transgenders for improving health services

HIV Education: Much of the problems of risk behaviours in sexual and intravenous drug practices may be related back to a lack of education on transmission. We asked the sample a number of questions on this issue. The presumption here is that the better educated a person is the less likely they are to practice risky behaviours. But this is not always the case and risky practices should also be correlated with self-esteem and idiosyncratic responses to discrimination issues. Table 8.9 indicates where tranys obtain their information on AIDS and STDs in general.

Source	Frequency (N=146)	Percent (of 146)
Sex industry	29	19.9
Sexual health clinics	25	17.1
Needle exchange services	14	9.6
Gay health services	24	16.4
Pamphlets	56	38.4
Friends/Relatives	28	19.2
School/University	14	9.6
General practitioners	72	49.3
Community health services	25	17.1
Outreach services	23	15.8
Other health services	6	4.1
Media (TV, radio, newspapers)	62	42.5
Regular sex partners	8	5.5
Women's health centres	6	4.1
Other	12	8.2

Table 8.9: Sources of information on AIDS and STDs for transgenders

Once again there is a heavy dependence on medical personnel for this information, but it is interesting to note that general practitioners were relied on more often than specialist services such as sexual health clinics, gay health services, outreach and needle exchange services, which are likely to know a great deal more about HIV and STD transmission than the average doctor. Street people, who are usually inundated with pamphlets will have found this medium a reliable source of information. But, it is disturbing to note the heavy dependence on the popular media, the sex industry and friends and relatives for information, although it is a relief to see so few relying on their regular sex partners for information. The high frequency of unsafe sex with regular sex partners noted in chapter 7 was due to a trust in fidelity rather than lack of knowledge.

Actual advice on AIDS and STDs, as opposed to merely receiving information, was sought more often from one's own doctor and less from non-professional sources of information, as figure 12 indicates. The heavy reliance on medical personnel continues to dominate in this issue.

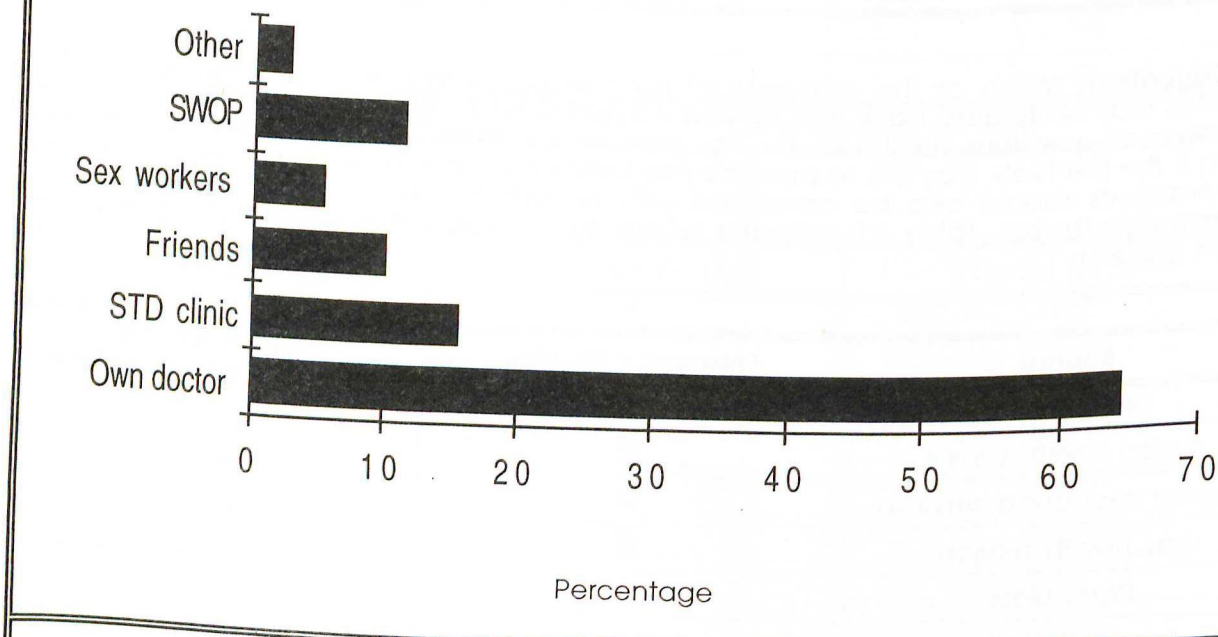

Figure 12: Source of advice on AIDS and STDs

To test the validity of the tranys' sources of information on AIDS we asked the sample to describe the means by which they felt HIV is transmitted. The results may be seen in table 8.10 below. It appears that most tranys possessed a fairly good knowledge on this subject. A small number were still uncertain, as the responses to masturbation, spas, kissing, hand relief, cutlery and/or crockery, merely working with HIV positive sex workers, and sex with a condom implies. Since there was a generally good understanding of HIV transmission, the high level of unsafe sex noted in chapter 7 is puzzling. One explanation here is probably found in the tranys' emotional responses to sexual activities with their sex partners.

Means of transmission	Frequency (N=146)	Percent (of 146)
Oral sex with a condom/dam	7	4.8
Oral sex without a condom/dam	79	54.1
Anal sex with a condom	7	4.8
Anal sex without a condom	133	91.1
Vaginal sex with a condom	7	4.8
Vaginal sex without a condom	123	84.2
Hand relief	3	2.1
Kissing	4	2.7
Masturbation	2	1.4
Touching	0	0
Sharing a spa	5	3.4
Sharing cutlery/crockery	3	2.1
Working with a HIV+ sex worker	3	2.1
Sharing needles	126	86.3

Table 8.10: Transgenders' knowledge on HIV transmission

Health Issues in Accordance with Demographic Trends: We thought to test the sample's responses to health issues by comparing age, gender at birth and environment to ascertain what differences might exist between the various demographic groups. We found that age was a significant factor in STDs in that the older tranys had contracted more diseases than the younger members of the sample. For instance, a third of the 51-60 year olds had contracted syphilis and gonorrhoea, compared to only 12.5% and 20.8% of the 31-35 year olds, respectively. Or, 27.3% of the 46-50 year olds had been infected with hepatitis B compared to only 16.7% of the 31-35 year olds. These findings should not surprise too many since the older one lives the greater the risk of infection through sexual transmission. In comparing the genders at birth we found that those tranys assigned male at birth (N=129) were infected much more often than those assigned female (N=14), only one of whose members had ever been infected, ie. with syphilis, gonorrhoea, trichomonas, chlamydia, NSU and hepatitis C. As for environment, it seems that refuge inmates and dwellers in rented premises were slightly more likely to be infected, except in the case of hepatitis B. We found that 27.3% each of refuge inmates and housing commission occupants had been infected with this disease, compared to a third of those tranys buying their own homes. We are at a loss to offer an explanation for this phenomenon.

With regard to present drug use we found a much lower demographic differentiation. The environment was a significant factor only with certain drugs. For instance, the home owners and buyers were hardly differentiated from the refuge inmates and rental dwellers in their extent of smoking cigarettes and in using cocaine, whereas they tended to use less heroin and marijuana, while both groups drank slightly less alcohol than the housing commission occupants. Gender at birth was significant in that many more tranys assigned male at birth smoked and indulged in "heavy" drugs than those assigned female, whereas both groups were compatible in their drinking habits. Age, on the other hand, was a much more definite factor. While no tranys over the age of 45 smoked, between a quarter and 40% of those aged 21-35 and 43% of those aged 36-40, compared to only 6% of 41-45 year olds, smoked in excess of 30 cigarettes a day. This age difference is even more dramatic for smokers of between 11 and 30 cigarettes a day. Twice the proportion of tranys between 21 and 40 consumed marijuana than those over 40, while even greater proportions of 20 year olds used cocaine,

heroin and "speed" than tranys 30 or more. It is hard to know what is happening here, but it seems that younger tranys in temporary residences are more likely to indulge in the "heavier" illegal drugs, probably in response to youth cult trends and peer pressure as much as anything else.

Finally, the question on HIV/AIDS knowledge was raised in accordance with the above demographic trends. The findings can be seen in table 8.11 below. It would appear that there is very little difference between age groups, the genders at birth and the tranys in various residential patterns. However, where the knowledge was found to be poor was among the younger rather than the older tranys, and among those living with peers, such as in shared rented accommodation and refuges, and those in relative isolation, such as living alone in a housing commission home or their own home. However, these are the exceptions rather than the rule in the overall sample, which has a good knowledge on HIV transmission.

(N=146) Age	con-dom used	oral sex with con-dom	oral sex without con-dom	anal sex with con-dom	anal sex without con-dom	coitus with con-dom	coitus without con-dom	kissing	share needle	sharing spa
16-20 (3)	0	0	66.7	0	66.7	0	66.7	0	66.7	0
21-25 (23)	56.5	8.7	69.7	0	95.7	0	78.3	0	91.3	4.3
26-30 (37)	64.9	2.7	51.4	5.4	91.9	2.7	81.1	0	81.1	2.7
31-35 (24)	41.7	8.3	54.2	8.3	83.3	8.3	87.5	4.2	83.3	8.3
36-40 (23)	60.9	4.3	47.8	4.3	95.7	13.0	91.3	8.7	95.7	4.3
41-45 (17)	58.8	5.9	47.1	11.8	88.2	5.9	76.5	0	82.4	0
46-50 (11)	54.5	0	54.5	0	90.9	0	90.9	9.1	81.8	0
51-60 (6)	50.0	0	33.3	0	100.0	0	100.0	0	100.0	0
60 + (2)	0	0	100.0	0	100.0	0	100.0	0	100.0	0
Gender at birth										
Female (14)	35.7	0	57.1	0	85.7	7.1	85.7	0	85.7	0
Male (129)	58.1	5.4	55.0	5.4	92.2	3.9	86.0	3.1	87.6	2.3
Accom-modation										
Refuge (11)	72.7	9.1	54.5	9.1	90.9	0	81.8	0	90.9	0
Rented (58)	56.9	0	56.9	5.2	93.1	3.4	86.2	1.7	86.2	0
Share (18)	50.0	5.6	50.0	0	88.9	11.1	83.3	5.6	83.3	0
Friends (10)	50.0	0	30.0	0	100.0	0	90.0	0	90.0	0
H'Comm (11)	54.5	9.1	54.5	9.1	90.9	0	72.7	0	81.8	0
Buying (6)	50.0	16.7	33.3	0	50.0	0	66.7	0	66.7	0
Own Hm(22)	50.0	9.1	59.1	4.5	100.0	0	90.9	4.5	95.5	0

Table 8.11: HIV/AIDS knowledge of transgenders according to demographic trends

Conclusion: In this chapter our findings indicate that transgenders have a high level of sexually transmissible diseases but with a relatively low incidence of recurrence. Most of these infections were contracted from non-commercial sex partners. Drug use was very high in the past, but its usage considerably declined in the present. Although more than a quarter of the sample have used intravenous drugs the recent rate of needle sharing is very low. For STD and drug treatment, as well as hormonal treatment and genital realignment, tranys have a heavy reliance on medical services. They also depend predominantly on the medical profession for information and advice on STDs and AIDS, despite a number of health services being better equipped as reliable custodians of this knowledge. Dependence on much less reliable sources such as the media, friends and the sex industry is also high. A great many tranys recognise problems with existing health services, but these relate mostly to an inability of personnel in these services to understand gender crossing issues.

In general, transgenders suffer with much greater health problems than the community at large, but much of this is related to social attitudes to crossing gender and society's inability to deal with it as a variance of normal human behaviour. The outcome then leads to a number of health problems, most directly stress, depression and emotional instability. Indirectly these may in turn lead to drug addiction to avoid confronting transgender social issues, and to unsafe sex practices as part of an emotional need to develop less tenuous relationships than with commercial sex clients, one-night-stands and casual non-transgender lovers.

9. SURVEY RESULTS: TRANSGENDER ISSUES

The purpose of this Chapter is to examine those areas of transgender social interaction that are specific to tranys. We asked questions about "sex change" surgery and related surgeries, transgender men's and women's opinions of the medical service providers, their relations with their families, the extent of the discrimination they experienced and what measures they felt could best be employed to try to remedy their situation.

As far as is known by us researchers, no serious attempts have been made to quantify the types, locations and levels of discrimination against transgenders. As was pointed out in chapter 2, the literature in this area is dominated by medical researchers, whose focus tends to be narrower than that adopted by this study. Even within this paradigm, the impact of broader social issues on individual health, and on methods of resolving transgender issues tend to be overlooked.

Within an HIV context, it is important to establish degrees of variance between genitally intact and genitally reconstructed transgenders, since such matters as their needs in relation to HIV/AIDS might be quite different. Would existing transgender-oriented medical services be an appropriate conduit for dissemination of HIV/AIDS education and prevention? The overall credibility of transsexual medical service providers would seem to be an important factor in answering this question. If these avenues are not seen as effective, then we are obliged to explore other avenues that might offer a more fruitful and promising prospect.

Within this context, it is also important to try to establish the exact nature of the relations between transgenders and their social milieu. Earlier in this report we remarked that HIV prevention strategies were not being internalised by the target group. By examining their relations with, say, their families, their peers, the wider community, and the medical personnel involved in the transsexual process, we might be able to locate where the problems of interaction and how these might be rectified. If, for instance, the HIV prevention messages are not having an impact, is it because of the transgender's desperate need to maintain a love relationship at any cost, or is due to loneliness which drives the transgender to seek companionship in dangerous company, such as a drug clique involved in sharing needles and unsafe sexual practices in transient and dubious liaisons?

Crossing Gender and "Sex Change": As we pointed out on page 2 our sample consists of people of both sexes who have crossed gender, or are in the process of doing so. However, 20 of our respondents felt uncertain whether they were far enough into the process to consider themselves as having actually changed their gender. The remaining 126 responded to our question on age of gender crossing, the results of which may be seen in table 9.1.

Age	Frequency (N=146)	Percent (of 146)
Under 13	4	2.7
14 - 17	18	12.3
18 - 20	12	8.2
21 - 25	30	20.5
26 - 30	27	18.5
31 - 35	12	8.2
36 - 40	10	6.8
41 - 50	12	8.2
51 - 60	0	0
Over 60	1	0.7

Table 9.1 : Age at which the sample group changed their gender

Almost 40% of the group changed their gender during their years 21-30. Outside of the 20s there appears to be a roughly uniform distribution, from the four people who were under 13 when they changed their gender to one who was over 60.

We asked the sample to tell us whether they had undergone genital reconstruction surgery or not. Only 38, or just over a quarter of the sample, had done so. One hundred (69%) had not had a "sex change" and the remaining eight (6%) failed to answer. What is immediately clear is that although over two-thirds of the sample had not undergone surgery, a considerable proportion of the rest was either undergoing assessment or considering surgery at the time of the study. However, according to some practitioners, only about 30% of those who undertake the process will see it through to its completion (Morgan 1978; Lothstein 1980). This finding is in line with those of Alan et al (1991), who found that approximately 80% of their sample group were genitally intact. Both of these findings are at considerable variance with the popular impression that all transgenders undergo surgery, and it is therefore important to develop strategies that will address the target group's real needs as opposed to their perceived needs.

Fifteen (10.3% of 146) transgenders in our sample underwent surgery in Sydney, 14 (9.6%) in Melbourne, four (2.7%) in Adelaide, two (1.4%) in Brisbane, two in Colorado USA and one in Morocco. Twenty-one of these postoperative tranys were between 21 and 30 years old at the time of the surgery, eight were between 31 and 40, and eight were over 40 (one failed to indicate). We asked those who had surgery to compare the outcome with their expectations. A wide range of views were received. Only 14, or 37% of the postoperatives, reported unequivocally positive outcomes, whereas a further nine (24%) reported mildly positive outcomes or seemed ambivalent, and 10 (26%) were definitely disappointed with the results (five provided no answer). These findings are at variance with a claimed surgical success rate by transsexual medical practitioners of approximately 80% (Walinder & Thuwe 1975; Walters & Ross 1985:147).

A total of 40 corrective surgeries were reported by those who underwent genital reconstruction surgery, an average slightly in excess of one corrective operation for each genital reconstruction operation performed. Figure 13 indicates the proportions and types of these corrective surgeries. These figures do not correspond with those usually presented in the literature such as McEwan et al in Walters & Ross (1985) who reported 17 "complications" in 68 cases, or a quarter of all their operations.

While it ought to be noted that the criteria for establishing success may vary from study to study, and in the case of our research, from individual to individual, our findings seem to suggest that the focus on surgical measures as a means of resolving transgender issues is misplaced, ignored by most transgenders and of value to a limited number within that group. However, it must be borne in mind that among the minority of transgenders who successfully undergo surgery, its importance should not be underestimated.

We asked the entire sample which surgeries apart from the "sex change" operation had they undergone. A total of 100 such surgeries were undertaken by a third of the sample. The results may be seen in figure 14 above. Apart from such minor operations as electrolysis, which is almost mandatory among many tranys, and perhaps breast enlargement, which too is considered essential by many since hormones alone do not produce satisfactory bosoms, some of the others may seem excessive, or unnecessary. Indeed, some people have been overtly critical about the amount of surgery transgenders commit themselves to (see, for instance, Raymond 1979). However, it should be realised that these surgeries are an individual decision often undertaken in efforts to relieve public ridicule and social contempt by successfully "passing" in the new gender. In a more tolerant society, ie. one which freely accepts gender crossing and does not define its genders by strictly genetic characteristics, such excesses may not be necessary. In any case these "other surgeries" are not typical of transgenders.

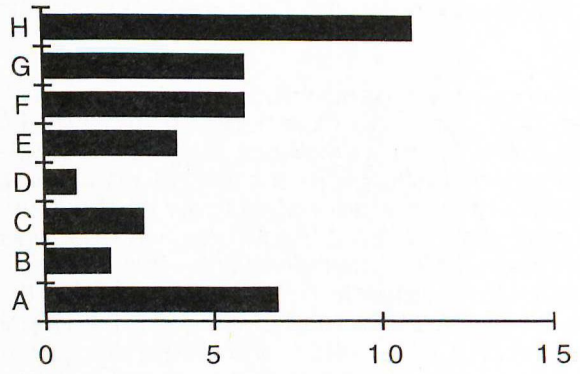

Figure 13: Corrective surgeries

A=bowel resection
B=skin graft rejection
C=labial surgery
D=clitorectomy
E=vaginal enlargement
F=scar tissue removed
G=urinary tract
H=other

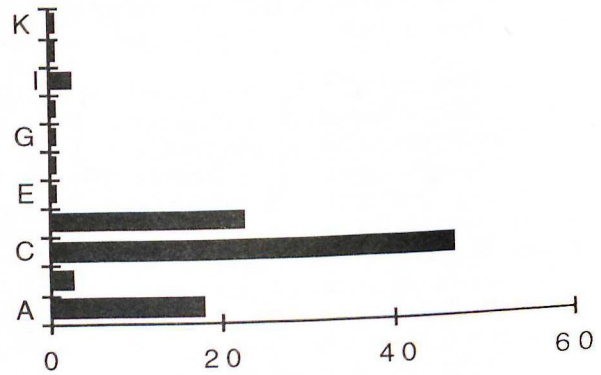

Figure 14: Other surgeries

A=nose job
B=adams apple reduced
C=electrolysis
D=breast enlargement
E=hip implant
F=dermabrasion
G=facelift
H=eyes lifted
I=chin reduction
J=lipectomy
K=other

With these surgeries and the above negative reactions to genital reconstruction surgery in mind, it would seem that transgenders' opinions of medical service providers are worth examining. We asked the sample to indicate whether they felt the medical service providers they saw were satisfactory or unsatisfactory. Table 9.2 lists their responses.

Medical professional	Satisfactory (N=146)		Unsatisfactory (N=146)		No response (N=146)	
	Fr	%	Fr	%	Fr	%
General Practitioners	106	72.6	21	14.4	19	13.0
Endocrinologists	70	47.9	23	15.8	53	36.3
Psychiatrists	60	41.1	44	30.1	42	28.8
Urologists	24	16.4	11	7.5	111	76.0
Surgeons	59	40.0	20	13.7	67	45.9
Psychologists	38	26.0	24	16.4	84	57.5
Nurses	68	46.6	15	10.3	63	43.2
Other	7	4.8	2	1.4	137	93.8

Table 9.2: Transgenders' responses to medical professionals

What seems to emerge from this table is that the performance of general practitioners and other non-specialist service providers is generally regarded as satisfactory. This seems to confirm our findings elsewhere (see chapter 8). Overall, one gets the impression that the everyday supply of medical services, including prescriptions for hormones, STD check-ups, general counselling, and general health needs by doctors, were considered satisfactory. However, opinions on the performance of specialised transsexual medical service providers (psychiatrists, endocrinologists, surgeons, etc.) were less positive. Given the amount of time many transgenders spend with medical specialists, and the high regard in which they are held by many tranys, one might assume that these specialists would be an ideal outlet for the dissemination of HIV/AIDS education and information on prevention strategies. However, their confined role in the "sex change" process and high consultation costs, as well as the existence of better informed AIDS agencies, suggests that it would be more appropriate for transgenders to seek the assistance and support from these agencies on issues relating to AIDS rather than the specialists, and medical practitioners for that matter.

To finalise the question of gender crossing, we asked the sample to nominate whether a range of social activities they were engaged in had increased, decreased or remained steady as a result of their gender change. The areas covered were: attending parties, theatre, cinema, going to restaurants, club memberships, other social life and social activities. No clear trends emerged however. Rather, there seemed to be a relatively even division between all three responses. However, three times as many transgenders reported a decrease in sports activities over those reporting an increase, with approximately 30% reporting a decline in going to the beach, as opposed to approximately 17% reporting an increase. These figures seem to underline earlier findings (see Chapter 8) about the lack of physical exercise among transgenders.

Discrimination: It may come as a surprise to learn that virtually no reliable data on the extent of discrimination against transgenders has been recorded. We asked those in our sample who had experienced some discrimination to nominate who discriminated against them, where this discrimination occurred, how often it occurred and what strategies they considered might help end these discriminations (tables 9.3- 9.6 below).

It would appear from the figures in tables 9.3 and 9.4 that almost all sections of society practice discrimination against tranys. That about 40% of our sample found their own families discriminating against them is startling, and perhaps ought to be read in conjunction with the figures below on isolation, family separation and suicide attempts. It is also unfortunate that gays, so often the victims of discrimination themselves, rated so highly as discriminators. This has implications for HIV/AIDS, for it cannot be expected that safe living materials aimed at gay males will necessarily carry any credibility with transgenders.

The sample's reported levels of discrimination by Government employees (public servants were nominated by almost a third of the sample and the Police were nominated by more than a third) is cause for concern. The high incidence of reports nominating police officers suggests a level of contact with law enforcement agencies well above the average. This would be in line with the experiences of other marginalised groups, such as Kooris. Transgender prostitutes have been a particular target of police harassment over the years, perhaps even more so than female and male sex workers. Perkins (1983:135-36) points out that in the early 1980s the tranys were singled out for attention from police and residents of Darlinghurst much more often than the other prostitutes in an area bristling with streetwalkers of all kinds.

Particularly unfortunate is the incidence of reporting professionals, such as doctors (16%), lawyers (10%) and ministers of religion (21%), as discriminators. It would seem that transgenders are victimised even when they seek medical, legal and spiritual assistance. The support services which other citizens find invaluable are not, it seems, available to transgenders without the same kind of judgemental attitude familiar to lay sections of society. Nor does there seem to be a class bias in discriminating against transgenders - employers rated 25% while fellow-workers rated 23%. Men in general (36%) rated more highly than women in general (15%), though it is impossible to say how much of this is due to a social tolerance of male assertion and a social insistence on female reticence.

Discriminator	Frequency (N=146)	Percent (of 146)
Neighbours	30	20.5
Friends	47	32.2
Fellow-workers	33	22.6
Gays	59	40.4
Men in general	52	35.6
Doctors	24	16.4
Lawyers	43	29.5
Public Servants	43	29.5
Religious Ministers/Congregation	30	20.5
Family	58	39.7
Employers	37	25.3
Other tranys	32	21.9
Lesbians	20	13.7
Women in general	22	15.1
Other health professionals	17	11.6
Police	50	34.2
Shopkeepers/Restaurateurs	33	22.6
Other	20	13.7

Table 9.3 : Who discriminated against transgenders

Not only does it seem that everyone practices discrimination against transgenders, but also this discrimination occurs just about everywhere. The Police Department, gay venues, the workplace, friends' and the family home were also specified as sites where discrimination had occurred by more than a quarter of the sample. Given the extreme difficulty transgenders experience in finding employment (see page 22, Chapter 6), it is not surprising to find nearly a third of our sample reporting experiences of discrimination in the workplace. Not that those who are unable to find employment fare any better, for one in five reported discrimination at the Department of Social Security and one in six reported it at the Commonwealth Employment Service. It is difficult to understand why such ongoing discrimination practiced by public officials in the performance of their duties is allowed to persist, given their responsibilities towards the public.

The figures in table 9.5 are simply staggering and are obviously the result of narrow attitudes by most Australians, with 37% of the sample reporting systematic (ie. once or more often per week) discrimination and only 12% reporting no experiences of discrimination. The discrimination appears to have taken place everywhere and seems to have been practiced by all sectors of the general community. With such almost total discrimination AIDS educators have an almost impossible task of devising successful strategies for transgenders to internalise safe living practices unless serious attempts are made to redress the systematic marginalisation of tranys. The case for immediate and effective anti-discrimination laws seems incontestable.

Place/Situation	Frequency (N=146)	Percent (of 146)
Family home	49	33.6
Friends' homes	39	26.7
Trany venues	29	19.9
Lesbian venues	12	8.2
Legal services	15	10.3
Dept Social Security	30	20.5
Welfare offices	15	10.3
Other Government offices	29	19.9
School/Tech/University	26	17.8
Public transport	27	18.5
Credit rating	12	8.2
Neighbours' homes	17	11.6
Workplace	45	30.8
Gay venues	43	29.5
Medical services	24	16.1
Police Department	39	26.7
Comm. Employment Service	26	17.8
Dept. of Motor Transport	11	7.5
Churches	23	15.8
Banks/Financial services	22	15.1
Shops/Restaurants	34	23.3
Other	14	9.6

Table 9.4: Where transgenders experienced discrimination

Frequency of discrimination	Frequency (N=146)	Percent (of 146)
Never	18	12.3
Daily	12	8.2
Several times daily	6	4.1
Once a day	6	4.1
Once a week	21	14.1
Several times weekly	9	6.2
Once a month	34	23.3
Once a year	20	13.7
Not clear	20	13.7

Table 9.5: How often transgenders experienced discrimination

In table 9.6 the level of approval amongst the target group for legislative measures, such as equal opportunity or anti-discrimination laws, legal recognition of transgenders, all of which achieved 80% or more approval by the sample, suggests that these measures should be given urgent consideration. Such measures will have a double impact on transgenders: on the one hand giving legal protection against some of the more excessive anti-transgender practices, and on the other hand, a measure of legal recognition sending a clear signal to tranys, who are excluded from many aspects of Australian society, that there is a place within our community for all its members.

Strategy	Frequency (N=146)	Percent (of 146)
Equal opportunities for tranys	118	80.8
Anti-discrimination laws for tranys	116	79.5
Legal recognition of tranys	120	82.2
Disadvantaged status for tranys	72	49.3
Public education re: trany issues	113	77.4
Funding trany organisations	86	58.9
Training tranys in job skills	98	67.1
Funding research/action on trany needs	92	63.0
Increased education access for tranys	86	58.9
Better media portrayals of tranys	118	80.8
Other	13	8.9

Table 9.6: Strategies that transgenders considered might help end discrimination against them.

Welfare dependency is another indicator of this marginalised status. We asked the sample for details of their accessing welfare benefits. The results are found in figure 15.

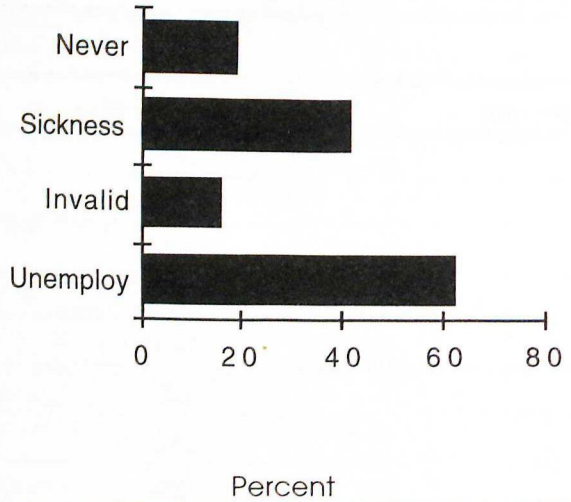

Figure 15: Welfare Benefits

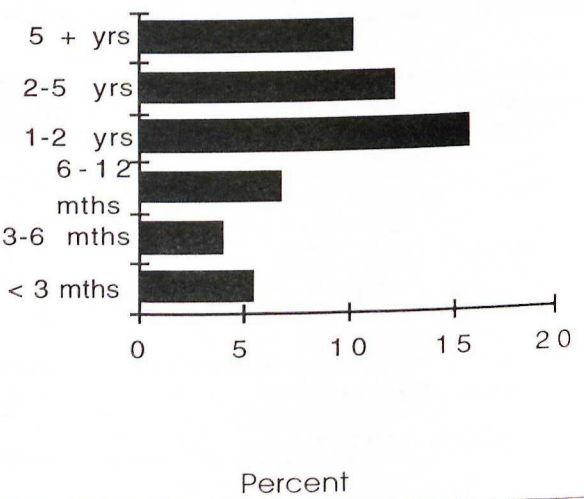

Figure 16: Duration of Benefits

Less than 20% of the sample had never been on any welfare benefit, which clearly means that over 80% had been so. Unemployment benefit was utilised by almost two-thirds of the group, which no doubt reflects the findings above describing the difficulties transgenders experience in finding employment and the discrimination that keeps them out of work. Sickness benefits were used by over 40% of the sample, underlining our earlier findings about the level of general health in the transgender community. Currently, 80 (54.8%) of the sample group are on benefits.

Figure 16 above shows the length of time those currently receiving benefits have relied upon welfare benefits. Of those receiving benefits, 56 (about 38.4% of the sample) could be classified as long-term welfare recipients, since they have been receiving benefits for one or more years. These figures would seem to reinforce the argument that insists that the levels of health, employment and general well-being in a particular community are irretrievably linked. They are excessive by any standard. Clearly the nexus between unemployment, welfare dependency, discrimination and poor health that is apparent in the transgender community needs urgent attention if the situation of transgenders is to improve.

The cause of much distress by transgenders may be related back to their relationships with people close to them, such as family, neighbours, workmates and social peers - in other words, the very people most of us depend on for support in our everyday lives. Table 9.7 indicates the extent to which our sample might count on this support.

Type of person	Good (N=146)		Indifferent (N=146)		Bad (N=146)		No answer (146)	
	Fr	%	Fr	%	Fr	%	Fr	%
Mother	98	67.1	15	10.3	18	12.3	15	10.3
Father	63	43.2	24	16.4	27	18.5	32	21.9
Brothers	50	34.2	24	16.4	24	16.4	48	32.9
Sisters	60	41.1	24	16.4	20	13.7	42	28.8
Neigh-bours	71	48.6	39	26.7	7	4.8	28	19.2
Work-mates	80	54.8	14	9.6	11	7.5	41	28.1
Other tranys	98	67.1	20	13.7	5	3.4	23	15.8

Table 9.7: Nature of relationship between transgenders and others close to them

Quite frankly we might have expected higher levels of "bad" relationships, in view of previous findings on discrimination. With such figures as nearly 40% of the sample having families who discriminated against them, or a fifth with discriminatory neighbours, as seen in table 9.3 above, the relatively much lower levels of "bad" relationships with family members and neighbours seems incongruous. Either the victims were remarkably forgiving, or the sample used different criteria for a "bad" relationship and a discriminative one. However, "indifferent" relationships might also be considered negative by many sensitive and fragile transgenders, who may assume an indifference to them to be a form of non-acceptance of their gender change. Also, there are very high numbers of tranys in the sample who simply did not provide us with any indication. For many of these the nature of relationships with family members, neighbours, work colleagues and other tranys might have been more negative than "indifferent" but not enough to describe them as "bad", or too painful to categorise. Perhaps, then, what we should be doing is focussing on the levels of "good" relationships. Thus, we find that mothers were the only ones whom the sample could clearly depend on for support, while only a third of their brothers and less than half of their fathers, sisters and neighbours could be counted upon. For a great many tranys, it seems, support from their families, neighbours and workmates is non-

existent. Such a situation is likely to be a causal factor in some of the more drastic actions seen in figure 17 below.

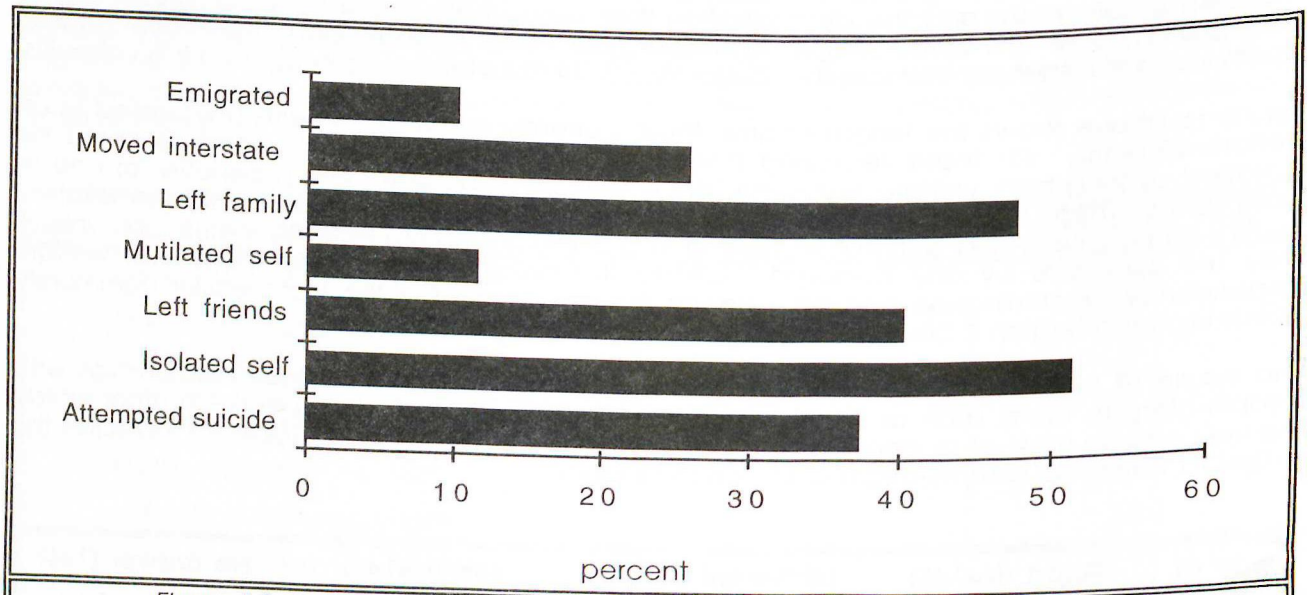

Figure 17: Actions taken by transgenders in response to their victimisation

This figure presents a depressing picture of transgenders as victimised by a society insensitive to their needs. Well over a third of the sample had attempted suicide, which is a staggering statistic, especially when compared with 1.5% to 1.8% of persons who actually died by suicide in 1980 and 1990 (ABS 1992:70). Transgender mortality has not been thoroughly investigated, but in a study of 425 Dutch male-to-female tranys the authors concluded that trany deaths by suicide and "unknown causes" is five times higher among the transgender population than in the population in general (Asscheman 1989). A further third of the sample who had emigrated or moved interstate to escape persecution and start anew is no less a disturbing finding. Taken together the findings on rates of discrimination, unemployment, dependency on welfare benefits, negative relationships with family, neighbours and workmates, and the figures on migration, isolation and suicide present a grim reality of the lives of many transgenders driven to desperate and extreme actions. It is doubtful if any other social group in Australian society would have a more depressing outlook. Transgenders, it seems, are at least as deprived and disregarded as native Australians, whose 23% unemployment rate (ABS 1992:188) compares to our sample's 25%, not including sex work or house work (table 6.4. page 25, chapter 6). Like Kooris, whose sole cause for discrimination is their skin pigmentation, the bleak picture of transgenders just described is due entirely to a single act of changing gender.

Conclusion: In this chapter we have concentrated on two aspects of transgenders' lives. These are quintessential events for tranys, since they shape and define social meaning for the individual and the group. The process of changing gender, and the medicalisation process often associated with it, resolves a personal conflict for the individual transgender. As we have seen, though, a majority either do not complete the process to genital surgery or regard it as inappropriate for them; but this does not make them any less transgenders than the others and makes little difference to the laws and social mechanisms that socially define them. Discrimination is the process of social ostracism that all tranys experience, which forces them to realise the exact extent of society's antipathy towards gender crossing. Even for the "sex changed" tranys the experience is virtually the same. The two processes, of changing gender and discrimination, are inextricably linked in our society (not, though, as we have pointed out earlier, in many past societies, such as the Cheyennes, Navajos, Tahitians, Aleutians, Bugis, Scythians and ancient Siamese, to name just a few). From crossing gender to social discrimination the everyday experience for many tranys is isolation, family rejection,

unemployment and maltreatment by just about everyone, from the courts, public servants, the police and professionals to the average person in the street. For many, far too many as our figures indicate, this leads to loneliness, depression, low self-esteem and poor health. For others, though, the inevitable conclusion sinks even lower, to incrimination, incarceration, drug addiction, and/or suicide. In such situations the likelihood of HIV infection and death by AIDS increases. Loneliness and depression are easy prey to desperate emotional needs and suicide may only be prevented by drug addiction or by finding a love relationship and regular sex partner. The lover is at last someone whom the transgender assumes cares for her/him and in desperate efforts to maintain this rarely felt euphoria safe sexual practices become a least consideration. Under such circumstances it is the transgender's sex partner who dictates the terms of their sexual behaviour. Thus, crossing gender, discrimination and AIDS have a definite relationship and the nexus is loneliness, low self esteem and love, strange bedfellows indeed. Scenarios such as those just described place transgenders amongst the most vulnerable of social groups for AIDS. This concept will be explored more fully in our next chapter.

III. CONCLUSION

10. AIDS AS A TRANSGENDER ISSUE

The Acquired Immune Deficiency Syndrome (AIDS) has been present in the Australian population for more than a decade now and made its initial impact in the gay male community. Over the intervening years the disease has spread more widely across the Australian population and has been transmitted via means other than male homosexual contact, such as by heterosexual contact, intravenous needle sharing, blood transfusion and through congenital inheritance (ie. infected mother to unborn foetus/child). Whilst initially it was the practice of governments, medical institutions, the media and the public at large to single out certain groups, such as gays, drug users and prostitutes, as responsible for the spread of AIDS, more recently the focus has been on certain practices rather than on groups. The number of people across Australia who were reported to have been seropositive to the human immunodeficiency virus (HIV+), the organism that causes AIDS or AIDS-related diseases, by 30th June 1993 totalled 17,475, in a sex ratio of approximately 18.6 males to each female (National Centre in HIV etc 1993:14-15). Since the projected Australian population for 1991 is 17,337,400 (ABS 1992:31) this would mean that about one in every thousand individuals, or 0.1% of the population, is infected with HIV.

The Prevalence of HIV in Transgenders: The actual number of transgenders who are HIV+ is unknown, as statistical information on tranys in general is wanting. However, the National Centre in HIV Epidemiology and Clinical Research (1993:14) reported 19 people (eight in NSW, seven in Victoria, three in Queensland and one in Western Australia) who were recorded as HIV+ and also "transsexuals". The Albion Street (AIDS) Centre had 77 transgenders recorded on their files to December 1989, of whom 14 were found to be HIV+, of whom all but one were either intravenous (injecting) drug users or sex workers or both (Alan et al 1990). In other western countries transgender HIV seropositivity seems closely associated with prostitution. In one American study, for instance, 68% of 53 transgender sex workers tested in Atlanta proved to be HIV+ (Elifson et al 1993). An Italian study revealed that 74% of 57 transgenders working in Rome were HIV+ but there was also definite links with injecting drug use as well as lack of condom use (Gattari et al 1992). In a German study of prostitutes 11.1% of 36 transgenders were HIV+, most of whom were non-drug users, compared to only 3.8% of 180 females, of whom the seropositive females were injecting drug users (Modan et al 1992).

The Gender Centre (formerly Tiresias House) had 18 HIV+ transgenders recorded on their files for 1993 (personal communication, December 1993). From these piecemeal bare threads one gets the impression that a considerable proportion of the transgender population is infected with HIV. If we take the largest estimate of transgenders in New South Wales given on page 18, which is 2,500, and the figure of HIV+ clients given by the Gender Centre, we arrive at a percentage of 0.7% infected tranys, nine times the percentage for the Australian population. Clearly HIV/AIDS is an important issue for transgenders. This chapter looks more closely at this issue by relating this apparently very high risk of HIV infection to trany lifestyles, psychology and social status.

As we pointed out in the last chapter transgenders have an alarming mortality rate by violence, overdose, and suicide. In recent years this has been compounded by a high rate of death by AIDS. Speaking to an ex-staff member of the Gender Centre with an interest in caring for the dying she recalls ten trany deaths in 1993. Five of these were due to AIDS, four were due to overdosing, which she suspects were suicides and at least one was HIV+, and one was due to heart failure. Using the above estimate once again this report (and this is only one person's memory) indicates that at least 0.25% of tranys last year died of AIDS. Compared to the 2,630 deaths of AIDS in Australia to March 1993 (National Centre in HIV etc 1993), or 0.015% of the total population, this is a staggering result. Obviously the causal factors for this alarming finding are to be found somewhere in transgenders' lifestyles. When we consider our earlier findings on sexual practices and injecting drug use an even more disturbing picture emerges. Less than two-thirds of our sample had any kind of regular sex life (see table 7.3, page 30, chapter 7) and only 42% of the sample, or just half of the sexually active tranys, used condoms all the time (table 7.8. page 33, chapter 7). The actual risk of HIV by sexual transmission then is applicable to only 43 tranys. Less than a third of the sample had ever used intravenous drugs, but only the

three who had shared a needle less than a year ago (table 8.3, page 46, chapter 8) can be considered in any real risk. Thus, less than a third of our sample group were in danger of being infected with HIV. If this is a reflection of the wider transgender community then the above death rate from AIDS represents about 0.6% of those transgenders involved in risky practices (ie. 5 of 833, being a third of 2500). Faced with figures like this we can only conclude that transgenders have a greater potential for HIV infection than any other social group in Australian society.

HIV Risk and Discrimination: What is it that places transgenders so much at risk? Is it attributable to a common psychological phenomenon in people with gender crossing inclinations? Is it due to a cultural trait peculiar to the transgender subculture that persistently places its members at risk? Or is it because of an external social dynamic that propels transgenders into the kind of behaviours that puts them at risk of HIV? We have concluded that it is more likely the third paradigm that produces those factors leading to HIV infection. This was mentioned briefly towards the end of the last chapter. But now we will examine the nexus between transgender lifestyles, social reactions to gender crossing and AIDS more fully.

Given the enormity of the range of problems tranys face living their lives in a society hostile to gender crossing, it almost seems pointless to try to identify the specific processes in which the possibility of HIV transmission becomes real. In previous chapters we have drawn links between the social ostracisation of transgenders, their consequent low self-esteem and their eventual vulnerability to succumb to high-risk behaviours. For many transgenders, the issue of their gender is one that is located at the core of their being. Many will speak of being unable to even consider any alternative lifestyle to the one they have chosen (or felt compelled to adopt). Indeed, suicide becomes a real option for many transgenders if a so-called 'normal' lifestyle is pressed upon them. If we can agree that the problematic term 'identity' is useful as an umbrella term to cover this central aspect of transgender existence (without necessarily implying any approval of the term), then the processes which can propel a transgender into high-risk behaviour become clearer.

For transgenders, to be discriminated against is not merely to be denied goods, services, rights and privileges freely available to other members of our society. The act of discrimination itself is only possible when it has already been identified by the discriminator that the transgender is engaged in gender-inappropriate behaviour or presentation. Closet tranys do not get discriminated against (although the fear of discrimination may well be a factor in their remaining in the closet). Nor do the small minority of transgenders who 'pass' successfully as members of their desired gender at all times. Because of this prior identification and judgement of the transgender by the discriminator, the act of discrimination is interpreted by tranys as an affront to their identities, an attack on the very core of their being. It is seen as the discriminator imposing their version of whatever identity they feel is appropriate for the transgender on her/him. Thus a single act of discrimination against a trany has an impact on multiple levels: it is a refusal of goods, services, rights and privileges open to other members of society or of the trany's desired gender; it is a denial of the trany's own identity and an imposition of an unwanted, inappropriate and often hated identity.

Despite the above argument demonstrating clearly that the nature of gender identity is socially constructed (as opposed to genetic explanations of gender identity), if challenged the discriminator would be likely to justify his/her action by referring to some 'real' man somehow maintaining its existence 'inside' the male-to-female transgender (or woman 'inside' the female-to-male). This reliance on a biological basis of gender determination is unsustainable, despite the mountain of 'scientific' evidence put forth in support of it. Nonetheless, such beliefs have a mythical status in our society (ie. so many people believe it to be true that it doesn't really matter whether it is actually true or not; see, for instance, the argument in Kessler & McKenna 1978). The effect of this is to deny transgenders reference to something we might agree to call "real" or "the Truth" (ie the founding myths of our society) for their validation. Worse still, the myths of this "real" or "the Truth" are constantly invoked to justify ostracising transgenders. One example of this is the psychiatric classification of 'transsexuality' as an "incurable mental disorder". To be transgender in this society is not merely to behave in a 'deviant' fashion, but it is to *be deviant*, to be labelled deviant, and be treated as deviant.

Society's behaviour towards transgenders is rationalised through a formidable, if ultimately, spurious series of arguments.

Thus, discrimination against transgenders is of a qualitatively different order to that of women, who, when discriminated against, can often have recourse to a series of support networks, such as their family, friends, other women, women's centres, to ameliorate the pain. Moreover, women's identity itself is seen as 'natural' (unlike the transgender's), and they are discriminated against not because they are deviant (unless they are too promiscuous or prostitutes), but because of the socially inferior status accorded to all women. Kooris too, or other ethnic minorities, are discriminated against because of racial differences and also have access to a range of similar support services, as well as established cultural and social structures. Gays and lesbians also, even though discriminated against because of a perceived deviance, have developed community structures that serve as a safe haven against discrimination and assault, as well as a base from which they have challenged, with increasing success, the social prejudices towards homosexuality.

Women, Aboriginal Australians and gays are all currently protected under anti-discrimination legislation and therefore have legal recourse against their discriminators. In some states they also have further protection under anti-vilification legislation. Transgenders, on the other hand, lack the legal protection provided other specific groups. It is even doubtful if they have as much protection as others under laws designed for the general population, judging by the extreme prejudices that permeate society from the lowliest ruffian to the highest judiciary, and the persistent maltreatment of tranys by police, professionals and government institutions that we have discussed in chapter 9. It is particularly ironic that what is for many the only feasible method of avoiding this discrimination, ie. to pass successfully, has come in for some of the most virulent criticism directed at transgenders (see especially Raymond 1975). It is a reflection of society's phobia of gender crossing that those tranys for whom passing successfully is a physical impossibility are less often the subject of anti-transgender rhetoric. Rather, the unpassable trany is treated as a joke and not taken seriously, while those most successful are prime targets for the most vicious vilification, as though they were being deceitful. It would seem hard for transgenders to avoid feeling that they're damned if they do and damned if they don't. The cumulative effect of this is that, because of the continual denial of their identities, transgenders feel they are treated as non-persons, and because of the continual denial of their rights, non-citizens.

Love, Sex and HIV/AIDS: Given the total rejection of transgenders, by much of society, it is not surprising that tranys are forced to look beyond usual social situations for validation of their identities. One means by which many tranys can find a sense of self affirmation in a socially-approved manner is through sex. In our society sexual attraction to a member of the opposite sex is one way of re-affirming one's gender, or, in other words, proof that one is a member of one or the other gender. In a predominantly heterosexual society such as ours a heterosexist model is assumed to be only acceptable mode of sexual behaviour. By finding sex partners opposite their own chosen gender, transgender women and men not only have their identities confirmed but also have what they and their peers consider to be incontrovertible evidence of their "real natures".

Finding and keeping the right (heterosexual) partner is thus given a high priority among transgenders, and those who succeed in this area are accorded high prestige by their peers. Even if the relationship is merely a one night stand, it can be an adequate short-term reinforcement of one's identity. It is relevant to note that quite often, the sex itself is not that important. Some transgenders have little or no sex drives (due to the effects of medicated hormones). Nor is emotional intensity a key issue. What is most important is that one can see oneself as a member of her/his desired gender, and equally so, that others can see her/him confirmed in that role. Consequently, the quality or suitability, or even the compatibility of the partner(s), may be of secondary importance. In such a schema, the number of partners is as acceptable a validation of one's identity as anything else (and sometimes more so).

For those attracted to transgenders, the social situation is very different than for transgenders themselves. Transgenders' lovers are literally caught between both worlds. The lovers live within normative models of gender but find themselves sexually attracted to those who live

outside their norms. There is a peculiar reversal of status here; among the trany's peers her/his status rises, while among the lover's peers his/her status falls. In many cases, the relationship automatically precludes the introduction of a trany partner into the lover's family circle or other social networks. The probability of being stigmatised deviant is sufficient to permanently deny this possibility. The tension between living what is considered a 'normal' lifestyle and having what would be labelled a 'deviant' sexuality is resolved by compartmentalising the various sectors and keeping them permanently separated. While this may have a negative effect on the lover, it has implications of a power imbalance for tranys, who, knowing that their chances of replacing a lover is slim, tend to offer themselves as the compliant and subservient partner in a relationship. In fact, the more the relationship endures the more power is reinforced in the hands of the lover, who permanently retains the right to nominate the times and length of their meetings. Another alternative for a lover is to forego a steady relationship and opt for a succession of one night stands, which also allows the lover even greater power, since he/she may have emotional control over more than one trany at a time.

Not many lovers of transgenders are prepared to be open about their affections for tranys. Those who do may also come from a marginalised background themselves and therefore have little to lose, or they are prepared to lose status among their peers and suffer the same consequences as the tranys they love. Because of transgenders ostracised position in society many have little other option but to choose lovers from marginalised groups, such as criminals and substance abusers. But in the social hierarchy of deviance transgenders continue to be on the bottom. Even though criminal or drug abusing lovers may not be concerned about public affirmation of their relationship with a trany, power remains in the hands of the lover. Transgenders succumb to this power imbalance because they feel they have no choice if they are to maintain the relationship. Their low self-esteem due to constant social and institutional reinforcement of their lowly status results in their low negotiation skills, while their desperate position in the love market, leaves them very little bargaining power. Consequently, a lover has almost a monopoly on the terms of sexual behaviour, with the compliant trany submitting to unsafe anal or vaginal sex on demand. The female-to-male transgender may have more room for manoeuvring with his partner, and may even assume a dominant role in the relationship if he and his female partner conform to the heterosexual pattern, but the lover in this relationship may also have great power to manipulate her transgender partner, who is, after all, as much limited in the love market as male-to-female tranys.

The point of all this is, of course, to demonstrate the vulnerability of transgenders to HIV. Where non-transgender people do have varying degrees of negotiable skills to protect themselves in sexual encounters, because of their fragile identities, constantly under attack from society, and their desperate need to reinforce these in a limited love market, tranys are less able to protect themselves when it's a tug-of-war between a lover, their identity and safe sexual behaviour. On top of this, as we have pointed out in the previous chapter, low self esteem, developed from having to live in a society which treats the transgender as an aberration, is hardly conducive to positive self-assessment and assertive action in interactions with others. The way is thus paved for an attitude of low self-worth and suicide, whether by direct methods or by indirect means of self-destruction by subconsciously placing oneself in life-threatening situations. A good example of this has been seen in our discussion on substance abuse.

Drugs, Prison and HIV: The same kind of internal needs that motivate tranys to seek sex partners for reaffirmation of identity and then to allow themselves to be dominated or manipulated in relationships, propels some of them into unsafe practices in a drug culture. Here the driving motivation is to belong to a group or social clique, but for the same need to find acceptance of their chosen identity. Drug cliques are less concerned for individual identities and more for the function of the group as sharing drug acquisitions and equipment. In some ways illegal drug abusers resemble transgenders: they are also stigmatised and they need reaffirmation of their identities as addicts. But, many achieve this reaffirmation through the group dynamics in a coterie of injecting drug users, such as the rituals of sharing a needle, a joint action which reinforces the bonds between the group's members. Tranys not only need their identities reaffirmed, they also desperately need to belong to a group. A drug clique is one of the few forms of social groups, outside the transgender subculture, which will accept tranys unequivocally, and sharing a needle is one of the few cooperative tasks they can

indulge in with non-transgenders. Low self-esteem may lead to the addiction in the first place, but the desperate need to belong will keep them attached to a drug group. And, the actual needle-sharing is not the only risky behaviour, because addicts are more likely to take trany lovers than non-addicts and since the same imbalance of power mentioned above will persist the same potential for HIV infection exists. The transgender addict who belongs to a drug coterie is, therefore, in a much more precarious position with regards to AIDS than the non-addicted trany. Thus, we see that transgenders are vulnerable to HIV infection through both their high incidence of unsafe sex and sharing needles. Needle sharing may also take place between some non-addicted transgenders where a group of them share a syringe containing hormones in viscous liquid form.

Curiously, those male-to-female transgenders in male prisons acquire some power of their own. There are at times as many as 20 or more (ie. c.1% of the transgender population) in New South Wales gaols. In June-July 1983 there were 23 in Long Bay Gaol alone (Perkins 1991a). In a male prison the transgender becomes the woman, in an exclusive men's society, even for heterosexual males who would normally spurn tranys as sex partners. This gives her greater bargaining power than she ever possessed outside. But, unfortunately, once a mate is selected the trany reverts to the usual exaggerated excesses of the heterosexual model by becoming the subservient 'wife' and is as vulnerable to HIV as non-incarcerated tranys. HIV prevention messages will not be internalised until the transgender identity issues are dealt with. Until then, if a trany's core identity is always under threat, it will not in many instances be able to withstand pressures to engage in unsafe behaviours.

The Other Tranys: Because we have concentrated on the vulnerability of transgenders to HIV infection as indicated by the evidence, we have tended to focus on those most at risk, ie. the addict and the sex worker who indulge in unsafe practices, those most subservient in a relationship, those who accept lovers on a casual basis, those with the lowest self-esteem. There are, of course, a number of transgenders who have somehow developed an inner strength to withstand the pressures of society's derogation, family rejection, institutionalised discrimination and social isolation. Some are fortunate to have supportive families and work in a supportive atmosphere, while others have achieved high status in professional and other fields considered prestigious by society, while others have an assertive personality able to overcome the oppression, and yet others have read widely and learned to understand that their gender crossing was due to no fault or flaw in their character. Of course, these tranys are subjected to the same discriminatory legislation, the same social disapproval of their gender change, and the same frustrating bureaucratic failure to recognise a change in gender, yet they are able to deal with life much better than most other tranys. Often there is a supportive network on which these transgenders rely and draw their strength from, such as positive family attitudes, accepting professional colleagues or a close coterie of non-transgender friends. Whatever the source of this strength these people are less vulnerable to HIV because they are not driven to find and keep a lover on his/her terms, they are not desperately lonely, nor suffer with low self-esteem, and have a greater a zest for life than most tranys because their strength avoids them internalising guilt about their gender crossing. It is not that they are better educated about AIDS (for indeed the trany street addict is likely to be much better educated), but it is that their strength has enabled them to develop a positive outlook, a definite identity based on factors other than their gender, and a self-reliance that is unlikely to lead to those prospects which make them more vulnerable to HIV, such as identity crises, a desperate loneliness and a dependence on others to constitute your own quality of life.

However, it is not the stronger transgenders that concern us here. Our study has attempted to seek areas where HIV/AIDS is a major issue, and the findings have indicated these. The most vulnerable transgenders are those who have suffered identity crises and extreme loneliness, which has led them into unsafe sex work, needle sharing and unevenly balanced relationships, and even crime and prison. Such a person was Kerrie, who died of AIDS in 1989 at 26 years of age. Her story is a particularly tragic one as her life was a rapidly downward spiral to doom. Beginning with difficulties in coming to grips with her urge to change gender and rejection by her family, she fled from Melbourne to Sydney in the hope of finding peace, happiness and acceptance. Instead, she wound up on the streets supporting a raging drug habit. When changes in prostitution laws forced her off the streets she turned to armed robbery and was

convicted to a gaol term for holding up a bank. In gaol she fell in love with a male inmate, but when he was released he returned to his fiance. After Kerrie was also released she desperately tried to renew her acquaintance with him, but he only visited her when he wanted drug money. Finally, he drifted out of her life completely and she never recovered from this ultimate rejection, just as she had never come to terms with her family casting her out. When she discovered she was HIV+ she assumed it was due to sharing needles in gaol, but the cause could just as easily have been the unsafe sex she had with her lover or that with clients on the street. Perkins did a series of interviews with Kerrie with intentions of writing her autobiography, but her story is much more poignant told in the third person, and the last year of her life is provided as Appendix II for the reader to appreciate a more human and personal side to the difficulties facing an HIV+ transgender with every imaginable pressure.

Conclusion: This chapter has attempted to look more closely at AIDS as an issue for transgenders. The statistics provided earlier indicate very clearly that this issue demands immediate attention. As we have pointed out, surprisingly, it has not been considered very urgent on AIDS agendas in Australia, nor across the world for that matter. This inaction might be seen as related to the same inertia that prevents Federal and State governments from introducing legislation on discrimination, anti-vilification, birth certification, legal "sex change", marriage and other areas of law and bureaucracy that continue to oppress transgenders through their lack of recognising gender crossing. We cannot tell whether this inaction is due to lack of clout, insensitivity, or simply trany-phobia.

As the discussion in this chapter clearly indicates, any strategies for reducing the risk of HIV amongst transgenders must first address the issues of gender identity and human rights as they are presently denied transgenders. The Federal Government has made its intentions on HIV clear when it stated that "people infected with HIV retain the right to participate in the community without discrimination" (Commonwealth of Australia 1993:10). This should include seropositive transgenders, even to the point of rectifying what is lacking in this regard at present. Further on it also states two of its guiding principles: "social justice principles and a supportive environment are integral to Australia's success in responding to the HIV epidemic" and "law reform should take a rational, humane and responsive approach to the problems of the HIV epidemic" (ibid:38). To date there has been little evidence of "a rational, humane or responsive approach" to recognising transgender issues in the legislation. Perhaps a realisation of the extent of the aetiology of HIV problems in the transgender community might cause it to adopt this approach where common sense and sensitivity have failed.

11. SUMMARY AND CONCLUSION

This report has detailed an investigation of a national sample of 146 transgenders surveyed by using a precoded (with some open-ended questions) questionnaire as the survey instrument (see Appendix I). At the beginning of the report we established our terms of reference, including the adoption of the word "transgender" (abbreviated as "trany") as the most appropriate term for the subject population. The sample was overwhelmingly male-to-females in a ratio of almost nine to every female-to-male, and just over a quarter had undergone genital reconstructive surgery (the so-called "sex change"). A little more than half of the sample resided in Sydney, while 10% lived in other cities of New South Wales or the state's rural areas, with 14% living in Victoria, 11% in Queensland, 5% in South Australia, and 7% elsewhere in Australia. Over half were born to white Australian parents and there was a slight trend towards a working class background.

Our findings from the study have established some very significant facts about the transgender community. Firstly, our demographic data indicates that most tranys gravitate to urban centres, such as Sydney, where a distinctive subculture of transgenders emerges as a result. The educational level of transgenders seems to be considerably higher than that of the general Australian population, yet there is an undoubted decline in their employment potential, which we interpret as clear evidence for socio-economic discrimination.

We found that a change of gender may also change the transgender's sexual orientation, particularly a strong swing from a gay orientation to heterosexual and, to a lesser extent, bisexual. Even so, heterosexuality represents only just over a third of tranys' sexual identities, indicating quite clearly that transgender sexuality is quite diverse. A notable feature in transgender sexual issues is that nearly half of them have only casual sexual partners or have no sexual contacts at all, implying a high level of loneliness amongst them. Of those who do have regular sex, oral and anal sex are dominant sexual behaviours. Well below half of the sexually-active transgenders use condoms on every sexual occasion. Nearly half of the trany population is involved in sex work, although only three-quarters of them practice safe sex with their clients every time. Sexual assault upon transgenders is alarmingly high, but especially so for the sex workers, who are twice as likely to have been raped by a single attacker and three times as likely to have been pack raped. Also, the sex workers are much more likely to have been sexually abused as children, or sexually assaulted in other ways. Interestingly, transgenders who have been victims of sexual assault are more likely to be receiving a welfare benefit, inject drugs or have attempted suicide.

In the areas of health, 60% of transgenders have been infected with some kind of sexually transmissible disease and most of them have indulged in one or more drugs. Of greatest concern are the number who smoke heavily and consume prescribed drugs. However, it seems that fewer tranys are indulging in drugs at present than in the past. Although over a third have at some time shared a needle, only a handful have done so recently enough to be at risk for HIV. Despite a high level of knowledge about AIDS, a strong potential for HIV infection, especially through unsafe sex, persists with transgenders. This risky behaviour should be correlated with tranys' desperate emotional needs expressed through sexual relations, their need for acceptance and to belong to non-transgender social groups, and the dominant role of non-transgender partners in their love relationships. In general, transgenders are much more vulnerable to ill-health than the rest of the community due to their risky lifestyles, low self esteem and facing what many perceive as a bleak and lonely future.

Transgenders' risky lifestyles and low self esteem are by-products of an almost continuous discrimination and social ostracism by others in society, from professionals, bureaucrats, law enforcers and employers, to their families, neighbours and the average person in the street. A combination of social ostracism, emotional deprivation and family rejection leads to a desperately lonely existence, which in turn often leads to drug addiction, crime and incarceration, and suicide. This combination can be an explosive situation for HIV infection, which explains why knowledge on HIV transmission does not necessarily result in HIV prevention.

Our evidence has enabled us to separate transgenders into three fairly distinctive subgroups according to AIDS risk: 1) those who are at high risk for HIV due to high levels of unsafe sex and/or needle sharing; 2) those who are at low risk for HIV because, although they have an active sex life, they use condoms regularly and/or rarely, if ever, share needles; and 3) those who are at no risk for HIV at all because they have negligible sexual experiences and never use injecting drugs. What this implies is that whilst some transgenders are amongst those at highest risk for HIV in Australia, an almost equal number are among those with the lowest risk of contracting the disease. This demonstrates what we have been suggesting throughout the report, that the transgender community is as socially heterogeneous as the rest of Australia.

A number of strategies need to be implemented to overcome this deplorable situation. These have been detailed in a list of recommendations following this chapter. As a way of concluding this report and study, however, we wish to discuss some of the more essential strategies for combating AIDS. Firstly, with regard to the sex workers, this is an area that desperately needs addressing. It should be pointed out, however, that what is the case for transgender prostitutes is not necessarily so for all sex workers. Even though the street tranys work alongside (biological) female prostitutes and in many cases share clients, peer-group regulation among the latter streetworkers and contraceptive needs maintains a high level of condom usage. In fact, the situation in female prostitution in general is almost the reverse of that for transgender sex work: the incidence of HIV in female prostitutes is even lower that for the total female population. The difference, though, is not just one of peer-group regulation, but one of self esteem and personal needs. Unlike female sex workers, transgender prostitutes are more likely to seek lovers from among their clients, so that their distinction between clients and lovers is much less clear than with female workers, whose risk for HIV is found in their private sex lives and not their occupation. For transgender sex workers the issue of emotional need and identity is the same as for all tranys.

What is needed for transgender prostitutes is not just AIDS education and a handful of condoms but strategies for manipulating their clients into practicing safe sex. We are here referring to self-assertion, which is very difficult for any marginalised group, but especially so for tranys in a subculture lacking pride or political motivation who have fully adopted the oppressive gender norms in our society. While condoms and AIDS information are important, it is more essential we address the issues of self esteem and assertion of transgenders in general, and the prostitutes in particular. The police and other officials should be made aware of the attitudinal differences between trany sex workers and other prostitutes. Armed with such knowledge police in Victoria, for example, might be more likely to react with more understanding than they have shown towards the two HIV+ transgender prostitutes arrested for "recklessly endangering life" (*The Age* 19/11/91) or in the more recent case of forcibly removing an HIV+ trany from the state.

Of course, it is one thing to expect transgenders to overcome their enormous social, psychological and emotional problems in preventing HIV infection, and quite another to educate men in general about the need to practice safe sex. The latter, in fact, might be the easier option. So far men in general have borne little of the responsibility for preventing AIDS, whilst government agencies, the media and the law have concentrated on targeting weaker groups in society, such as gay men, prostitutes, injecting drug users, women, aboriginals, migrant sex workers and transgenders. Much of this could be achieved more effectively were heterosexual males encouraged to share this responsibility. But, it will mean challenging traditional values of male dominance and sexuality. Advertisements featuring prominent male figures whom other men admire, such as politicians, sportsmen and rugged film stars, could be used to promote safe sex. "When I go out for the night." says Alan Border, "I always take me mate along (pointing to a condom) because you never know". Thousands of male cricket fans, at least, would follow suit.

Society itself must learn how to deal sensitively with transgenders if it expects their co-operation in the battle against AIDS. This means not only an end to everyday discriminations, but also to the public persecutions of the kind that deprived Renee Richards and Noelena Tame of their rights to compete as successful sportswomen, or April Ashley of the right to be a married woman, or Susie X of the right to receive welfare benefits as a woman. These persecutions are nothing more than public condemnations for gender transgressions in a

society paranoid about maintaining the fiction of biological immutability of the binary gender system. Many people would be truly amazed at the current extent of gender crossing behaviour, from closeted transvestism to the hundreds of men who daily seek out prostitutes or understanding sex partners to unleash the cross gender fantasies in their heads. Programs educating the public about the realities of gender, and transgenders in particular, should be devised for school curricula and beyond. Only with this education will the persistence of moral conservatism that currently condemns gender crossing cease. But this education should be supported with legislative reforms (eg. anti-discrimination, anti-vilification, birth re-certification and flexible sex identification) to give a wider focus to the re-education programs. Only with widespread appreciation of gender as a social and not a biological phenomenon can we expect the situation to change for transgenders. And only then will we be able to reduce the appalling statistics on self-destruction revealed by this study and bring the present high risk for HIV amongst transgenders to an end.

RECOMMENDATIONS

A. Policy:

Numerous findings in this report point to the need to facilitate the growth of a strong, self-sufficient transgender community that is capable of responding to the HIV pandemic in a manner similar to that of the gay community. Therefore:

> **A.1: We recommend that the creation of a strong, self-sufficient transgender community be adopted as a public policy goal by all the Federal, State and Territorial Governments, and the adoption of such policy initiatives as are necessary to ensure this goal is met as quickly as possible.**

A number of legislative changes require immediate enactment in order to achieve the goal set out in A.1. These are enumerated in the following recommendations:

Our findings (p.60, Table 9.6) indicate the need for Anti-Discrimination and Equal Opportunity legislation. Therefore:

> **A.2: We recommend that all States and Territories immediately enact comprehensive Anti-Discrimination and Equal Opportunity legislation to protect transgenders.**

Our findings (p.60, Table 9.6) indicate the need for legal recognition of transgenders' statuses. Therefore:

> **A.3: We recommend that all States and Territories, and the Federal Government immediately enact legislation to recognise transgenders' right to change their gender, to allow alteration of identity and other legal documents to reflect gender changes and to ensure that all transgenders can enjoy all the rights and privileges available to other members of the transgender's chosen gender. Recognition of gender changes under such legislation should be independent of medical criteria.**

Our findings (p.60, Table 9.6) indicate that transgenders are concerned about the quality of media representations of transgender people. Therefore:

> **A.4: We recommend that efforts be made to ensure more accurate and less disparaging media portrayals of transgenders. Consideration to be given to extending Anti-Vilification legislation to protect transgenders.**

Our findings (pp.38-41 Tables 7.16-7.22) indicate appalling levels of violence against transgenders. Therefore:

> **A.5: We recommend that: (i) further research be funded to look into the causes of violence, both sexual and non-sexual, against transgenders; (ii) consideration be given to having a 'hate-crime' loading in sentences for violent offences, to be employed in sentences for acts of violence against transgenders; and (iii) funding be provided for community-based transgender anti-violence projects.**

Our findings (p.60, Table 9.6) indicate that transgender community organisations require funding if they are to adequately represent their constituency and enable the development of a strong transgender community. Therefore:

> **A.6: We recommend that transgender community organisations be adequately funded.**

Our findings (p.58-59, Tables 9.3-9.4) indicate unacceptable levels of discrimination against transgenders by the police and the entire justice system. Therefore:

A.7: We recommend that special attention be paid to sensitising the police and all officers in the entire justice system to transgender issues.

Our findings (p.58-59, Tables 9.3-9.4) indicate unacceptable levels of discrimination against transgenders in all sectors of the public service. Therefore:

A.8: We recommend that all federal, state and local government public service departments and statutory authorities immediately implement policies to eliminate discrimination against transgenders.

Our findings (p.60, Table 9.6) indicate a lack of public awareness, knowledge and sympathy for transgenders. Therefore:

A.9: We recommend that: (i) an ongoing campaign be implemented to educate the public about transgender issues, with particular emphasis on eliminating discrimination and violence against transgenders; and (ii) the production of materials that address issues of discrimination, marginalisation, hatred, and violence against transgenders and educational material about transgenders for distribution throughout the education system.

Our findings (p.60, Table 9.6) indicate a lack of research on and action thereof for transgender needs. Therefore:

A.10: We recommend that sufficient funds be made available to finance comprehensive ongoing research into transgender needs and to monitor integration of, and methods of integrating, transgenders into Australian society.

Our findings (p 37, Table 7.14) indicate that significant numbers of transgender sex workers are working without insisting their clients wear condoms, but this situation is unlikely to change without first lifting laws which continue to make prostitution operations illegal or, at most, quasi-legal. Therefore:

A.11: We recommend the total decriminalisation of prostitution in Australia.

Our findings (p 58, Table 9.3) indicate that some tranys find lawyers discriminating against them. Therefore:

A.12: We recommend the establishment of special programs for lawyers in transgender legal issues similar to legal services for aboriginals and women, covering such areas as discrimination, sexual identity, assault, family law and other matters requiring legal assistance.

B. Health:

Our findings (p 33, Table 7.8) indicate that a large proportion of transgenders practice unsafe sex. Therefore:

B.1: We recommend that the Federal and State Departments of Health develop a number of HIV education programs aimed specifically at the transgender community;

Our findings (p 37, Table 7.14) indicate that an unacceptable percentage of transgender sex workers are practising unsafe sex with their clients. Therefore:

B.2: We recommend that the Federal and State Departments of Health develop a number of HIV education programs aimed specifically at transgender sex workers.

Our findings (pp 43-46, Tables 8.1-8.4) indicate that transgenders face health risks in AIDS, STDs, substance abuse and a number of physical and emotional problems. Therefore:

B.3: We recommend that the Federal and State Departments of Health fund an ongoing trany organised outreach program sufficient to reach both transgender sex workers and non-sex workers in the capital cities and rural areas.

Our findings (p 51, Table 8.10) indicate that some transgenders are still uncertain about the dynamics of HIV transmission. Therefore:

B.4: We recommend that the Federal and State Departments of Health produce brochures, pamphlets, booklets and other such material on HIV prevention and awareness that are specific and sensitive to transgender needs and suitable for multi-cultural distribution.

Our findings indicate that due to the transgender community's unacceptable level of unsafe sexual practices (p 33, Table 7.8), to its high incidence of sexually transmitted diseases (p 43, Table 8.1), and to its demands for improved services (p 49, Table 8.8), greater availability of condoms and other safe sex materials is required. Therefore:

B.5: We recommend that the State Departments of Health ensure easier access and greater availability of safe sex materials to transgenders.

Our findings (p 45, Table 8.2) indicate that, despite downward trends in use and abuse of all substances, the levels of usage are still unacceptably high. Therefore:

B.6: We recommend that special transgender-specific substance abuse services be established in each State.

Our findings (p 46, Table 8.4) indicate that transgenders suffer numerous psychological, emotional and physical problems that detrimentally affect their health. Therefore:

B.7: We recommend that special transgender counselling services be established in each State.

Our findings (p 49, Table 8.8) indicate that transgenders are dissatisfied with a number of aspects of existing health services. Therefore:

B.8: We recommend that the State Departments of Health expand their outreach services, introduce more flexible hours of operation in their health services, separate needle exchange services from other services accessed by transgenders, and improve the efficiency of sexual health screening.

Our findings (p 49, Table 8.8) indicate that transgenders feel that there should be more multi-racial staff in health service delivery. Therefore:

B.9: We recommend that the State Departments of Health employ more people from diverse ethnic backgrounds to match the ethnic diversity of their client population.

Our findings (p 49, Table 8.8) indicate that transgenders feel that there should be more tranys employed in the health services in order to sensitise these services to transgender issues. Therefore:

B.10: We recommend that the State Departments of Health train and employ more transgender women and men to service the needs of transgenders.

Our findings (p 49, Table 8.9) indicate that a large number of tranys depend on pamphlets for AIDS and STD information. Therefore:

B.11: We recommend that the State Departments of Health employ tranys with the ability to design pamphlets, brochures, booklets and other graphic material aimed at the transgender community.

Our findings (p 46, Table 8.4) indicate that there is a high level of stress, depression, and other emotional and psychological problems with transgenders which need specific attention. Therefore:

B.12: We recommend that the State Departments of Health devise specialised psycho-social counselling training programs for tranys to become skilled in counselling other transgenders with various psychological, emotional and social problems.

Our findings (pp 38-41, Tables 7.16-7.22) indicate that there exists a high incidence of sexual abuse of transgenders. Therefore:

B.13: We recommend that the State Departments of Health fund a specific service for transgender victims of child sexual abuse, rape and non-sexual violence to be staffed by tranys trained in this type of counselling.

Our findings (pp 56-58, Tables 9.2-9.3) indicate that some general practitioners offer unsatisfactory services to transgenders and some discriminate against them. Therefore:

B.14: We recommend the establishment of special training programs for general practitioners in transgender medicine similar to aboriginal and women's health programs, covering such areas as substance abuse, hormonal treatment, stress reduction programs, diet, hygiene education, STD awareness and HIV prevention for transgender patients,

Our findings (pp 55-56, Figures 13-14) indicate that genital reconstructive, corrective and other surgeries are essential for many transgenders, but most of these are prohibitive due to cost. Therefore:

B.15: We recommend that genital reconstructive (the "sex change" operation) surgery and any other operations essential for transgender well-being be supplied on Medicare.

Our findings (p 57) indicate that not enough statistical information exists on transgenders on the incidence of HIV seropositivity and AIDS mortality, as well as in other areas of health and social issues. Therefore:

B.16: We recommend that the Federal and State Governments introduce a new transgender category into their statistical, health and other records so that trends may be made clearer for prospects and strategies concerning the future of transgenders.

Our findings (pp 5-6) indicate that not enough social research into the transgender community has been conducted to make realistic appraisals of the extent of HIV risky behaviours. Therefore:

B.17: We recommend that the enough government funding be made available for ongoing research into, and monitoring of, HIV awareness and prevention practices amongst transgenders.

Our findings (pp 61-62) indicate that male-to-female transgenders are often in a submissive role with their sex partners, which places them at high risk for HIV due to their unsafe sex practices. Therefore:

B.18: We recommend that the Federal and State Departments of Health devise AIDS education programs aimed directly at men, especially advertisements with dramatised real life scenarios featuring prominent sportsmen, actors and other high profile male figures.

C. Initiatives:

Our findings (p 25, Table 6.4) indicate that many tranys possess skills in a variety of occupations that have been allowed to stagnate since their gender change. Therefore:

C.1: We recommend that affirmative action programs be created for re-training tranys for work in the public service.

Our findings (p 60, Figures 15-16) indicate that a large number of tranys have received unemployment benefits, or have been granted sickness benefits under the assumption that they are unemployable, for long periods of time. Therefore:

C.2: We recommend that affirmative action programs be created by the Commonwealth Employment Service for tranys in job skills training.

Our findings (p 58, Table 9.3) indicate that employers are high on the list of discriminators. Therefore:

C.3: We recommend that programs be devised to educate employers about transgenders and encourage them to hire tranys on the basis of qualifications and job suitability.

Our findings (pp 25-26, Figure 5) indicate that, whilst transgenders are better educated than the rest of the population, those who are poorly educated virtually stand no chance of even achieving the most lowly-paid employment. Therefore:

C.4: We recommend that tranys be given access to better education through trany-specific adult literacy classes which are sensitive to trany needs, as well as higher education training programs.

Our findings (p 60, Table 9.6) indicate that even if they manage to get work transgenders are discriminated against by their fellow workers in the workplace, as well as just about everywhere else in public places. Therefore:

C.5: We recommend that government funding be provided for public education about trany needs, from school level upwards.

Our findings (pp 56-57, Table 9.2) indicate that one reason for so much trany dissatisfaction with psychiatrists and other medical professionals in the genital reconstruction process is due to a medical perception of transgender as a psychological dysfunction. Therefore:

C.6: We recommend that "transsexualism" as a symptom of gender dysphoria syndrome be removed from further editions and reprints of the Diagnostic and Statistical Manual.

Our findings (pp 5-6) indicate that there is a need to encourage more social research into transgenders in order to expand knowledge in the area of gender crossing. Therefore:

C.7: We recommend a creation of transgender status on databases.

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QUESTIONNAIRE FOR PEOPLE WITH TRANSGENDER ISSUES

PLEASE NOTE: WHERE ANSWERS ARE GIVEN NUMBERS 01, 02, 03 ETC. ONLY ONE RESPONSE IS REQUIRED, SO PLEASE CIRCLE ONLY ONE ANSWER. WHERE ANSWERS ARE GIVEN NUMBERS 1., 1., 1., THESE ARE MULTIPLE CHOICE ANSWERS AND YOU CAN CIRCLE MORE THAN ONE.

PART 1: DEMOGRAPHY.

1. What is your age?

01. <15
02. 16 - 20
03. 21 - 25
04. 26 - 30
05. 31 - 35
06. 36 - 40
07. 41 - 45
08. 46 - 50
09. 51 - 60
10. 61 and over

2. What gender were you given at birth?

01. Female
02. Male

3. What is your current gender?

01. Female
02. Male

4. Where are you living at present?

01. Sydney City & Inner Suburbs
02. Sydney - Eastern Suburbs
03. Sydney - Northern Suburbs
04. Sydney - Western Suburbs
05. Sydney - Southern Suburbs
06. NSW Country
07. Canberra
08. Melbourne
09. Brisbane
10. Perth
11. Other.....

5. What kind of accommodation are you currently living in?

Part 1: Accommodation type:

01. Refuge
02. Rental house/unit
03. Boarding house
04. Hotel
05. With parents
06. Other short term.....
.....
07. Share accommodation
08. With friends
09. Homeless
10. Housing Commission
11. Buying house/unit
12. Own house/unit

Part 2: What % of income is spent on rent?

01. 0 - 10 %
02. 11 - 20 %
03. 21 - 30 %
04. 31 - 40 %
05. 41 - 50%
06. 51 - 60 %
07. 61 - 70 %
08. 71 - 80 %
09. 81 - 90 %
10. 91 - 100 %

Part 3: How often have you moved in the past 5 years?

01. None
02. Once only
03. Twice only
04. Three times
05. Four times
06. Five times
07. Six times
08. Seven times
09. Eight times
10. Nine times
11. Ten times
12. More than ten times

6. What is your level of education?

01. Not attained School Cert.
02. School Certificate
03. Higher School Cert.
04. Matriculation
05. Trade Certificate
06. Currently doing tech. course
07. Currently doing a degree
08. Tertiary degree

7. What work experiences have you had?

Part 1: Before Gender change:

1. Own business
1. Factory work
1. Service industry
1. Transit industry
1. Beautician/hairdresser
1. Sales work
1. Porn actress/stripping
1. Sex work
1. Theatre
1. House work
1. Skilled trade
1. Welfare/health
1. Domestic work
1. Nursing
1. Teaching
1. Office work
1. Arts
1. Administrative
1. Other professional
1. Other work .....
.....
1. Never done other work

Part 2: After gender change:

1. Own business
1. Factory work
1. Service industry
1. Transit industry
1. Beautician/hairdresser
1. Sales work
1. Porn actress/stripping
1. Sex work
1. Theatre
1. House work
1. Skilled trade
1. Welfare/health
1. Domestic work
1. Nursing
1. Teaching
1. Office work
1. Arts
1. Administrative
1. Other professional
1. Other work .....
.....
1. Never done other work

Part 3: Present occupation

1. Own business
1. Factory work
1. Service industry
1. Transit industry
1. Beautician/hairdresser
1. Sales work
1. Porn actress/stripping
1. Sex work
1. Theatre
1. House work
1. Skilled trade
1. Welfare/health
1. Domestic work
1. Nursing
1. Teaching
1. Office work
1. Arts
1. Administrative
1. Other professional
1. Other work .....

.....

1: Never done other work

8. What Job Skills do you possess?

.....

.....

.....

.....

.....

9. What is your Marital Status?

01. Never married
02. De facto married
03. Married
04. Divorced
05. Separated

10. Where were your parents born?

1. White Australia
1. Aboriginal Australia
1. New Zealand
1. Polynesia
1. Melanesia/Micronesia
1. South East Asia
1. East Asia
1. Southern Asia
1. Africa
1. Middle East
1. Eastern Europe
1. Southern Europe
1. Northern Europe
1. British Isles
1. North America
1. Latin America
1. Other.....

11. What are/were your parent's occupations?

Part 1: Mother's occupation:

01. Home duties
02. Farmer
03. Own business
04. Professional
05. Manager
06. Executive
07. Clerk/Secretary
08. Labourer
09. Factory worker
10. Trades person
11. Transport worker
12. Service industry worker
13. Sex industry worker
14. Unemployed/Not employed
15. Other.....

.....

Part 2: Father's occupation:

01. Home duties
02. Farmer
03. Own business
04. Professional
05. Manager
06. Executive
07. Clerk/Secretary
08. Labourer
09. Factory worker
10. Trades person
11. Transport worker
12. Service industry worker
13. Sex industry worker
14. Unemployed/Not employed
15. Other.....

.....

12. What was your religious upbringing?

1. Church of England
1. Catholic
1. Other Protestant Churches
1. Orthodox (Greek or Russian)
1. Other Christian

.....

1. Islam
1. Buddhism
1. Hinduism
1. Jewish
1. Other Religion(s)

.....

1. Agnostic
1. Atheist

13. What is your current belief?

01. Church of England
02. Catholic
03. Other Protestant Churches
04. Orthodox (Greek or Russian)
05. Other Christian

.....

06. Islam
07. Buddhism
08. Hinduism
09. Jewish
10. Other Religion(s)

.....

11. Agnostic
12. Atheist

PART 2: SEXUAL ISSUES AND PRACTICES:

14. How would you describe your sexuality?

Part 1: Before Gender Change

01. Heterosexual (Straight)
02. Homosexual (Lesbian)
03. Bisexual
04. Asexual (Celibate)
05. Other.....

Part 2: After Gender Change:

01. Heterosexual (Straight)
02. Homosexual (Lesbian)
03. Bisexual
04. Asexual (Celibate)
05. Other.....

Who is/are your regular sex partner(s)?

Part 1: Type of Sex Partner(s):

1. No one
1. Casual acquaintances
1. Casual lovers
1. Regular lover(s)
1. De facto Husband/Wife
1. Other.....

Part 2: What is the duration of your longest above relationship (see part 1)?

01. Less than 3 months
02. 3 - 6 months
03. 6 - 12 months
04. 1 - 2 years
05. 2 - 3 years
06. 3 - 5 years
07. 5 - 10 years
08. Over 10 years

Part 3: When was the last time you had a meaningful relationship?

01. Less than 3 months ago
02. 3 - 6 months ago
03. 6 - 12 months ago
04. 1 - 2 years ago
05. 2 - 3 years ago
06. 3 - 5 years ago
07. 5 - 10 years ago
08. Over 10 years ago

16. What kind of sex do you have with these partners (see Q. 15)?

1. Oral
1. Anal
1. Vaginal
1. Group sex
1. B & D/ S & M
1. Fantasy
1. Other .....
.....

17. When you have sex with these partner(s) (see Q. 15) do you use:

Part 1: Safe sex items:

1. Condoms
1. Dental dams
1. Latex gloves
1. Other.....

Part 2: How often do you use condoms (see part I):

01. Always
02. Most of the time
03. Some of the time
04. Rarely
05. Never

Part 3: How often do you use other safe sex items (see part 1):

01. Always
02. Most of the time
03. Some of the time
04. Rarely
05. Never

18. Have you ever engaged in sex work?

Part 1: What kind of sex work?

1. Street work
1. Private
1. Parlour
1. Escort
1. Other .....

Part 2: What was the total length of time that you worked in the sex industry?

01. Less than 3 months
02. Between 3 and 6 months
03. Between 6 and 12 months
04. 1 - 2 years
05. 2 - 5 years
06. More than 5 years

Part 3: When did you last work in the sex industry?

01. Still working
02. Up until recently
03. 3 - 6 months ago
04. 6 - 12 months ago
05. 1 - 3 years ago
06. Over 3 years ago

19. As a sex worker, which of the following services do/did you offer?

1. Massage only
1. Hand relief only
1. Full French
1. French and Sex
1. Sex only
1. Anal sex
1. Kissing
1. Double/threesomes
1. Lesbian acts
1. Light dominance
1. Heavy dominance
1. Light submissive
1. Heavy submissive
1. Cross-dressing
1. Other fantasy
1. Stripping
1. Bucks parties
1. Sexual surrogate (therapy)

20. As a sex worker, do you use:

Part 1: Safe sex items:

1. Condoms
1. Dental dams
1. Latex gloves
1. Other.....

Part 2: How often do you use condoms (see part I):

01. Always
02. Most of the time
03. Some of the time
04. Rarely
05. Never

Part 3: How often do you use other safe sex items (see part 1):

01. Always
02. Most of the time
03. Some of the time
04. Rarely
05. Never

21. Have you ever experienced any of the following:

Part 1: Type of experience:

1. Rape (single)
1. Pack rape
1. Incest
1. Sex with other relative
1. Sex with family friend ("uncle" etc)
1. Other sexual assault

Part 2: Did this/these experiences occur at any of the following age(s) :

1. under 5
1. 5 - 7 years
1. 8 - 10 years
1. 11 - 13 years
1. 14 - 16 years
1. 17 - 19 years
1. 20 - 25 years
1. 26 - 30 years
1. 31 - 40 years
1. Over 40 years

Part 3: How did you feel about this/these experiences:

.....
.....
.....
.....
.....

PART 3: HEALTH ISSUES

22. STD Information:

Part 1: Which of the following diseases have you had?

1. Syphilis
1. Genital Herpes
1. Trichomonas
1. Non-Specific Urethritis (NSU)
1. Thrush
1. Lice
1. Hepatitis C
1. AIDS
1. AIDS-Related Illness
1. Gonorrhoea
1. Chlamydia
1. Gardnarella
1. Pelvic Inflammatory Dis. (PID)
1. Genital Warts
1. Hepatitis B
1. HIV
1. Other.....
1. Never had any of the above

Part 2: From whom did you get these?

1. Clients
1. Lover
1. One night stand
1. Through incestuous contact
1. Not applicable
1. Husband
1. Casual Lover(s)
1. Rapist
1. Other.....
.....

Part 3: Of those diseases you have had, how many have you had more than once?

01. None
02. One
03. Two
04. Three to five
05. More than five
06. Never had any diseases

23. Health Checks

Part 1: Which medical services do you use?

1. Private Doctor
1. Sexual Health Clinic
1. Psychologist
1. Endocrinologist
1. Community Nurse
1. Other.....
1. Community Health Centre
1. Psychiatrist
1. Plastic Surgeon
1. Urologist
1. Alternative therapists

.....

Part 2: Why do you see this/these medical service provider(s)?

1. STD check-up
1. HIV treatment
1. Genital realignment (sex-change)
1. Psychiatric Assessment
1. General Counselling
1. Dependency problems
1. HIV check-up
1. Prescription Drugs
1. Hormones
1. Other cosmetic surgery
1. Methadone treatment
1. Other therapy
1. Other .....

Part 3: How often do see this/these medical service provider(s)?

01. Once a week
02. Once a fortnight
03. Once every three weeks
04. Once a month
06. Every 2-6 months
07. Every 6 months-1 year
08. Less often than yearly
09. Never

24. Which of the following have you used?

Part 1: At present:

1. More than 30 cigarettes a day
1. 11-30 cigarettes a day
1. Less than 10 cigarettes a day
1. Non-smoker
1. Prescribed tranquillisers
1. Prescribed Anti-depressants
1. Prescribed Barbiturates
1. Other Prescribed pills
1. Prescribed Amphetamines
1. Marijuana
1. Ecstasy/MDA/Super K/Golden Dreams/Orgasm/other designer drug
1. LSD/Acid/Trips/Hallucinogenics
1. More than 4 drinks a day
1. More than one drink a day
1. More than a few drinks a week
1. At least one drink a week
1. Less than one drink a week
1. Never drink
1. Cocaine
1. Crack/Ice
1. Speed
1. Methadone
1. Heroin
1. Amyl Nitrate
1. Other.....

.....

Part 2: In the past:

1. More than 30 cigarettes a day
1. 11-30 cigarettes a day
1. Less than 10 cigarettes a day
1. Non-smoker
1. Prescribed tranquillisers
1. Prescribed Anti-depressants
1. Prescribed Barbiturates
1. Other Prescribed pills
1. Prescribed Amphetamines
1. Marijuana
1. Ecstasy/MDA/Super K/Golden Dreams/Orgasm/other designer drug
LSD/Acid/Trips/Hallucinogenic
1. More than 4 drinks a day
1. More than one drink a day
1. More than a few drinks a week
1. At least one drink a week
1. Less than one drink a week
1. Never drink
1. Cocaine
1. Crack/Ice
1. Speed
1. Methadone
1. Heroin
1. Amyl Nitrate
1. Other.....

.....

25. Intravenous Drug Use:

Part 1: Have you ever injected any drugs?

01. Yes
02. No

Part 2: If you answered yes when did you last share a needle?

01. Within the last 24 hours
02. Within the last week
03. Within the last month
04. Within the last 3 months
05. Within the last year
06. Within the last 5 years
07. Less often
08. Never Shared

26. Where do you mostly get information on STDs and AIDS?

1. Sex industry
1. Sexual health clinic
1. Needle exchange
1. Gay health service
1. Pamphlets
1. Friends/Relatives
1. School/University
1. Doctor
1. Community health service
1. Outreach service
1. Other health service
1. Media (TV, Radio, etc.)
1. Regular sex partners
1. Womens' health centre
1. Other.....

27. Who do you see for advice on STDs/HIV?

1. Your doctor
1. Sexual health clinic worker
1. Friends/Relatives
1. Other workers
1. SWOP worker
1. Other.....

.....

28. How do you think HIV is transmitted?

1. Oral sex with a condom/dam
1. Oral sex without a condom/dam
1. Anal sex without a condom
1. Hand relief
1. Kissing
1. Masturbation
1. Sharing needles
1. Vaginal sex with a condom
1. Vaginal sex without a condom
1. Anal sex with a condom
1. Touching
1. Sharing spas
1. Sharing cutlery/crockery
1. Working with HIV positive workers

29. What other general health problems do you experience?

1. Stress
1. Chronic Fatigue Syndrome
1. Emotional problems
1. Bad diet
1. Infections other than STDs
1. Depression
1. Isolation
1. Physical problems
1. Lack of exercise
1. Loss of sexual pleasure
1. Other.....

.....

How could existing health services be improved?

1. More outreach services
1. More flexible hours
1. Separation of needle exchange & sexual health issues.
1. Improved efficiency in dealing with regular check-ups
1. More multi-racial staff
1. More tranys in health services
1. Condoms more readily available
1. More sensitivity to trany issues
1. Improved attitude to workers
1. Other.....

PART 4: TRANSGENDER ISSUES

31. At what age did you change your gender?

01. Under 13
02. 14 - 17
03. 18 - 20
04. 21 - 25
05. 26 - 30
06. 31 - 35
07. 36 - 40
08. 41 - 50
09. 51 - 60
10. Over 60

32. Genital realignment (sex-change) surgery:

Part 1: Have you undergone genital realignment (sex-change) surgery?

01. Yes
02. No

Part 2: Where did this take place?

01. Sydney
02. Melbourne
03. Adelaide
04. Brisbane
05. Elsewhere in Australia .....
.....
06. U.S.A.
07. Europe
08. Nth Africa
09. Asia
10. Other.....

Part 3: At what age did you have this done?

01. Under 15
02. 16 - 20
03. 21 - 25
04. 26 - 30
05. 31 - 35
06. 36 - 40
07. 41 - 45
08. 46 - 50
09. 51 - 60
10. Over 60

Part 4: Describe how the outcome compares to your expectations?

.....
.....
.....
.....
.....

. **Have you had any of the following corrective surgery?**

1. Bowel resection
1. Skin graft rejection
1. Labial surgery
1. Clitoridectomy
1. Other vaginal enlargement
1. Scar tissue removal
1. Urinary Tract
1. Other.....

34. Which of the following other surgeries have you had?

1. Nose job
1. Adam's apple reduced
1. Electrolysis
1. Breast enlargement
1. Hip Implants
1. Dermabrasion
1. Facelift
1. Eyes lifted
1. Chin reduction
1. Cheekbones
1. Lip Collagen Implants
1. Lipectomy (Liposuction)
1. Other.....

35. How do you feel about the services provided by the following health professionals?

	A. Satisfactory	B. Unsatisfactory
1. General practitioners		
1. Endocrinologists		
1. Psychiatrists		
1. Urologists		
1. Surgeons		
1. Psychologists		
1. Nurses		
1. Other		

36. Please indicate whether any of the following have increased or decreased since your gender change:

	A. Increase	B. Steady	C. Decrease	D.n/a
1. Income				
1. Assets				
1. Attending parties				
1. Attending theatre				
1. Attending cinema				
1. Going to restaurants				
1. Going to Beach				
1. Going out in public				
1. Sports activities				
1. Club memberships				
1. Social Acceptance				
1. Other social life				
1. Other				

. Tell us about the ways in which you have been discriminated against on the grounds of your preferred gender:

Part 1: Who of the following have discriminated against you in this way?

1. Neighbours
1. Friends
1. Fellow-workers
1. Gays
1. Men in general
1. Doctors
1. Lawyers
1. Public Servants
1. Religious Ministers/Congregation
1. Family
1. Employers
1. Other tranys
1. Lesbians
1. Women in general
1. Other health professionals
1. Police
1. Shopkeepers/Restauranteurs
1. Other.....

.....

.....

Part 2: Where has this discrimination occurred?

1. Family home
1. Friends' homes
1. Trany venues
1. Lesbian venues
1. Legal Services
!. D S S
1. Welfare Offices
1. Other Govt. Offices .....
1. School/Tech/University
1. Public Transport
1. Credit rating
1. Neighbours' homes
1. Workplace
1. Gay venues
1. Medical Services
1. Police Department
1. C E S
1. Dept. of Motor Transport
1. Churches
1. Banks/Financial Services
1. Shops/Restaurants
1. Other .....

.....

.....

Part 3: How often do you suffer discrimination?

1. Never
1. Daily
1. Several times daily
1. Once a day
1. Once a week
1. Several times weekly
1. Once a month
1. Once a year

Part 4: Which of the following measures might help end discrimination:

1. Equal opportunities for tranys
1. Anti-Discrimination laws
1. Legal recognition of tranys
1. Disadvantaged status in law for tranys
1. Public education about trany issues
1. Funding trany community organisations
1. Training tranys in job skills
1. Funding research and action about trany needs
1. Increased access to education for tranys
1. Better media portrayals of tranys
1. Other .....

.....

. **Which of the following welfare benefits have you been on:**

Part 1: Type of Benefit:

1. Unemployment
1. Invalid Pension
1. Sickness Benefit
1. Never been on welfare

Part 2: If you are currently receiving a benefit, for how long have you been receiving this benefit?

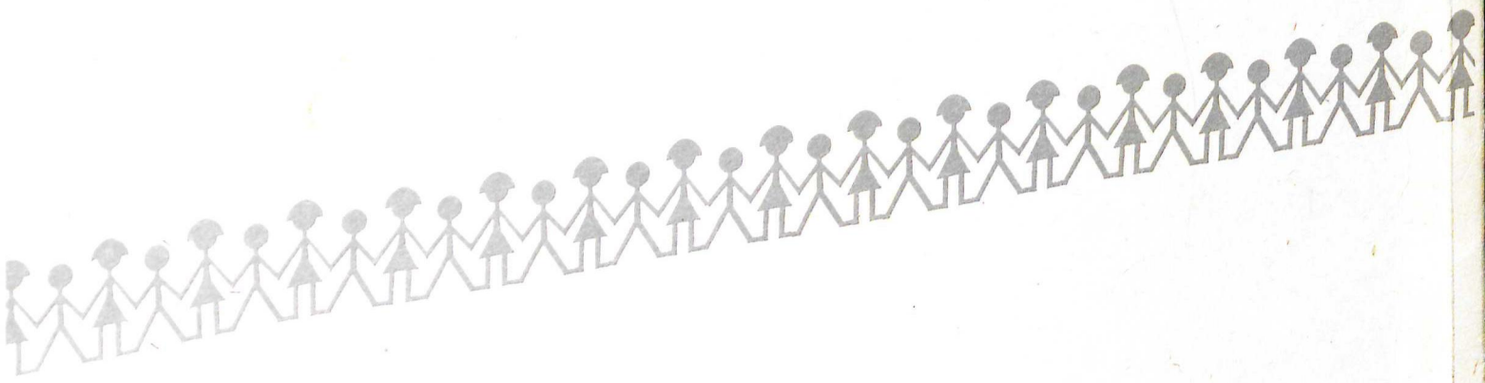
01. Less than 3 months
02. 3 - 6 months
03. 6 - 12 months
04. 1 - 2 years
05. 2 - 5 years
06. More than 5 years

39. How would you describe your relationship with the following people:

	A. Good	B. Bad	C. Indifferent
1. Mother			
1. Father			
1. Brothers			
1. Sisters			
1. Neighbours			
1. Work colleagues			
1. Other tranys			

40. Which of the following actions have you taken:

1. Suicide
1. Isolated yourself
1. Left family
1. Moved Inter-State (gender change related)
1. Emigrated (gender change related)
1. Left friends (gender change-related)
1. Self-mutilation



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