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Gender identity, healthcare access, and risk reduction among Malaysia's mak nyah community

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Abstract

Transgender women (TGW) face compounded levels of stigma and discrimination, resulting in multiple health risks and poor health outcomes. TGW identities are erased by forcing them into binary sex categories in society or treating them as men who have sex with men (MSM). In Malaysia, where both civil and religious law criminalize them for their identities, many TGW turn to sex work with inconsistent prevention methods, which increases their health risks. This qualitative study aims to understand how the identities of TGW sex workers shapes their healthcare utilization patterns and harm reduction behaviours. In-depth, semi-structured interviews were conducted with 21 male-to-female transgender (*mak nyah*) sex workers in Malaysia. Interviews were transcribed, translated into English, and analysed using thematic coding. Results suggest that TGW identity is shaped at an early age followed by incorporation into the *mak nyah* community where TGW were assisted in gender transition and introduced to sex work. While healthcare was accessible, it failed to address the multiple healthcare needs of TGW. Pressure for gender-affirming health procedures and fear of HIV and sexually transmitted infection screening led to potentially hazardous health behaviours. These findings have implications for developing holistic, culturally-sensitive prevention and healthcare services for TGW.

Keywords

transgender women; gender identity; gender-affirming care; HIV/STI prevention

Introduction

In public health research, a number of frequently-conflated terms serve as significant barriers to truly understanding and addressing a population's health needs. For instance, there is a common misclassification of the terms “sex”, “gender”, and “sexual orientation” as synonyms, which perpetuates a heteronormative structure with binary classifications for: 1) a person's biology as male or female; 2) socio-sexual identity (i.e. masculine or feminine);

and 3) sexual orientation (i.e. opposite-sex or same-sex attraction) (Valdes, 1996). For many transgender persons, this structure creates dissonance between their social identification and their biological sex, as well as sexual orientation. Not surprisingly, many researchers perpetuate this incorrect conflation of terms, which causes misunderstanding in service provision for diverse groups of people (i.e. gay or bisexual men, other men who have sex with men [MSM], and transgender women [TGW]) by virtue of inadequate targeted services and/or data granularity. Male-to-female transgender persons, or TGW, are individuals who are born biologically male but identify as women and may or may not have undergone gender-affirming surgery (e.g. vaginoplasty, breast augmentation, facial reconstruction, etc.) (Beemyn, n.d.); this term is distinct from sexual orientation. TGW, however, are often grouped with MSM, largely because of similar biological risk, resulting in a lack of specific data on health concerns within this specific population worldwide (UNAIDS, 2014). In one qualitative study, TGW expressed being socially excluded from MSM groups and that outreach efforts were largely focused on MSM and sex workers, but not targeted to TGW (Logie, James, Tharao, & Loutfy, 2012). Thus, TGW remain a vulnerable population with inadequate representation in HIV programming and insufficient data quantifying their burden of disease.

Where data on TGW are available, HIV burden is extremely high, with prevalence rates reaching 49% in some contexts (UNAIDS, 2014). A meta-analysis on the global burden of HIV among TGW found pooled HIV prevalence at 19.1%, with HIV prevalence in TGW being 48.8-fold higher compared to reproductive age adults (Baral et al., 2013). Despite excess burden, HIV prevention strategies lack specificity for TGW programming with only 43% of countries reporting in 2012 that they targeted TGW (UNAIDS, 2014). Consequently, TGW are both socially and medically marginalised, including from traditional healthcare settings and from HIV/AIDS prevention and treatment services.

The disproportionate HIV rates seen in TGW are related to mutual HIV risk and increased vulnerability. ‘Risk’ and ‘vulnerability,’ however, represent another set of frequently conflated terms relating to HIV in TGW. “Risk” refers to an individual’s likelihood of acquiring HIV infection, which is determined by engagement in behaviours that may result in transmission, such as unprotected sex or sharing needles (UNAIDS, 1998). It is rooted in the concept of “vulnerability,” which refers to social and structural factors that influence the likelihood that a person will contract HIV when they engage in elevated HIV risk behaviours, such as their social network, legal and economic structures, accessibility of prevention and treatment services, and societal marginalisation (Sumartojo, 2000; UNAIDS, 1998). While some TGW have similar biological risk as MSM, they may experience social vulnerabilities similar to cisgender females and structural vulnerabilities that are unique to them, given dichotomous gender structures (Daryani, 2011; LeBreton, 2013; Logie et al., 2012; Nemoto, Luke, Mamo, Ching, & Patria, 1999).

Several studies have highlighted the structural and social factors that stigmatise and marginalise TGW. Transphobia and societal discrimination are common experiences for TGW, which contribute to high rates of depression, suicidal ideation, substance abuse, and other mental illnesses within this population (Clements-Nolle, Marx, & Katz, 2006; Nemoto et al., 1999). Increased stigma and discrimination also impacts TGW’s ability to find and

maintain employment, leading many to turn to sex work to support themselves financially and increasing their risk for HIV and sexually transmitted infections (STI) (Nemoto et al., 1999; Reisner et al., 2009).

Gender-based health needs of TGW are also inadequately addressed in healthcare settings, due in part to individual and structural factors. Stigma, discrimination, and erasure (the lack of recognition of gender identity outside a male/female binary system) may restrict TGW's health-seeking behaviours for prevention, treatment, and care (Bauer et al., 2009). Additionally, TGW are often overtly stigmatised by or discriminated against in healthcare settings, ranging from incorrect pronoun use, insensitive treatment, judgmental statements and unwillingness to provide care (Logie et al., 2012; Lombardi, 2010). While most research on TGW health assessments focus on HIV and STI risk, it is evident that healthcare providers lack the crucial knowledge and cultural sensitivity regarding other important and relevant health concerns, including gender-affirming care, like hormone replacement therapy (HRT) and cosmetic surgery. In this context, we explore the importance of holistically integrating HIV/STI prevention with culturally-relevant and contextually-affirming healthcare to address the complex needs that are crucial to longitudinally engage TGW in care.

Background on Malaysia

Malaysia is a high, middle-income country of 29.7 million people located in Southeast Asia. Predominant ethnic groups include Malays and indigenous persons (67.4%), Chinese (24.6%) and Indian (7.3%). While Islam is the country's major religion, a sizeable portion of the population practices Buddhism (19%), Christianity (9%), or Hinduism (6%) (Department of Statistics Malaysia, 2011).

Though TGW are historically significant in Southeast Asia and Malaysian culture, the legal and public attitudes toward TGW have been tumultuous. TGW could access gender-affirming surgery and change their national identification cards to match their gender through the early 1980s. By 1983, however, mounting Islamic conservatism resulted in a *fatwa* that banned Muslims (and consequently all others) from genital-altering surgery, further increasing stigma and discrimination. In 1996, even surgically-affirmed non-Muslim TGW were unable to change their sex designation on their identification card (Suresh, n.d.).

Despite Malaysia's overarching secular government, religious (Sharia) law is also present and influences policies and practices. In this system, Muslim TGW risk imprisonment for publically expressing their gender identity and are charged as "men dressing as women," an offence punishable by fine and imprisonment. Secular laws also continue to criminalise "carnal intercourse against the order of nature," including oral and anal sex, which may uncommonly be invoked to fine or imprison TGW of any ethnicity (Attorney General's Chamber of Malaysia, 2006; Ghoshal, 2014).

The TGW community coined the term *mak nyah* ("mak" means "mother" in Malay) in 1987 to refer to TGW as a way to counteract growing discrimination of derogatory labels that grouped them as "effeminate males" (Slamah, 2005). Thus, the term *mak nyah* dually

distinguished TGW from MSM, while also preserving their dignity. Though the total number of TGW in Malaysia is unknown, an estimated 21,000 TGW engage in sex work, with 37.5% of them residing in greater Kuala Lumpur (Lim, Ang, & Teh, 2010); HIV prevalence among all TGW is estimated at 10% (Ministry of Health Malaysia, 2013). While some literature has highlighted the need for HIV prevention and advocacy services for *mak nyah* (Teh, 2008a), there is otherwise limited recent research available, particularly surrounding how their identity influences access to and engagement in healthcare generally and specifically for HIV prevention and treatment services.

Methods

Data from 21 *mak nyah* sex workers were analysed from a larger study that included an additional 19 female sex workers (FSWs) in greater Kuala Lumpur.

Data collection

Semi-structured, in-depth interview guides were developed to explore the topics of health behaviours, healthcare access, substance use, violence, and discrimination among FSW and *mak nyah* sex workers, recruited through convenience sampling at community-based organisations and through peer referral with the aim of targeting ethnic and geographic mobility, as well as diversity in sex work involvement. Interviews (60–90 minutes) were conducted between September 2013 and January 2014 in English, Malay, or Tamil.

Definitions

For the purposes of this paper, we use TGW as a global or general term, *mak nyah* for TGW specifically in the Malaysian context and *mak nyah* sex workers as TGW who met inclusion criteria for this study, encompassing those who traded sex for money, rent or services.

Data analysis

All interviews were recorded, transcribed, translated into English and back-translated (Brislin, 1970). Key findings from interviews were discussed between interviewers and investigators to understand broad themes. Transcripts were reviewed and thematically coded (BAG) and then collectively reviewed and discussed (BAG, SB, RR, FLA) to understand the prominent themes that emerged. After finalising coding structure, interviews were reviewed again to ensure accuracy of all codes. Coding and analysis was done using Atlas.ti software (ATLAS.ti, 2014). Institutional Review Boards at Yale University and the University of Malaya approved the study.

Results

A description of the 21 *mak nyah* sex workers can be found in Table 1 and linked to selected quotes. Overall, mean age was 41.5 years, including ethnic Malays (47.6%), Indians (42.8%), and other (9.5%). No significant differences emerged between ethnicities. Three prominent and connected themes emerged from the data: gender identity, healthcare utilisation, and HIV prevention priorities.

Gender Identity

Gender identity, central to all discussions, was of prime importance, which participants clarified was not defined by their biological sex designation. Concerns were raised about how their lives were commonly influenced by societal gender norms in relationships, behaviours, and occupational choice. Most participants focused on their childhood and gender transition. Common to these stories was the conflict in childhood that their inner gender awareness did not match their biological sex.

When I was in school at kindergarten, my late father dressed me in girl's clothes. When I was 12 years old, I was close to girls, not guys. In Form 3 [age 15], I would [pretend to be a] supermodel in the school's hall. Until now, I still act like this. It has come from my soul since I was small. – [4]

Many participants recalled displaying similar effeminate behaviours from a young age, often referring to themselves as “soft” and noting their inclination towards traditionally feminine activities. These behaviours were commonly met with resistance and abuse from family, teachers, and peers.

From the time I was small, I have been very soft. I used to wear my mother's sari. My mother would beat me but it is not like I wanted to be [like this]. God made me to be like this. I didn't like to play football with the boys; I cooked for fun like a girl. I only played volleyball like a girl. I only liked to be friends with girls.- [8]

Participants also felt their gender identity was not their choice. They often discussed the inevitability of their gender identity in the context of violence and discrimination.

In the world, there is male, female, and after that is transgender. We did not want be transgender but that is how God created us.- [20]

Of course I feel sad. People discriminate against you because you are transgender. It's not that you want to be like this.- [14]

As participants began to recognise and identify themselves as transgender, the transgender community played an important role in assisting them with transitioning and teaching them how to be a *mak nyah*.

I was born as a guy who is soft. I started to socialize [with other mak nyah] when I was 12 and I was already 'doing drag' when I was in Form 1 [age 13]. At that time, I was still confused about myself... [Then], around 15 to 16 years old I started having long hair.- [16]

We knew [mak nyah]. They wear women's clothing. They also wear wigs. We also want to look like those people. After that, [the mak nyah] gave us clothes. After one or two days, we also liked to dress like that. Before I came to KL (Kuala Lumpur), I always dressed like a male. Even though I was soft, I dressed like a male. I never took hormones. I just started doing that [in Kuala Lumpur]. I started dressing like a woman here. They taught me how to dress, also.- [8]

It should be noted that with gender transition, *mak nyah* participants did not necessarily identify as female. Participants seemed to find their gender identity across a spectrum, with

some feeling fluid in masculine and feminine expression, others feeling they are strictly women, and most identifying as transgender.

When [people] come to talk [to me], they always ask why can't I be a woman, a perfect woman or a perfect man. I say there is no perfect person in this world. If you tell me a woman is perfect, why are they killing their babies? Why does a man rape his daughter? Is there a perfect person in this world? No, sorry to say that...I was born to be a she-male and I didn't change myself to be like that. I didn't change myself to be a woman.- [18]

As part of the discussion on their identity, participants spoke about systemic discrimination embedded in the political and religious climate of Malaysia that marginalized them.

The government doesn't give any support for transgenders. In Singapore, India, and other countries, they support transgender: employment, housing, identity. Like in Singapore, they get female identity after [vaginoplasty]. They can get married and live. In Malaysia, it is a Muslim country, [there are] so many problems. Overseas [countries] have everything but here in Malaysia, we don't have [anything]. We only have ourselves.- [20]

As an Islamic country, we know we can't have equality. I just want no discrimination, to have my own rights, open minded organizations, companies that can accept transgender [women]. Most of the companies that accept transgender [women] are retail, hotels, shopping complex and [jobs are] very limited. Most transgender [women] are not stupid, but because of restrictions, they can't join government jobs. There are a lot of boundaries. It's because we have no chance that we are doing sex work. We don't want to do sex work.- [14]

The multiple levels of discrimination faced by *mak nyah* cause many to turn to sex work as their primary source of income, as they are unable to obtain and maintain formal employment (Teh, 2008b). As *mak nyah* help support each other, sex work is taught as a substantial source of income in a society that marginalises them. All participants mentioned that other members of the transgender community introduced them to sex work.

My friend was working in Singapore. She told me, 'You suffer with problems. You [should] come and work here. We are born as transgenders. We can work at a company but...that is too difficult. If you work at a company, you will not be satisfied. The guys will tease you. Here you will find some money and when you become stable, you will see.' After she recommended that, I started working there.- [20]

I knew of one Indian [mak nyah]. She asked me, 'You want money? Accompany me to [the red light area].' I noticed a lot of beautiful [mak nyah] and I became excited and wanted to be like them...She said if I want to get more money after work, I need to work here [as a sex worker]. Since then, I have gone to [the red light area].- [5]

Although a high proportion of *mak nyah* are sex workers (Teh, 2008b), the community is not defined by participating in sex work and camaraderie is much more dependent on gender than occupation. (Note: *Though mak nyah are not legally allowed to marry a male, several*

participants referred to their long-term intimate partners as “husbands,” supporting their identification as women).

I have a husband. We stay together. I’m a dancer. I come [to the red light area] to meet transgenders. Sometimes [I also come] to meet my regular customers for sex. Once they call me, then I come.- [13]

The transgender community is quite close. We always meet, mix up with each another once in a while. We know people from other places and other cities also.- [3]

There remains considerable competition between *mak nyah* who sell sex, as they try to solicit customers to support themselves. This is largely based on appearance, with substantial emphasis placed on beauty and femininity to attract customers.

[Competition] is quite strong...they say beauty is number one. Actually, breast is number one and second is beauty...the third, we call it ‘services.’- [3]

There are so many she-males who are bad looking, so they can’t work as a sex worker because when you talk about sex work, you need ‘the package.’ If you are not beautiful, you can’t earn and if you can’t earn, what will you do? I am so lucky I am beautiful so that I can make money... I thank God that I have this ‘package’ for me to work on the streets and get easy money.- [18]

For *mak nyah* sex workers, feminisation procedures play a dual role in both affirming an individual’s gender with their appearance and also helping them to solicit more customers. HRT is common and many had also undergone surgery for cosmetic procedures, with five participants having received vaginoplasty. Because of the religious climate, regulation, and cost in Malaysia, *mak nyah* usually travel outside the country, generally to Thailand, to receive gender-affirming surgeries.

I started taking hormones when I was 15. Now still take them but with my age being 37, the doctor advised me to reduce it. So, I just get extra vitamins. [I got] breast implants in Thailand because in Thailand the cost is a bit lower than Malaysia, RM4000 (USD\$1100). In Malaysia, it may be a bit expensive.- [5]

With such pressure for feminisation, widespread societal discrimination, and difficulty in accessing gender-affirming procedures, several practices have emerged that pose health concerns.

Healthcare access and utilisation

While *mak nyah* often experience stigma and discrimination in healthcare settings, they also must navigate through a system that largely does not recognise or accept their gender identity. Many healthcare providers are unaware of the health risks faced by *mak nyah* who self-regulate the transition of their bodies. There may also be a lack of clarity and comfort in discussing medically-assisted gender transitions, sexual organs, and high-risk behaviours between providers and their *mak nyah* patients who are sex workers.

A common practice among participants included HRT without prescription by a supervising physician. Often, HRT pills were purchased at pharmacies or obtained from friends and

multiple pills would be taken daily, with the aim of “speeding up” their transition. Participants spoke to their independence with HRT.

Sometimes, I inject hormones. I will accompany a friend to do an operation in Thailand and I will buy hormones there. Then, I will inject it here.- [17]

I take hormone injections. I will go to clinic only if my blood pressure goes up. I give myself injections once a week. Then, I take [hormone] capsules in the morning and at night.- [16]

Despite mostly non-supervised treatment, some participants mentioned receiving HRT from doctors at private, ‘for profit’ clinics who were friendly toward *mak nyah* and offered HRT, which allowed some monitoring of their transition. Beyond monitoring the gender transition, these *mak nyah*-friendly doctors also seemed to provide a safe, non-judgmental environment where some *mak nyah sex workers* would discuss sexual behaviors and receive screening for HIV and STIs.

I used to go and see my doctor at the clinic. My doctor really understands me and really understands she-males. She is very good with me and she always gives good advice. Even if I’m itchy, I go to her, [she asks] ‘Do you need injections? Cream?’ I don’t simply go to the pharmacy and buy the medicine. I believe I need to consult a doctor.- [18]

Sometimes I’m afraid to go to government hospital because my body is a ‘hormone body.’ Sometimes they inject a different injection. I’m scared about that. If we go to a clinic that knows we are transgender, they give medicine, take care and give results. That’s why we go there.- [20]

For blood tests...there is a special doctor for us. There’s [a private] clinic. They know we are [transgender] and doing this job [sex work].- [17]

Other participants mentioned receiving care from private doctors because they felt by paying more money, they would receive better care. While these providers were not labelled as transgender-friendly, they were seen as a way to maintain privacy and confidentiality.

At a private [clinic], they cost more money. If you pay, they will do their jobs. If [we go to a government [clinic], they will treat us, but very poorly...If at a private clinic, we don’t have any issue. It’s because we pay for it, right? If we pay for government clinic, we get less service.- [5]

While the government healthcare system is free, many reported avoiding it due to past discriminatory experiences. Participants who used government clinics recounted being denied care, mistreated, asked to change their appearance, or felt they had to present as male in order to receive proper care.

[The government clinic] staff is rude. When I say, ‘Doctor, I am [HIV-positive],’ they start thinking negatively and act uncomfortable towards me. When asked for bathing assistance, they got mad and asked me to clean myself...When my CD4 dropped, I was admitted to the ward for 5 days, 4 nights. They asked me to cut my hair... I had long hair but I accepted it.- [6]

When I'm sick, I go to my friends. My biggest worry is that I am infected with any virus. I'm very, very worried about that. I go to my friends and ask them first. Then, I go to the clinic. I will go to government clinic as a boy. Every time I go to the clinic, I camouflage myself as a normal male. [They don't say anything] because I came as a male.- [19]

To avoid discrimination, participants often withheld their sexual history from healthcare providers. For some, however, this meant that they were unable to be tested for HIV and STIs because they were not willing to share high-risk behaviours.

Oh. I do not tell [that I do sex work]. I hide everything. [The doctor] has asked, 'Do you have anal sex?' I said no because I'm afraid of disclosing my 'taboo' behaviours. [I don't know] if they can accept it or not.- [19]

I wanted to [get tested for HIV]. I have wanted to do it but I went to a government clinic and asked for it. The staff asked whether I am at risk for HIV and [if I told them], only then they would do a test.- [15]

Participants were asked about their mental health and while several responded that they often felt sad and depressed, they preferred keeping their feelings to themselves or turned to religion, friends, or substance use.

[When I'm depressed], I pray to God. I cry. He listens to me. He loves me. That is the only person I believe. He is the only person who can listen to me and he is the only one who can understand me.- [18]

After I separated with my husband, the first thing I wanted to do is commit suicide. I climbed to the 9th floor and stood. I wanted to jump but my friend grabbed me. When I was at home, I tried to play with knives...[My friend] took leave from work for a week to take care of me and it took me about 3 months to stop crying.- [19]

Risk reduction behaviours

As *mak nyah* sex workers are at increased risk for HIV and STIs, it is important that they utilise evidence-based prevention strategies. Condom use is the most commonly used risk reduction strategy for sex workers, but not fully effective without proper lubricants or if expired. To avoid healthcare systems, participants chose alternative and ineffective methods for preventing and treating HIV/STIs, such as self-medication with antibiotics, inspecting clients, and washing with antibacterial soap.

Testing for HIV/STIs was neither regular nor typical, partly due to healthcare-related stigma and discrimination, but additional fears emerged about learning they are HIV-positive and how they would be treated.

I have not tested. I'm afraid. HIV is not something like cancer or...if you ask me, I'm more worried about myself. HIV is not something that you easily get support from doctors, family or someone else. If you know you have HIV, your life will change immediately. This is not something easy and it's very serious. Definitely, it will change your life.- [14]

Despite reporting high-risk behaviors, they feared being HIV-positive but perceived themselves at low risk for HIV.

I feel I haven't had the chance [to test for HIV] and I'm scared. I know its important [but] I'm scared of the result. But my heart says strongly that I'm still clean.- [2]

Risk perception appeared to be mitigated by viewing condoms as fully protective against HIV/STIs. Multiple contradictions about condom use occurred, including use with paying but not regular customers and negotiated non-use situations. However, some participants were insistent on using condoms with all customers.

Yes, [customers] offer to pay more, RM50 (USD\$14) or RM20 (USD\$6). I won't do that. I advise them that in one day, ten customers have sex with me. So, if a customer has HIV, that means you will get it. It will spoil your life.- [20]

Of course I use condoms. All the time. Of course [customers request no condom], but normally I discuss this at the beginning and if the customer says he doesn't want to wear condom, its ok. I don't want your money.- [2]

Despite knowing that water-based lubricants with condoms were important, a few used a variety of lubricants that are incompatible with condoms.

When I was teenager, I used saliva, lotions, and K-Y [for lubricant]. The funniest thing I have used is mayonnaise. My K-Y finished, I saw mayonnaise so I took it for an instant fix...it's better than lotion because lotion has alcohol, right? [But] K-Y is better than mayonnaise.- [15]

Paradoxically, when probed, many participants did not use condoms with some customers, and instead inspected their customers and/or self-medicated with antibiotics.

I am doing sex work, and it impossible to use condoms for everyone, right? It depends, if he is good-looking and handsome, I will not use [condoms].- [16]

Honestly, no, sometimes I am not using [condoms]. I do my personal check to the person I am not using condoms with to see whether he has gonorrhoea or not. I pull from the [penis] base to tip. If he doesn't have anything, I will begin sex.- [15]

When I have sex with someone that I like without condoms, I will shower and clean myself. After that, I will take the antibiotic. I am also worried, so we need to prevent [infections].- [17]

With non-paying partners, condom use was much lower regardless of whether it was with a regular partner or a casual partner. In long-term relationships, no participant reported consistently using condoms.

[For customers], I use condoms. I only won't use condoms for my husband. Sometimes, I use condoms with my husband also. He works in Singapore and I don't know what happens there. If I feel something happened, then I use a condom with my husband. When we are drunk, sure, no condoms for my husband.- [13]

Discussion

Findings from this qualitative assessment provide important insights into how gender shapes not only past and current experiences within society, but also within healthcare establishments, especially surrounding gender-affirming treatments and HIV/STI prevention. Findings here build on a previously published legal framework for *mak nyah* in the Malaysian context and how it impacts sex work, other criminal behaviour and societal engagement. Figure 1 represents how the trajectory of a *mak nyah*'s identity influences their health risks and HIV risk behaviours in an environment with high levels of stigma and discrimination. While recognition of gender incongruence happens internally, it is typically with integration into the *mak nyah* community that individuals begin their gender transition. Sex work is generally introduced by key members of the *mak nyah* community but also is uniquely tied to gender transition. Transitioning often leads to workplace discrimination and a lack of other employment options, but sex work is also commonly used to finance gender-affirming procedures. *Mak nyah* who engage in sex work are thus subjected to increased levels of stigma and discrimination based not only on their gender identity and community affiliation, but also heightened by their engagement in illegal sex work. The synergy of these factors requires focused and concerted efforts to holistically create a supportive environment to meet the unique prevention and healthcare treatment needs of the *mak nyah* community.

Gender identity among *mak nyah* is similar to existing literature on TGW globally, especially in the shared experience of recognising the incongruence of their gender and biological sex early in childhood, and also in how they are treated. In Malaysia, however, the transition process happens later and importantly, with the support and guidance of the *mak nyah* community through trusted insights, friendship, and a strong community network. These same *mak nyah* also provided guidance about survival and initiated them into sex work.

The *mak nyah* community creates a de facto ethnic enclave that is not geographically restricted, demonstrating strong social cohesion. However, this is not always positive (Caughy, O'Campo, & Muntaner, 2003). While the community is supportive, it also promotes competition between *mak nyah sex workers* through guidance that accelerated and exaggerated the transitional process by endorsing self-regulation and overuse of HRT and medical tourism to Thailand for HRT and surgical gender-affirming activities (breast implants, etc.), all of which resulted in lack of supervision by licensed doctors locally.

Healthcare utilisation for *mak nyah sex workers* was rarely normative, despite multiple health risks that could be effectively addressed by holistic and comprehensive services. Healthcare use generally fell into three categories: 1) private and expensive "for-profit" care, from a transgender-sensitive doctor in some cases; 2) acute and erratic care from free governmental settings; or 3) care from free governmental clinics, but disguised physically as male. Neither HRT, other gender-affirming care, nor HIV/STI prevention or treatment was accessed at free clinics. Those seeking gender-affirming care at transgender-friendly clinics often still avoided HIV/STI prevention and treatment. Fear and stigma of positive test results often further restricted participants from seeking screening procedures. Though 14 of 21 participants had ever received HIV testing and 10 had ever received STI screening, only 8

were regularly screened for either HIV and/or STIs. Several participants reported commonly feeling sadness or depression, but mental health was never discussed or addressed in clinical or professional settings.

Not surprisingly, despite high HIV and STI prevalence among *mak nyah* sex workers, low perceived risk may have contributed to low screening levels, potentially due to denial given the contradictory statements about condom use. Moreover, most associated HIV with symptoms that they did not have, thereby assuming they were not infected and did not need to test routinely. Self-medication with antibiotics as a means to avoid HIV and not undergo testing is also concerning. Despite all participants recognizing the importance of condom use, only 15 of 21 participants reported consistently using condoms with customers and none of them consistently used condoms with non-paying, intimate partners.

Until funding ended in 2012, a sexual minority clinic (Safe Clinic) that provided tailored services for *mak nyah* and MSM was available. Since then, culturally-sensitive HIV prevention and treatment for *mak nyah*, aligned with HRT, are no longer routinely available in a single setting. Moreover, the Malaysian government does not provide funding for targeted HIV prevention or clinical care services for *mak nyah*. Such integrated services are likely to have the highest yield for retaining *mak nyah* in care, especially in Malaysia where gender identity for *mak nyah* is criminalised and where stigma and discrimination prevail. Routine and regular HIV/STI testing and other prevention services linked to gender-affirming care are urgently needed.

Additionally, *mak nyah* face legal barriers that prevent the recognition of their gender identity and instead criminalise it. This contributes to the widespread stigmatisation and marginalisation of *mak nyah* and prevents them from accessing adequate health and social services. It also perpetuates harmful practices, such as self-medication with antibiotics and the overuse of HRT, which can have detrimental health effects when not provided in a treatment setting.

Ultimately, evidence-based HIV treatment and prevention would greatly benefit from removing the existing structural barriers that perpetuate stigma and discrimination for *mak nyah* and specifically, *mak nyah* sex workers. Decriminalisation of gender expression and ability to change sex markers on national registration cards are crucial first steps. Given the community cohesiveness, social-network based prevention and healthcare engagement strategies should be considered and if efficacious, expanded more broadly. Culturally-sensitive education and supportive services are also necessary and should include providers in healthcare settings. It has been proposed that such cultural training should start during medical and nursing training (Earnshaw et al., 2014; Jin et al., 2014) and extend to current clinical providers.

Limitations

While a sample of 21 participants was sufficient for qualitative research (Mason, 2010), this data is descriptive and cannot be extrapolated to the entire TGW sex worker population nor the TGW population as a whole. Though a substantial proportion of *mak nyah* reside in Kuala Lumpur, these findings may not be representative of the experience of all *mak nyah*

who may not have access to clinical services, HIV prevention and/or related education. Moreover, Kuala Lumpur is an urban and more secular area of Malaysia and *mak nyah* may be more repressed, stigmatized and discriminated against elsewhere, resulting in less engagement in services and HIV prevention strategies. Lastly, our sample consists of predominately Malay and Indian *mak nyah* and thus, these results may not be characteristic of other ethnic communities in Malaysia, such as the Chinese.

Conclusion

This qualitative assessment adds to the limited information on identity and healthcare utilisation of *mak nyah* sex workers in Malaysia, who are even further marginalized in society, but remain at higher risk for HIV/STIs than *mak nyah* who do not engage in sex work. Importantly here, the healthcare and prevention system is poorly equipped to provide targeted HIV prevention and treatment, which would be optimized if aligned with gender-affirming treatments, such as HRT and other gender-affirming procedures. Ultimately, decriminalisation of both gender identity constraints and homosexuality will contribute to improved HIV prevention and treatment strategies, especially when provided in a culturally sensitive and supportive environment.

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Figure 1.
Model for understanding and holistically addressing health concerns relevant to *mak nyah*

Table 1

Participant references with demographics

Participant	Age (years)	Race	Healthcare utilization site	Gender-confirmation surgery?	Ever tested for HIV?	Ever tested for STIs?	HIV/STI screening within last year?	Reported condom use during SW
1	50	Malay	Transgender-Sensitive Provider	No	Yes	Yes	No	Consistent
2	50	Malay	Transgender-Sensitive Provider	No	No	No	No	Consistent
3	43	Malay	Private Clinic	No	Yes	Yes	Yes	Consistent
4	50	Malay	Governmental Hospital	No	Yes	Yes	No	Inconsistent
5	37	Malay	Private Clinic	No	Yes	No	No	Consistent
6	43	Indian	Governmental Hospital	No	Yes	No	No	Consistent
7	57	Indian	Governmental Hospital	Yes	No	No	No	Consistent
8	40	Indian	Transgender-Sensitive Provider	No	Yes	Yes	Yes	Consistent
9	47	Indian	Governmental Clinic	No	Yes	No	No	Consistent
10	55	Indian	Governmental Clinic	No	Yes	Yes	Yes	Consistent
11	33	Indian	Private Clinic	Yes	Yes	Yes	Yes	Consistent
12	44	Indian	Governmental Clinic	Yes	Yes	Yes	Yes	Consistent
13	40	Indian	Governmental Clinic	Yes	Yes	Yes	Yes	Consistent
14	35	Malay	Private & Governmental Clinics	No	No	No	No	Inconsistent
15	33	Bidayuh	Private Clinic	No	No	No	No	Inconsistent
16	26	Malay	Private Clinic	No	No	No	No	Inconsistent
17	35	Malay	Transgender-Sensitive Provider	No	Yes	No	No	Inconsistent
18	50	Iban/Chinese	Transgender-Sensitive Provider	No	Yes	Yes	Yes	Consistent
19	38	Malay	Governmental Clinic	No	No	No	No	Consistent
20	40	Indian	Transgender-Sensitive Provider	Yes	Yes	Yes	Yes	Inconsistent
21	26	Malay	Governmental Hospital	No	No	No	No	Inconsistent

NOTE: STI= Sexually Transmitted Infection; SW=Sex Work