RESEARCH **FINDINGS**

Female transgender in Pattaya: Age category based social relations, and pathways through the HIV testing, care and treatment cascade

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretro Viral
CAP-3D	Behavior Change Communication for Infectious Disease Prevention Program (Control and Prevention of 3 Diseases)
CBO	Community Based Organization
DIC	Drop-In-Center
FSW	Female Sex Worker
HIV	Human Immunodeficiency Virus
HIV+	HIV positive
HCT	HIV counseling and testing
IDI	In-Depth Interview
IPC	Interpersonal Communication
LNGO	Local Non-Governmental Organization
MSM	Men who have Sex with Men
MSW	Male Sex Workers
NGO	Non-Governmental Organization
NHSO	National Health Security Office
OI	Opportunistic Infection
PSI	Population Services International
STI	Sexually Transmitted Infections
SW	Sex Workers
SWING	Service Workers in Group
TB	Tuberculosis
TG	Transgender Person
TRCARC	Thai Red Cross AIDS Research Center
USAID	United States Agency for International Development

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EXECUTIVE SUMMARY

Program design. PSI/Thailand's support to Sisters provides prevention, HIV counselling and testing (HCT) and follow-up support and services for transgender women (TG) diagnosed HIV(+). This study finds that testing and treatment services for the TG population in Pattaya that are provided by Sisters through a peer driven approach should be strengthened to assure confidentiality. Specifically, clients accessing services need to be assured that other transgender persons will not come to know about health and treatment seeking behaviours related to sexually transmitted infections, including HIV and tuberculosis (TB). Disclosure is a significant barrier to practicing promoted behaviours.

Findings:

1. **Avoiding disclosure.** TG persons in Pattaya typically invest considerable amounts of time and energy to avoid disclosure of HIV+ status to other TG persons. TG persons reported perceiving themselves to be at risk of disclosure when visiting hospitals with specialised units offering HIV and TB services or when undertaking counselling at CBOs/LNGOs providing HCT (such as Sisters).
2. **Stigma among TG persons and importance of gossip.** TG persons in Pattaya do not divulge their innermost, private thoughts linked to anxieties about health (including HIV, STIs, and TB). A central element of the social practices of TG persons in Pattaya (as reported by TG respondents) include "bitching" and "gossiping" about each other. If a TG person's HIV+ status is disclosed, this person will be talked about by other TG persons and probably marginalised, stigmatised and excluded, both socially and from any money-making opportunities. This practice leads to a sense of competition and paranoia among members of the TG community.
3. **TG persons and the cascasde.** When TG persons are diagnosed HIV+, very few of them leave Pattaya to return to their homes (places of origin). The majority remain in Pattaya maintaining a low profile, avoiding CBOs acquaintances and other actors who might know their status. Many TG persons also migrate away for other sex work opportunities, are incarcerated in prison or change their mobile phone numbers.
4. **Delaying testing.** Many TG persons engage in risky sex for many years and experience HIV-related symptoms for long periods of time prior to undertaking testing.
5. **Quality of services.** A number of key health service providers within the HIV testing and treatment arena in Pattaya are not designed to, and do not offer a service, which guarantees a confidential, quality and respectful service for TG persons in Pattaya. This is a major barrier to testing, treatment initiation and treatment compliance.

6. **Social structure and social capital.** This study was premised on the notion that TG persons exist within a hierarchical social structure in which senior TG persons might be leveraged programmatically to message to and influence younger TG persons with regard to a range of important behavioural domains (condom use, HIV testing, initiation of ART, and compliance). Many respondents (particularly HIV+ respondents) live an isolated existence as individuals rather than as social actors in a hierarchy or community. It is not correct to consider the TG persons to be living in a community of social actors with a clearly understandable social structure. There is a loose social structure in place where a more senior TG woman will help the more recent arrivals with beauty tips and finding employment, but this role is more professional than intimate.

Recommendations for Social Marketing Program Design

- Refocus support from a static clinical site (Sisters) DIC to mobile HCT, provided by cis-gender individuals who are separated from the TG social network. Provide testing and treatment through private general health providers within a Social Franchise network. Provide confidential mobile phone-based and social media-based counselling about key behaviors.
- Conduct training with auxiliary and administrative staff in government hospitals (particularly Banglamung Hospital) on: (i) practical approaches to treating clients with respect; (ii) interpersonal skills; (iii) confidentiality and privacy, especially in the context of the unique needs of transgender individuals.
- Conduct advocacy to Banglamung hospital where TG persons go for testing and treatment. Provide advice in the redesign of schedules, facility/specialist unit physical design and client flow management to maximise privacy and confidentiality and minimise risk of disclosure.
- Conduct promotional campaigns to remove misconceptions about the negative experience of ART and emphasise the benefits of early initiation of and compliance with treatment. Focus messaging on the benefits of ART helping TG persons to stay healthy and maintaining a healthy appearance. Emphasise that this will mitigate obvious symptoms of HIV (which provides a tactic for avoiding disclosure and stigmatisation). Emphasise the benefits of ART, including the ability to continue living and earning money. The goal should be to paint HIV as a chronic but manageable disease, not a death sentence.
- Social Marketing Programs should not be designed / initiated to influence or message to younger/more junior TG persons via older/more senior TG persons given as there is limited evidence that this social structure exists in a uniform, consistent and widespread fashion.

1. INTRODUCTION

1.1. Background

PSI/Thailand is implementing a program targeting transgender women (TG women) in Pattaya. The purpose of the program is to promote safer sex among TG persons through peer education and drop in centre activities in Pattaya (Sisters organisation), and using a high coverage social marketing strategy to increase access to and availability of condoms and water-based lubricant. Activities in the drop-in centre include: (i)designing and implementing culturally appropriate behaviour change programs through interpersonal communication, (ii)ensuring access to high-quality voluntary counselling and testing services, (iii)developing the capacity of most at risk populations to lead prevention activities, (iv)creating safe spaces for most at risk populations, (v)enhancing access to essential care and treatment services for HIV, (vi)monitoring and evaluation of all activities and documenting lesson learned. Outreach activities through peer educators are conducted at their places of residence and public venues frequented by TG women, such as pubs, bars, apartments, the beach, and parks. Interpersonal communication sponsored by Sisters TG persons includes HIV knowledge and promotion of safer sex.

1.2. Research aims and objectives

The study aims to inform future demand generation activities and strengthen programming to reduce leakage along the HIV testing, care and treatment cascade.

1.2.1 Hypothesized social dynamics

The first element of the study aims to explore the nature of the relationship between two hypothesised categories of social actors of the female transgender target group. The first was thought to be composed of older more experienced transgender women. The second was assumed to be composed of younger female transgender individuals who have shorter periods of experience of working in Pattaya. These categories of actors are referred, in Thai language, as 'phee saw' (older and more professionally experienced) and as 'nong saw' (younger, less experienced). The study aimed to understand the evolving nature of the relationship between these two categories of actors to establish what strategies and programmatic interventions can leveraged off the well-observed relationship between the two categories of actors (which was understood to be informed by hierarchy, status, esteem and respect). This component of the study aimed to understand these population segments in order to inform PSI's communication approach to generate demand for HIV counselling and testing services.

1.2.2 Navigating the HCT cascade

The second element of the study aims to investigate at what point TG are lost within the prevention, care and treatment cascade and why. This includes a detailed understanding of barriers to HCT uptake and common responses to diagnosis, and

how and where services are accessed. The rationale for this focus emerges from PSI/Thailand's anecdotal observation that a small number of TG in Pattaya undertake HIV testing and remain within the testing to treatment cascade. PSI/Thailand has very little empirically grounded understanding of what happens to TG after they test positive. This study aims to fill this empirical gap in order to strengthen programming to retain TG-positive individuals within the program.

1.3. Participants

The study population includes transgender women residing in Pattaya for at least three months who are over the age of 18.

1.4. Study location

The study was carried out in the city of Pattaya. Pattaya has been selected as a study location because it is a hub for in-migration of tansgender women and is an important focus of PSI/Thailand's work with Transgender women in partnership with Sisters.

1.5. Research context and significance

PSI has conducted three rounds of TRaC – (Tracking Results Continuously) surveys among Transgender women in Pattaya. Survey rounds occurred in 2005, 2006 and 2009. The surveys focused on correct and consistent condom use behaviours and additionally generated behavioural data, including data on uptake of HIV testing.

There were no statistically significant differences between the second and third survey rounds for condom use at last sex with regular and casual partners, but for commercial partners, it increased significantly from 85.28% to 92.56% ($p<.001$). In 2006, water-based lubricant used at last sex decreased significantly from 2005 but improved in 2009 (2005: 78.52%, 2006: 71.34% and 2009: 83.86%, $p<.001$). Water-based lubricant use along with condom at last sex also improved in 2009 (2005: 75.73%, 2006: 67.84% and 2009: 81.91%, $p<.001$).

In 2011 PSI/Thailand also implemented a FoQus (PSI framework for qualitative research in social marketing) qualitative study investigating factors associated with sexual risk behaviors among Transgender women in Pattaya, Satthip and Sriracha (Chonburi Province). The key behaviour of focus for the FoQus study was correct and consistent condom use.

These studies have provided insights into factors impacting correct and consistent condom use and, to a smaller extent HIV testing. This study will focus specifically on HIV testing and expand upon the findings of the previously mentioned investigations.

2. STUDY APPROACH

2.1. Methodology

The study employs a qualitative research method to generate narratives from TG respondents and key informants. The attached study design presents the study methods in details.

2.1.1. In-Depth Interviews: Key Informants

"Key informants" are individuals who are not TG themselves, but work closely with the target group and are able to provide insight into the behaviours, motivations and social structures of TG women in Pattaya. Eleven key informants were selected to provide expert insight on a range of aspects of behavioural, programmatic and strategic issues that are relevant to the study. Key informants were selected from the following professional areas: (i) managers and staff members of organisations providing services for, and products and information to, TG persons; (ii) counsellors within organisations offering HCT in Pattaya; (iii) One TG person who is HIV+ who lived in Pattaya but is now resident in Bangkok who shed light on how TG persons access ART outside Pattaya to avoid disclosure.

2.1.2. In-Depth Interviews: Individual TG respondents

Sixteen individual TG persons were selected from four strata of TG persons (described in section 2.2. 'Sampling' below). Participants were interviewed around the following thematic areas: (i) behavioural (condom use; undertaking HCT; ART initiation; ART compliance), (ii)socio-demographics, (iii)psychographics, (iv) 'openings' to information and (v) how the respondent reacts to a HIV+ diagnosis.

The 16 interview respondents were stratified according to the following variables:

2.1. Never Tested	2.2. Tested positive but not yet on ART	2.3. Tested positive – already on ART but inconsistent user	2.4. Tested positive – compliant user of ART
5	5	0 (2 substitutes used, please section below for explanation)	6
TOTAL			**16**

2.2. Recruitment

The research team faced a large number of challenges recruiting TG persons from group 2.3. (see table above: Tested positive – already on ART but inconsistent user). There were two main reasons for this. First, TG persons who have tested HIV+ but are inconsistent users tend to deliberately avoid CBOs (Community Based Organisations)

and other health providers. Given that recruitment for this study was implemented through CBO partners and actors working in the HIV prevention, testing and treatment arena, it proved very difficult to locate and recruit TG persons in this strata. Second, TG persons in the category typically make considerable efforts to avoid contact with health providers and community members, who might disclose their status to other TG persons. It was therefore not feasible to recruit subjects from the TG population in Pattaya.

Given challenges in recruiting for group 2.3, the research team employed two strategies to mitigate the risk of a biased or incomplete sample. An additional subject was recruited from strata 2.4. (Tested positive – compliant user of ART). The sample of strata 2.4. was increased to six. The researchers explored phases in the health, and treatment, seeking trajectories of TG persons in this group at points in their lives when they were inconsistent users of ART (which was a common phenomenon) to compensate for the difficulties in recruiting for strata 2.3. In addition to this, the team boosted the number of key informant interviews. The team included two additional HCT counsellors working at CBOs who are exposed to a large number of TG persons who are already on ART but are inconsistent users. These two additional HCT counsellor respondents are referred to as 'substitutes' within the context of group 2.3.

3. FINDINGS

3.1. Archetype

3.1.1. Section introduction

This section presents insights emerging from an analysis of the target audience's archetype data (which includes socio-demographics and psychographics).

3.1.2. Socio-demographics

Twenty-seven in-depth interviews were conducted with key informants and transgender respondents. Eleven out of 27 interviews respondents are key informants and the remaining 16 are transgender respondents (IDIs).

The age of TG IDI respondents was diverse. The youngest informant was 19 years old. Six of them were 29 years and younger. Half (8/16) of informants were aged 30 to 39 years. The remaining 2 informants fell in the 40 to 48 years age range.

3.1.2.1. Internal Migration in Thailand

Over half of the TG respondents were from one of two regions: seven reported Northeast of Thailand as their place of origin while four of the 16 respondents were from North of Thailand. Two were from the East, three from the Central region (including one from Bangkok) and one from Laos PDR. Income disparity across regions in Thailand has driven internal rural-urban migration, especially from the North and Northeast, as people migrate into cities to look for work. By 1991, the income in the Northeast was 10 times lower than in Bangkok (Krajangvej 2001, 21). According to World Bank in 1992, 'more than a fifth of the population in the Northeast and a seventh of those in the North remained poor.' Over three-quarters of Thailand's poor population lived in these two regions, especially rural areas, in 2011. Regional income inequality remains today and the most destitute regions are in the North and Northeast (Bird, et al. 2011, 1). Driven by economic hardship, rural poor migrate to urban areas and tourist destinations like Pattaya and Phuket to seek income-generating opportunities. Many respondents reported that they decided to emigrate from home because they needed to find an income source to support their family.

> *"I decided to pack my bag and come with a sex work broker, who back then went to poor rural households to buy girls and pick them up in a van. My parents did not want me to go. It was my own decision because we were so poor."* SH41505, 46 (TG Case 14 IDI)

The majority of TG respondents are from these rural areas. Seven of them come from broken families (their parents have separated and one of the parents has a new partner). Typically, they also have half-siblings.

3.1.2.2 Demographics of Independent Respondents

With regard to education, five TG persons finished school in a range from grade four to six. Two of them were educated to the 7th-9th grade level. Five finished high school. Two of them attended and finished vocational school, which is equivalent to the first year of college. One of the informants graduated from a university, and one is currently enrolled at a university. In the past, education was accessible to children from families with higher incomes and a privilege reserved for the economically prosperous. (Krajangvej 2001, 21). Therefore, poverty also resulted in low levels of education resulting in limited economic opportunities for rural people.

Chronologically, the IDIs arrived in Pattaya over a long period of time. One arrived between 1985 and 1989. Four arrived in Pattaya between 1990 and 1994. Eight respondents arrived in Pattaya between 2000 and 2009. Two informants arrived in Pattaya around one to five years ago (from 2010 to 2013). One respondent arrived in 2014. Six respondents have lived in Pattaya for 20 years or more, but some of them have not stayed in Pattaya continuously. More than a half of the respondents settled down in Pattaya more than 10 years ago.

In terms of their occupation, almost all respondents had engaged in transactional sex work at some phase in their lives whilst in Pattaya. Some respondents reported engaging in transactional sex at present. Some work as sex workers on an occasional basis or to generate a secondary income. Other respondents have other permanent jobs, working as hotel staff, hotel promoters, or motorcycle taxi drivers. There was only one respondent who is currently a student.

Almost half of all the respondents did not talk about their living circumstances (i.e. where they live and who they live with). Three of the respondents reported that they live alone. Three of them are living in a transgender house at Glory Hut (Bann Phak Rak Phuen), which is a shelter for HIV + people who do not want to go back to live with their family or have been ill and do not have a place to stay. One of them indicated that she lives with her boyfriend. Two live with their family and one lives with her TG friend who inspired her to come to Pattaya.

3.1.3. Psychographics

There are various reasons why transgender respondents came to Pattaya. Most of the respondents stated that they decided to come to Pattaya to seek financial opportunities. They learned about this possibility from different sources, usually friends or senior transgender women who came to Pattaya and earned quite a bit of money to support their families. Most of them came to Pattaya with the hope that they will find a good job with a steady and sizeable income, enabling them to support their family back in their region of origin. Some of them have regularly remitted money home. A couple of them shared that their families could not accept the fact that they are male-to-female transgender. Therefore, they decided to leave home and seek jobs in which they can earn a lot of money, sending it back home and proving that, regardless gender identity, they are capable of supporting their family financially. Some respondents felt that it is their responsibility to work hard and support their family because they are a single child or the oldest child in their families, fitting into traditional family roles despite their gender identity.

With regard to their emotional aspirations, most transgender women admitted that they want to find husbands who could support them financially. This was the original aspiration, almost like a fairytale, that attracted them to come to Pattaya. Most informants said that it was all TG persons' dream to have a farang husband, so that their economic status will be improved and they will be well accepted by other TG persons and their families. If this happens they can remit more money back home.

However, many respondents shared that they would be happy if men just gave them money, as some do not want steady partners. Some respondents indicated that they would be happy to receive money from men, but those men do not need to take care of them mentally, emotionally or sexually. They preferred to spend their live alone and wanted to continue to live without commitments to another individual.

Some respondents came to Pattaya hoping to earn enough money to have their breasts enlarged or have sex reassignment surgery and beautify themselves, connecting economic and emotional aspirations. However, some TG persons stated that after some time they realized that true love or lifelong partnerships are not realistic for TG persons because ultimately those men decided to marry cisgender women and have children.

When they were asked about fears and anxieties, some TG persons indicated that after being diagnosed HIV+ or getting sick, they were more concerned that they would never be able to financially support their families than they were about dying. Most respondents stressed that they are afraid that their family will be disappointed if they came to know that they are HIV+. Some are afraid that they will be isolated if anyone (especially their family, steady partners and other TG persons in Pattaya) knows their status. Anxieties about loss of physical beauty were also common. One respondent said that she is afraid that people will look down on her because people believe that all TG persons in Pattaya are sex workers, but she is not.

Only a small number of TG respondents described having role models. Their role models are successful TG persons who have been well accepted by people in society. They are famous singers, super models and Miss Tiffany. They include, for example, Aunt Zhen Zhen (singer), Ornapa Krisadee (super model, actress, make-up artist, talk show host and celebrity) and Mick, Miss Tiffany 2010.

ORNAPA KRISADEE

Source: BE Magazine

ZHEN ZHEN

Source: http://www.siamrath.co.th/web/?q=node/48283

Some respondent have role models who are senior TG persons from their same place of origin. Alternatively, the Khun Mae can serve as a role model, especially if she is financially successful or pretty. One of the respondents described Erin Brokovich, the strong successful woman with a low level of education, as her role model.

3.1.4. Media habits and "openings" to information and modes of communication

All respondents frequently used a variety of media, and "openings" to information and modes of communication, especially HIV-related information, are common. The most common media that the respondents use are Facebook and LINE. Most of them use these two types of media to socialize with their friends. However, some who have worked as NGO outreach officers or care and support officers have also used LINE to follow-up with their peers about consistency of treatment or HCT services. Some respondents have used Facebook and Badoo, WeChat and WeTalk to flirt with men and search for potential clients or casual sex partners. Moreover, there are a many respondents who use Facebook for online shopping.

Many respondents described searching for information about HIV and STIs on the Internet. Some also watch TV and YouTube. Most of the respondents seek information from their friends or outreach and care support officers for different kinds of information. They talk to friends about beauty, plastic surgery, how to earn more income and how to seek better jobs with higher income. However, they do not talk about HIV, STIs, sexual health or care and treatment for HIV and OIs. Most of them are afraid that their acquaintances will make an assumption about their health condition, and gossip with other TG persons, spreading a rumor that they are HIV+.

Some watch video clips, movies and TV series for relaxation after a stressful day of work and to distract themselves from their problems.

3.2. Social structures and relations

3.2.1. Background

This section explores social structures and arrangements of TG in Pattaya, relating a set of interlinked objectives in the study design. The study aimed to better understand social structures within the TG community to leverage predicted social hierarchical relationship of reciprocity, utilizing the influence of older and respected TG persons to promote behaviour change among younger transgender women.

3.2.2. Starting assumptions and social structure

This study was carried out under a number of assumptions. First, TG persons in Pattaya could be conceptualised as a population, consisting of discrete categories of actors within a defined and describable social network. Second, the assumption that TG persons inhabit a hierarchical social structure composed of debutants and more experienced and well-respected women.

3.2.3. Terminology

TG respondents in Pattaya used three key terms in Thai language that will be deployed throughout this section. 'Khun Mae' are older TG persons that have some measure of respect or seniority. 'Mamasang' are brokers or managers within a bar, strip-club or nightclub venue in which transactional sex is arranged. 'Looksaw/Looksaaw' are younger, more junior TG persons.

The definitions of key terms are presented in an extremely simplified form and are in some ways misleading. The analysis in this section will shed light on the challenge associated with these terms.

3.2.4. Lack of continuity across relationships

The social structure and relationships of TG persons in Pattaya are superficially enigmatic, confusing and unclear. No clear set of narratives were generated about TG social structures/relationships across segments of TG persons (seniority, age, length of duration in Pattaya). The main reason for this superficial lack of clarity and existence of an empirical enigma is informed partly by the assumptions underpinning the study design. These assumptions are based in a widespread understanding that populations must exist within a context of definable social structures that can be conceptualised as a community. This was not found to be applicable to the TG persons of Pattaya.

This section will present the different dimensions of social structures and relationships of TG in Pattaya. However, the key characteristic of TG persons' narrated life-experiences in Pattaya is the sense of isolation, loneliness and dislocation.

3.2.5. Key findings: Social structure and relations

Causal factors in the sense of isolation and lack of community
There are several distinct structural factors which inform TG persons' sense of isolation and lack of community.

Analysis of the socio-demographics of respondents indicates that the majority of TG persons originate from poor households in North and North-Eastern Thailand. TG persons in Pattaya feel a need and pressure to generate income for their poor families. This often leads to TG persons engaging in transactional sex or other income generating activities in a competitive and risky fashion.

Analysis of the psychographics and narratives of TG respondents indicate that many TG persons feel marginalised, stigmatised and excluded from mainstream society. Many feel that their family members disapprove of them and their life-choices. TG persons deal with this experience of low self-esteem and perceived stigma and disapproval by engaging in livelihood activities that are risky but generate high levels of income. The heightened sense of guilt that many TG persons experience leads TG persons to engage in competitive and risky behaviors to attempt to compensate for these perceptions by earning money.

The transactional sex industry in Pattaya is extremely visible. However, the illicit nature of the business forces the business underground, and allows it to operate independently of the legal system. This means that workers in the sex industry do not benefit from the protections of rights and accountability measures that would protect a legally employed labor force. TG persons can often therefore be subjected to pressures, incentive systems and coercive profit-motivated practices. Because of this, TG persons relate to each other in a cautious, suspicious fashion. Transgender women tend to view each other as competitors rather than in solidarity with each other.

"When a TG with a new face appears who does not have a Khun Mae, they can be attacked and/or slapped by TG persons gangs. If they are not a tough kind, it is very risky to be freelancers on walking street." (KII2_SWING)

From a practical perspective TG persons have spatio-geographically limited networks of TG acquaintances. Pattaya is a large city, and the population of TG persons in Pattaya is large. Networks tend to form among TG women working in the same geographic area. Additionally, the sex industry in Pattaya in organized by territories. Transactional sex businesses typically organise themselves geographically into zones and sois (smaller streets), for example. TG persons that stray across zonal boundaries risk physical and verbal assault from other TG persons. The spatial organisation of business is overseen by what are described as "gangster" Khun Mae.

"On Walking Street, there are specific zones for different groups of TG persons. There is ton makham zone and ton soi zone. If any of them cross the boundary, conflicts occur. At the moment there are beer bars in ton makham zone, which have some conflicts as some TG persons cross the boundary. Physical violence is involved." (KII2_SWING)

As a result, TG persons who work in the sex industry (which is a large proportion the TG persons in Pattaya) typically only know other TG persons that work in their vicinity.

"Yes, like Soi 7, Soi 8, we would know [all TG persons] but beyond that 'no'. Pattaya is big."
SS42007, 37 (TG Case 9 IDI)

This phenomenon creates a very practical and concrete barrier to many TG persons interacting with other TG persons outside of a limited geographical context who are in the same socio-professional domain as themselves. Many TG persons are not able to interact freely with TG persons from other socio-professional domains in other geographical contexts. This limits the formation of community, interdependency and a mature level of social support that goes beyond the functional.

Social hierarchy

This section presents a small number of references to a social hierarchy within the population of TG persons within Pattaya. TG persons are described by a minority of respondents as existing within a distinct social hierarchy.

"There is a hierarchy among TG persons. The one on top of the hierarchy is the queen or " Khun Mae, who usually does not have to do things and younger TG persons (based on age or numbers of year working in Pattaya) serve them. Their jobs are to take care of younger TG persons." (KII1_HON)

TG persons are described by some respondents as being close and having a social structure akin to a 'traditional' nuclear family.

'How close they are? They said that they treat each other like family. They take care of new comers and look saaw. They trust each other like family members." (KII1_HON)

This may appear to contradict the points made earlier in this section about the isolation and atomised experience of TG persons in Pattaya. It is a frequent phenomenon within social scientific studies that social actors have divergent and contradictory understandings of social structures. Often their understandings are based on their position within the social structure. Furthermore, it is apparent that whilst particular social actors may construct narrative descriptions of a social structure, these structures are only a superficial manifestation, and provide no network for describing the inner thoughts that dominate in social actor's minds and that inform their individual and often private social practices. This appears to be the case among the TG persons of Pattaya.

Social Support

Whilst the vast majority describe a sense of dislocation, fragmentation, isolation and atomisation based on a competitive 'bitchiness' with each other, some respondents described a number of examples of social support.

This section investigates the kind of social support that TG persons offer one another and the characteristics of that social support.

<u>Social support: professional/financial</u>

Senior TG persons help other TG persons find work.

"Some senior katoeys usually introduce the jobs to me." SS42007, 37 (TG Case 9 IDI)

Mamasang help sex workers working as venue-based FSWs help FSWs get more clients.

"…but mamasung, who are a type of Khun Mae, have a managerial role in their work places. If she asks jae or look saaw to do something, they cannot deny. What they say/order is an absolute. If look saaw deny their authority, they may get into trouble and may not find any clients because mamasang are responsible for finding clients for their look saaw." (KII2_SWING)

There are examples of TG persons helping each other when their acquaintances are sick or HIV positive.

"When some TG persons get sick, I take them to clinics or hospitals." CS50502, 49 (TG Case 6 KII)

Social support: general

In a number of cases TG persons provide each other with multidimensional support and assistance.

"Quite a lot of TG persons did not know anybody in Pattaya when they arrived and most of them started to work in strip clubs and then the so call "Khun Mae" or the queen or mom provide them various kind of support including giving them clothes, beautify them, (making them more ready for the [sex/ entertainment] industry), food, advice, lending them money if they need it (as some of them come here with very little money)." (KII1_HON)

"When she first came to Pattaya, Khun Mae provided some help, accommodation and guided her how to survive in Pattaya. They talked about health and beauty. She went to beauty clinics together with her Khun Maes for beautification and the older TG persons paid for her." CS32810, 36 (TG case7 KII)

Situational/fluid nature of support

Whilst TG persons may provide one another social support in some contexts, the assumption within the study design that social support was based on a platform of solid, stable and hierarchical social relationships is not consistent with insights and the data. Social support is garnered and offered in a fluid, dynamic, situational, ephemeral and opportunistic manner. The actors involved in these social support interactions change and shift.

"Some daughters may come to me for this advice and to others for another advice." CS50502, 49 (TG Case 6 KII)

Generational shifts and differences of perspectives

One strand in the narratives of respondents emphasised that the relationship between elder and younger TG persons had changed from previous times. In contemporary Pattaya younger TG persons feel that it is important to pay lip service to established customary relationships of hierarchy and etiquette. However, they increasingly question and challenge this relationship and pay decreasing levels of respect to this relationship of hierarchy.

"The relationship among katoeys in the past and these days is different. These days, they don't respect the elders anymore. They think they are perfect and more beautiful than the others." CS50502, 49 (TG Case 6 KII)

Functional / reciprocal support

This section presents data which helps describe reciprocal nature of functional social support among TG persons. Help is provided by one person to another, but it is clearly understood to have practical and concrete benefits to both actors. Help is provided that has functional value to both parties (increased clients, increased income, greater levels of beauty, money in times of need), but truly altruistic behavior is rare.

> *"When she arrived in Pattaya, her Khun Mae helped her to get a job in a bar and advised her how to get clients. She stayed with her Khun Mae and when she earned money, she gave some to her Khun Mae, who was also the Mamasang at the bar she worked for more than 2 years."* SH41505, 46 (TG Case 14 IDI)

> *"Working as Mamasang, she has a responsibility to help SWs to get clients, get clients to buy drinks and also manage the payment for drinks and bar commission. Some of her look saaw gave her some money. For example, when she negotiated the service for her look saaw at 1,500 baht but her look saaw got 3,000 baht from her client, her look saaw gave her 200 to 500 baht. Some of them bought her food."* SH41505, 46 (TG Case 14 IDI)

TG persons collectively understand that social support is given in order to receive support in return of the same level and magnitude. What is invested should be reaped in equal measure.

> *"People whom I can help and satisfy their expectations, they respect me a lot but those who are always needy, they would respect me only to the level that I can satisfy their needs."* TP12911, 31 (TG Case 3 IDI)

> *"Mamasang or Khun Mae are on the top of the hierarchy. Look saaw serve them and take care of them. For example, they can just tell look saaw what they want to eat and look saaw will provide it and give Khun Mae money, especially if the look saaw earns a lot."*

The private world of TG persons

TG persons do provide some social support to one another, but these examples are uncommon. Generally, TG persons keep their private thoughts and life experiences to themselves. They inhabit largely private spheres of existence in regard to important life-experiences, personal concerns and anxieties.

> *"She had some look saaw and TG friends whom she hung out together with at bars but they did not share much of their personal life or about sexual health with each other."* SH41505, 46 (TG Case 14 IDI)

> *"Friends are hanging-out friends, dining friends, but not friends that can die for me. I'm not that close to people. But they are fine. But no friends that I can rely on if I get sick. They're just friends for chatting and hanging out with"* TW73001, 37 (TG Case 1 IDI)

"I have a group of 10 friends. They are colleagues and mostly we meet at Sisters. The longest lasting friendship is a friend from Chiang Mai but I don't meet with her that often" TW73001, 37(TG Case 1 IDI)

"One of my clients has a Mamasang who is a female owner of the bar and she calls her pee (or older sister). They do not usually talk about their personal life, either with Mamasang, Khun Mae, pee saaw or friends. She only hangs out, talks and gossips with them." SS71301, 34 (TG case11 IDI)

TG persons do not trust each other and do not divulge their private world with other TG persons or share with other TG persons when they experience genuine life crises. There is a very limited level of trust among TG persons.

"It is very difficult to get any related information and they usually don't share their secrets." S50502, 49 (TG Case 6 KII)

"If a katoey knows that you are listening into her conversation she will start a fight with you" CS50502, 49 (TG Case 6 KII)

This has a profound impact on TG persons with regard to discussing and managing their lives, especially areas pertaining risk of being HIV positive, testing and treatment. This is discussed in detail in other sections of this report.

"Some decide to return home because they do not want other TG friends to know [they are HIV positive]." SH41505, 46 (TG Case 14 IDI)

Many TG persons described feeling a sense of loneliness and isolation. They live their lives as individuals, not as a community.

"Nobody can help you. You have to fight for yourself. Talking to other people is pointless. For instance, if I lost a job and talk to a friend, she would just simply say "why not try wandering around [to find a job]"" TW73001, 37 (TG Case 1 IDI)

"She shared that apart from information about work, senior TG persons and she did not talk about personal issues and sexual health or health in general. They just lead their lives independently. When asked if the kind of relationship has changed over the 15 years that she lived in Pattaya, she said it remains the same. TG persons spend time on their own" SS71301, 34 (TG case11 IDI)

Competitiveness

TG persons in Pattaya view one another as competition. Another TG is a rival, potentially usurping a high-paying client to have transactional sex or capturing a well-paid job in a business. Another TG may reduce a TG's social status and value by being comparatively more beautiful and sought-after.

"Nobody shares what hormones they take because they are afraid that one [TG] might look better than the other." CS50502, 49 (TG Case 6 KII)

"Some [TG persons] are too arrogant and try to present themselves as stars. And what I do is to drag them back to earth, biting them." CS50502, 49 (TG Case 6 KII)

"Pattaya is a very competitive society. You have to buy a value for yourself to compete with others". TP12911, 31 (TG Case 3 IDI)

(Fights among TG persons?) Yes, very common because TG persons are always envious of each other. SR40604, 19 (TG Case 5 IDI)

(Any fights?) Yes, they fight over clients because they need money. Sometime, they hit, they slap in front of the clients – quite often. But I never go physical with anyone. SJ61908, 26 (TG Case 10 IDI)

Gossiping

TG persons' social identity and interaction is often based on gossip as entertainment and a way of garnering social esteem.

"…they like to gossip about others within the TG community." (KII1_HON)

Often this tendency to gossip is a harmless and amusing way to entertain each other in the public domain. However, the degree and constant nature of gossiping acts as a very real barrier to TG persons disclosing HIV status, health issues, internal anxieties and discussing negative life-experiences.

Implications of this section for the study

After two phases of data-collection and interviews it became clear that the study's starting assumption (that there was a uniform and broad hierarchical social structure underlying a community in which older/more senior TG persons influenced younger/junior TG persons) was not correct. The study Team Lead and PSI/Thailand made the decision not to undertake focus group discussions among TG persons of different strata based on the observation that TG persons would be very uncomfortable discussing their HIV positive status or even the issue of HIV-related testing and treatment in a public setting within a group of TG persons (given issues around disclosure, confidentiality, privacy and 'bitching').

3.3. Health actors and providers

This section provides a brief outline of the assortment of actors providing services STI (including HIV) and TB related services in Pattaya and the health systems and referral mechanisms within which these actors are connected.

All CBOs in Pattaya have at least one care and support officer who work full-time to refer HIV+ clients into relevant healthcare systems. CBOs in Pattaya have the capacity to help clients to move their health insurance to Pattaya city. TG persons within the National Health Security scheme are mostly referred to Banglamung Government Hospital.

Those within the Social Security scheme are referred primarily to Queen Savang Vadhna Memorial Hospital of the Thai Red Cross Society.

CBO care and support staff help communicate with the health facilities to ensure that the clients receive a quality service and adhere to treatment consistently. This includes appointment management with health facilities, and ensuring that positive clients visit their health facilities routinely. CBOs have access to patients' information, whom they refer to the health facilities, to monitor their health and to ensure that they have access to relevant services.

Sisters and SWING provide prevention, same day HCT, care and support services. Sisters focuses primarily on TG persons and SWING (Service Workers in Group) on male sex workers. HON provides services for only those who are living with HIV and aims to ensure that they are adhering to treatment. Glory Hut has the same function as HON but also provides shelter. All four CBOs working in Pattaya have regular coordination meetings.

All CBOs referred to experiencing similar challenges. Government hospitals have limited capacity and are somewhat bureaucratic, which often results in low quality and unfriendly service. It takes at least 15 days to assist a client to move their health insurance to Pattaya (from another location if their health insurance is registered elsewhere) and this may delay access to treatment for those who need urgent attention. Non-Thai nationals have no health insurance and they are required to be responsible for their own treatment expenses. This is particularly relevant for Laotian and Cambodian TG persons who are working illegally in Pattaya.

3.4. Behaviours and factors of behaviour

3.4.1. Condom use

3.4.1.1. Drivers

The drivers of condom use are presented in this section

Knowledge and locus of control

One of the strongest factors positively associated with correct and consistent condom use is knowledge about HIV and how HIV can be transmitted to others. This knowledge promotes a motivation and perception of control to make positive health choices. This includes correct and consistent condom use.

An example of the relationship between knowledge and condom use is this statement by a TG person, who had never been tested, stating that she always use condoms with all of her sex partners, reasoning that:

> *"we haven't known each other before and we had no idea who the other person had sex with – positive or negative."* TW73001, 37 (TG Case 1 IDI)

Fear of becoming HIV positive

Fear of becoming HIV+ is an important driver of condom use. Respondents referred to a range of reasons why being HIV+ would be problematic. Many TG persons felt that they would not be able to find or keep a partner who would love them and look after them. Many TG persons feared being rejected, stigmatized and marginalized by peers. A large number of TG persons were anxious about losing income generation opportunities and not being able to sustain their lives and send money back to their (often poor) families. A small number of consistent condoms users described wanting to use condoms to avoid becoming HIV+ and being forced to take medicine for the rest of their lives.

This quote illustrates the important role that fear of being diagnosed HIV positive has in motivating condom use even in circumstances when it is tempting not to use a condom.

> *"If the guy doesn't use it, then I will just say no even if they are really handsome. I don't care if I don't get the guy. If I don't use condoms I feel scared."* OC21407, 22 (TG Case 2 IDI)

Prevention and ethical responsibility

Two HIV positive respondents reported that they used condoms regularly because they do not want to transmit HIV to both their clients and regular partners. Both respondents changed their condom use behaviours when they tested HIV+. One even described using condoms with her boyfriend (which many TG persons described as being particularly challenging to negotiate); she described her motivation to use condoms with her boyfriend as follows:

> *"I don't want him to be hurt because of I am HIV+ because one day, that person may ask to have sex with men without condoms"* JP10102, 27 (TG Case 23 IDI)

Reinfection and superinfection

Some HIV+ TG respondents described starting to use condoms to protect themselves from reinfection and superinfection. (Do we have a quote we can use here?)

Critical thinking skills and understanding of partner's motivations

Several TG persons' inclination to use condoms was heightened by clients offering large payments for sex without condoms. For instance one stated that:

> *"There were people who offered me 10,000 Baht per hour but without condoms. Then again I thought, a sane and healthy person wouldn't pay this much money to have unprotected sex."* SS42007, 37 (TG Case 9 IDI)

Policy

Policy and enforcement of policy was referred to as a driver of condom use by one TG (TG Case 7, KII) who had worked abroad as a sex worker. She had migrated to sell sex in Germany many years ago now lives and works in Pattaya. She mentioned that the first time she became aware of condoms was when she moved to Germany. At that time, there was a rule that all brothel-based sex workers had to always use condoms. They also were legally obliged to undertake routing HIV testing and show medical certificates to their employers that they are free of HIV or other STIs.

3.4.1.2. Barriers

The barriers to condom use are presented in this section.

Failure of risk assessment and pretext for safer sex

The use of condoms is informed by beliefs about exposure to risk. Often these beliefs are not based on accurate knowledge. Condoms may not be used when TG respondents perceive a low risk of HIV exposure, basing this assumption on characteristics of their partner. For instance, a TG respondent did not use a condom with a partner believed to be a virgin. Condoms are not used by TG persons who practice what they believe are risk management practices, such as cleaning of the anus and genitals after unprotected sex. Other respondents stated that they had no knowledge of condoms and did not understand that they were at risk of becoming HIV +through unprotected sex.

> *"At first, I used condoms but I know that I was his first. So, we were confident. I know the technique (to clean my anus) how to clean it so now we don't use condoms anymore. I am not so worried about HIV. "* SR40604, 19 (TG Case 5 IDI)

> *"If you have unprotected sex, if you have wounds in your mouth, when you do oral sex, then that's when you would be afraid of HIV."* OS23006, 32 (TG Case 4 KII)

> *"When I give people oral sex, I didn't use condoms"* SS42007, 37 (TG Case 9 IDI)

Some TG persons felt that, given that they had practiced many years of unprotected sex with commercial partners and had never become infected, it was reasonable to assume that they were at a very low risk of being infected with HIV in the future and could continue to have sex without using a condom.

> *"When I moved to Bangkok, I did not use condoms with any sex partners and thought that if I would get infected with HIV as I have never used condoms. I should already have been infected. When I moved to Pattaya, I never used condoms."* WB32209, 31 (TG Case13 IDI)

TG persons that engaged in occasional transactional sex perceived themselves to be at a low risk of HIV transmission when they practiced unprotected sex.

" I just thought that I was not that much at risk. I wait tables. It was just only occasionally that I sold sex. I didn't use condoms because I thought that I was not at risk because I didn't do it often." OP50609, 39 (TG Case 8 IDI)

Other TG persons stressed that they had no knowledge of condoms and did not understand that they were at risk of becoming HIV positive through unprotected sex. Some have inaccurate knowledge about HIV which, leading to incorrect risk assessment.

"I do oral sex without condoms but I don't eat the pre-cum discharge." TW73001, 37 (TG Case1 IDI)

"But for blow job – no condoms because the risk is minimal since I am the one giving the blow job" TP12911, 31 (TG Case 3 IDI)

"Sometimes, farang (Westerners) told me that they were healthy, so I agreed not to use condoms. When I had Thai boyfriends, I had never used condoms with them. I was thinking that I would not get infected very easily. I had no knowledge about HIV transmission/infection." WB32209, 31 (TG Case13 IDI)

Lack of knowledge

Some of TG SWs had not practiced protected sex because of lack of knowledge. Some TG persons reported that they had not used condoms because they did not know about or have access to sexual health and HIV prevention information.

"I did not know anything about sexual health." SS71301, 34 (TG Case11 IDI)

"When I was in Pattaya, there was no information about HIV at that time at all." AJ41205, 48 (TG Case17 KII)

Failure of negotiation

While some TG persons shared that they do not have knowledge about HIV transmission, some are well informed but failed to negotiate for safe and protected sex.

"I told all of my boyfriends that I had HIV but they said it doesn't matter. So, using condoms was their choice." AJ41205, 48 (TG Case 17 KII)

Condom availability

One of the respondents reported that neither she nor her partner had purchased condoms or kept condoms on their person prior to the sex act.

"I did not use condoms before I knew that I got infected because neither my sex partner nor I had condoms. There were no free condoms provided and she did not think about buying some" PS61403, 32 (TG Case 16 KII)

Physical appearance of sex partners

Some TG persons indicated that they decide not to use condoms with some clients or casual sex partners if they are handsome.

"I did not use condoms with some clients I liked, especially those who are good-looking and in good shape." CS32810, 36 (TG Case 7 KII)

"The reason that I didn't use condoms is because the clients were handsome." SJ61908, 26 (TG Case 10 IDI)

Financial incentives offered by clients

Some TG sex workers reported that they had accepted higher payment from their clients who requested them not to use condoms. Some respondents emphasized that if they insist on using condoms her clients will not use her service. These respondents described feeling pressured to accept sex without condoms because they need money.

"Some of my clients offer better pay if I do not use condoms and I accepted the offer because I wanted to earn more money. I believe if I had sex without condom just one time, it should be OK." SS71301, 34 (TG case11 IDI)

"Clients offer better pay if sex workers agree to not use condoms or if they insist on using condoms, their clients will not use their service." WB32209, 31 (TG Case 13 IDI)

"I used condoms every time I had anal intercourse, and used it even when having oral sex. But if they paid more money for oral sex without condoms, I did it but I don't swallow anything" JP10102, 27 (TG Case23 IDI)

"In case of TG sex workers, their clients (farang) pay more, so they agree not to use condoms." (KII4_Sisters)

Alcohol and drug use

The use of alcohol and drugs are also associated with unsafe sex among TG persons. TG sex workers who work in open or closed bars earn some incentives from selling drinks. If they can get their clients to drink more, they will earn more money. However, some clients also request that the TG person drink with them. In some cases they were requested by their clients to use drug with the client. Clients are willing to pay more if a TG is willing to use drugs in combination with unprotected sex.

"I had used drugs and alcohol for sexual activities and also did not use condoms with clients. Some of my clients asked me to use drugs with them. They gave me more money if I did what they asked." SS71301, 34 (TG Case 11 IDI)

"I had no fear of infection. Sometimes I was drunk. Sometimes, my clients would refuse my service if I insisted that I wanted to use condoms. I was just thinking about how I could earn a lot." WB32209, 31 (TG Case 13 IDI)

"There were times that I was drunk and I knew that the guys did not use condom but they did not come inside me." JP10102, 27 (TG Case 23 IDI)

Beliefs concerning condom use and pleasure

One TG who had a partner who visited her almost every year described some men not wanting to use condoms because they believe that condoms will reduce their sexual pleasure. The key informants from Sisters described this being a common barrier to condom use.

"Some men said it is not natural and condoms reduce their sexual pleasure." PS61403, 32 (TG Case 16 KII)

"Some believe that condoms reduce sexual pleasure." (KII4_Sisters)

Stigma

Because of early condom use campaigns promoting 100% condom use with sex workers, the general public still perceive that those who carry condoms, especially women (who are expected not to practice premarital sex or not to have multiple sex partners) can be perceived as being sex workers. Similarly the general public think that men carry condoms because they visit sex workers.

"In the past, people knew that if someone carried condoms, that person would be stigmatized. People would think that that person is slutty or had sex with sex workers." PS61403, 32 (TG Case 16 KII)

Trust

Trust is a barrier to condom use, especially among intimate partners. Many TG persons still believe that if their partner tries to negotiate condom use when they are not willing to, it means that their partner does not trust them.

"Most intimate partners (IP) do not use condoms because they believe that using condom with IP means that they do not trust their IP." WB32209, 31(TG Case 13 IDI)

Several TG persons described agreeing to unprotected sex with her steady partner because they trust the partner.

"I had never used condoms when we had sex. I trusted him." PS61403, 32 (TG Case 16 KII)

Emotional: physical arousal and attachment

Some TG persons made a decision not to use condoms based on their levels of sexual arousal, level of attraction to partners and degree of attachment to the individual. One respondent said that when she got really aroused, she did not care about condoms; whilst another one said that if she liked those men, she did not use condoms.

"When it comes to sex, it really depends in 'that moment and mood'. You know, when you feel so aroused, we don't care about condoms. There is a very thin line." CS32810, 36 (TG Case 7 KII)

"If I didn't use condoms, that was because I decided not to use because I like the guy." NS12303, 34 (TG Case 21 IDI)

Sexual pleasure for partner

TG persons who have been in steady relationship often want to satisfy their steady intimate partners sexually. One means of ensuring this is to not use condoms.

"With my boyfriend, I don't use condoms anymore. It was like a month later, that we didn't use condoms anymore. He asked because he said that it made him feel much better – gave him more feeling." SR40604, 19 (TG Case 5 IDI)

" It had something to do with his feelings. I wanted to do my best to sexually satisfy my boyfriend" SS71301, 34 (TG Case 11 IDI)

Deception and unmanageable risk

One TG narrated a story about a Thai client who had deceived her during transactional sex. At first he wore a condom and then removed the condom just before penetration.

"Thai people are the most tricky and most dangerous. Foreigners are always honest and pay. But some Thai people, during sex, took off their condoms and some do not pay properly." (TG case9 IDI)

3.4.2. Negotiating condom use

Respondents described employing a number of strategies to negotiate condom use with clients and regular partners.

TG sex workers ask for money before sex and negotiate condom use after getting paid. They find that they have more negotiating power after they have been paid.

If a client is insistent that he will not use condoms TG sex workers negotiate to provide oral sex (without a condom) or a hand job instead of penetrative intercourse.

Some TG persons, but not all, can negotiate for safer sex such as outercourse- penetrative sex with external ejaculation.

The following extracts provide some illustrative examples of narratives about successful condom negotiating strategies and tactics:

"…in the past month, mostly I use condoms…in fact I always use condoms, even with the ones who flirt with me, giving the reason what we haven't know each other before and we had no idea who I or you had sex with – and whether they are HIV positive or negative. With clients, I always use condoms, giving the reason that I don't know you and you don't know me. I have sex with many people. I don't need that much money, just give me as much as you want to give me."

Respondents referred to a number of challenges in negotiating condom use. TG persons tend to have less negotiation capacity if they have regular partners. Some TG persons who are HIV positive do not use condoms with their regular partners because they do not want to tell their partners that they are positive. Some TG persons do not talk about condoms with their regular sexual partners at all. The condom use decision is almost entirely the domain of the regular male partner.

"I didn't say anything, nor make any decisions about condom use. I didn't talk about condoms with guys that I didn't use condoms with." Ref?

3.4.3. HCT

3.4.3.1. Drivers

This section presents drivers of HCT.

Symptoms

One of the main drivers of HCT uptake was identified as troubling symptoms that were either known to be associated with HIV or were concerning or suspicious from some perspective. Respondents mentioned specific examples of symptoms, usually opportunistic infections; testing positive for STIs (such as herpes); tiredness and lethargy; weight-loss; and respiratory problems including coughs. The following two excerpts capture specific experiences of symptoms leading to testing among TG respondents.

"She fell sick and could not work. Her weight dropped from 60-70 to 49KGs. She was very skinny and people started to suspect that she was infected with HIV. Her hair fell out and she had TB. She went to see a doctor at Queen Savang Vadhana Memorial Hospital and the doctor asked her if she wanted to have an HIV test. Afterwards he told her that she had TB and explained that usually TB comes together with HIV infection." PS61403, 32 (TG Case 16 KII)

"The first symptoms she had were difficulties with coughing and breathing. She was kept in jail for more than 20 days. After she was released from jail she stayed with her friend. She could not go to work some days as she felt tired. She coughed and thought that it was unusual. [She then had a test]" SH41505, 46 (TG case 14 IDI)

A large number of respondents described delaying testing for significant periods of time, despite experiencing symptoms for extended periods of time:

> *I got tested because my symptoms were severe. I was knocked out and I went into a coma. I had no idea what was going on with me. I just worked, worked, worked.*
> OP50609, 39 (TG Case 8 IDI)

Risk
Another important driver of behaviour is perceptions of risk considering history of condom use. Some respondents were motivated to undertake HIV testing if they did not use a condom or if the condom broke.

Concern for health and age
Some TG persons felt more concerned about their health and the consequences of being HIV positive as they became older.

Social support
TG persons with friends who encouraged them to go for HIV testing described being motivated to go for testing.

Partner has physical symptoms
Some TG persons that had sex with partners with physical symptoms that are perceived to be associated with being HIV+ (i.e. having wounds on the penis) reported being motivated to go for a test.

Outreach/Peer Education
TG persons who have been exposed to outreach or peer education sessions implemented by CBOs/LNGOs messaging around HIV prevention and treatment reported being motivated to go for HIV testing. Only a small minority of TG persons referred to this driver.

Positive friends
TG persons with a large number of friends and acquaintances who were openly HIV positive, described being more inclined to go for testing.

Partner HIV Positive
TG persons with regular partners who are HIV positive are more inclined to undertake HIV testing.

<u>Social seniors: influence</u>

A small minority of TG persons referred to more senior TG persons influencing more junior TG persons to access HIV testing services.

> *"Khun Mae [senior TG persons] also help SWING to get their look saaw [more junior TG persons] to get HIV tested. If Khun Mae have been tested before, TG persons tend to follow their Khun Mae and decide to get tested"* (KII2_SWING)

Beliefs

Interviews with key informants working as HCT counsellors indicate that some TG persons have an inaccurate understanding of the outcomes of ART treatment. Some TG persons appear to believe that after an extended course of ART that a person can actually become HIV negative. This extract captures this belief:

> *"Some may think that after taking ARV for a couple years, the virus would be all gone and they are cured; therefore they want to take a chance to test again in the hope of a jackpot"* CW50602, 39 (TG Case 25 KII)

In this quote, the respondent undertakes HCT thinking that there is a chance that her test results will become negative after many years of treatment.

Incentives

The Sisters counsellor felt that some TG persons come for testing to receive incentives even though they were confident that they are HIV negative.

Transactional value and social prestige

Going for an HIV test and testing negative increases the social prestige of TG persons and augments the value of that person when engaging transactional sex. TG persons who are considered physically attractive assume that their physical beauty means that they are HIV negative. These pretty TG persons want to be tested to formally establish their negative status and reap the social prestige and income generating benefits. This quote from a SWING staff member illustrates this point:

> *"Some pretty TG persons are confident that they are not HIV-positive, so they want to get tested (they are very confident and want to show their friends that their sero status is negative) in order to prove that they are HIV negative and then they can increase their rate to 2,000-3,000 bahts (pretty+healthy= higher pay for their sex services)."* (KII2_SWING)

Employment/compulsory

A small minority of TG persons were required to undertake HIV testing by employers in Pattaya. One respondent indicated that the job was in a large spa and that many large spas and massage parlours in Pattaya require HIV tests as a prerequisite for employment.

3.4.3.2. Barriers

This section investigates barriers to testing.

Fear

A key reason for not undertaking HCT was that TG persons did not want their TG peers to come to know of their status. If disclosure occurs without the consent of the individual it is perceived that this will inevitably lead to loss of income-generating opportunities and to marginalisation and stigmatisation by other TG persons. An important and powerful barrier to HIV testing is the social practice of gossip. "Bitching" about other TG persons is a favourite pastime and a foundational component of the socially constructed identity of TG persons.

Many TG persons felt that given the array of services provided for HCT in Pattaya for TG persons (CBOs, LNGOs, government hospitals) that disclosure of their status was not under their control because the maintenance of privacy and confidentiality is almost impossible. This extract illustrates one of the key factors that act as a barrier to testing, fear of breach of confidentiality:

> *"One of the challenges for Sister's HCT work is confidentiality. Previously, the counsellor worked on the first floor and she is the one that every TG has to meet before going to the clinic on the third floor. Some TG persons were afraid that their sero-status will not be kept confidential and so they did not come back to Sisters for counselling and other services. So, the counsellor has moved to work on the third floor to provide a one-stop service"* (KII4_Sisters)

It should be stressed that Sisters has taken action to mitigate the risk of fear of disclosure of HIV status by changing the strategy and location of HCT.

Many TG persons feared isolation, separation from loved ones and a lack of social support:

> *"I'm afraid of separation – from the ones I love or I lose moral support ifother people know that I am sick"* TW73001, 37 (TG Case 1 IDI)

Many TG persons would prefer not to know if they are HIV positive so that they do not need to disclose this fact to their family members. They fear that the will be disowned, marginalised, stigmatised by their family members. More often they fear disapproval from their families as their income generating possibilities diminish.

Many TG persons described being fearful of a positive result because it would destroy their dreams and aspirations. A common theme was that TG persons feel that they would never be able to find somebody, or keep a partner, who would love them and care for them.

A common theme across IDIs was that TG persons were fearful of getting a positive HIV diagnosis. Many TG persons have observed friends, community members and other TG peers experience disabling symptoms resulting from HIV and often undergo what is considered a terrifying experience of death.

Some respondents emphasised that the higher the level of risk they are exposed to of HIV the less they want to undertake testing.

Often TG persons are afraid of obtaining a positive diagnosis because they are unsure how they will manage their lives as a positive person. One fear articulated by TG persons about being HIV positive was the need to go for routine blood testing and needing to take medications on a regular basis which was considered to be inconvenient and a barrier to generating a reliable income.

A small number of TG persons stated that they were afraid of having blood tests.

Knowledge
Key informants (who are counsellors in CBOs offering HCT) stated that many TG persons do not understand what HCT is and the benefits of HCT.

Several respondents explained not going for a test because they had not identified any of the symptoms they understood to be associated with HIV.

Denial and peace of mind
Many TG persons felt that it was likely that they were HIV positive, but did not want to go for a test. If was confirmed that they were HIV positive, they would experience anxiety, agitation and lack of a peace of mind. They preferred to delay the confirmation of HIV and live in denial.

Time and work pressures
Several respondents described lack of time and work commitments as barriers to going for a HIV test.

Motivation and intention
Some TG persons narratives suggested that they do not have sufficient motivation and intention to undertake the sometimes fraught and difficult process of testing.

"As time passed, I started to have suspicious minor symptoms. I was planning to go [for HIV test] and did not have a chance to go until I was knocked out and went into a coma." OP50609, 39 (TG Case 8 IDI)

It is hypothesised that fear, anxiety, denial sit behind these factors. The fear of a positive result makes it unlikely that an individual would "make time" to get tested until the symptoms could no longer be ignored.

3.4.4. What does it mean to be HIV+?

TG respondents and key informants shared diverse lived experiences of what it means to be diagnosed HIV+. Their experience and feeling are presented in this section.

Frustration and hopelessness and feeling lost
A number of respondents narrated that after an HIV positive diagnosis, they experienced stress, hopelessness and frustration. They described not wanting to live anymore. Some TG persons though about committing suicide and some even attempted suicide.

"Sometimes I feel frustrated and I do not want to see the doctor and I feel like going back to work until I die." OP50609, 39 (TG Case 8 IDI)

"I felt really stressed. I was thinking about dying and death." SS42007, 37 (TG Case 9 IDI)

"I used to feel frustrated when I had allergic reactions to drugs. I thought that I wanted to die." TP12911, 31 (TG Case 3 IDI)

"The first day that I knew I had HIV my body was frozen. I cried. I was thinking about death. I even had a thought of suicide." JP10102, 27 (TG Case 23 IDI)

The other three respondents admitted that they were totally lost and did not know what to do with their lives.

"After I knew that I was positive, I didn't have any plan for my life." SJ61908, 26 (TG Case 10 IDI)

"I was lost and did not know what to do. I attempted suicide by hanging myself by the neck but the cloth was torn. So, I did not die." WB32209, 31 (TG Case 13 IDI)

"I was admitted to the hospital and started to think about where to go and what to do after this" SH41505, 46 (TG Case 14 IDI)

Fear of failing family

Several respondents reported not disclosing to family that they are HIV positive because they fear failing their family. Almost all mentioned that they did not want their mother to worry or feel sad.

"I don't want my family to know. My mother would worry sick if she knew." SJ61908, 26 (TG Case 10 IDI)

"She did not tell her family and her boyfriend that she is living with HIV because it would worry her mother and they would feel sad." PS61403, 32 (TG Case 16 KII)

"They have some concerns about how they will cope, how to tell their family, whether their family will understand and accept them if they are HIV-positive." (KII1_HON)

Not being able to support their family financially

Two of the respondents were worried that they will not be able to provide adequate financial support to their families after being diagnosed as HIV positive.

"About this sickness, I don't feel particularly sorry. I'm just afraid that I cannot support my family. I want to send money to my mother, to make her happy." OP50609, 39 (TG Case 8 IDI)

"After I came to know that I was positive, I felt hopeless. I didn't plan anything at all. I just do my best today. I try to support my family as much as possible." SJ61908, 26 (TG Case 10 IDI)

Fear of being ostracized

Many TG persons are afraid that they will not be accepted by family, community and society or considered to be disgusting if people know that they are HIV positive. The information obtained from key informants supports and corresponds with the narratives of TG IDIs.

"I had to experience discriminatory behaviors from my boyfriend. Sometimes I thought of swallowing bleach just to end my life. He didn't allow me to use his shampoo because he was afraid that I might infect him." TP12911, 31 (TG Case 3 IDI)

"I did not want to go home because I was afraid that my family would not accept me." WB32209, 31 (TG Case 13 IDI)

"If that person has HIV, that person would not tell anyone. That person might be afraid that other people would not be able to accept them." NS12303, 34 (TG Case 21 IDI)

"I was scared that people would be disgusted by me." JP10102, 27 (TG Case 23 IDI)

"Most HIV-positive persons do not want to go home as they feel insecure (they stigmatize themselves) or are afraid that family and community will not accept them if they know that they are HIV-positive." (KII2_SWING)

"Some have concerns about how they will cope, how to tell their family, whether their family will understand and accept them if they are HIV-positive." (KII1_HON)

Living secretively

Most respondents did not want others to know that they are HIV positive. They do not wish to disclose their sero status. They keep this information private and live secretly. Some TG persons stated that other TG persons might have suspicions about their HIV status. TG persons did not disclose their status to other TG persons because TG persons of the fear of becoming a subject of gossip.

"This is after I got sick and I didn't want other people to be suspicious." OP50609, 39 (TG Case 8 IDI)

"I plan to stay in Pattaya until I die. Here I live far from the doctor. Back in my hometown, I have many friends working in the hospital and I don't want them to know [that I am positive]." SJ61908, 26 (TG Case10 IDI)

"I did not want them [my family] to know that I got infected with HIV and so I did not want to go home." SS71301, 34 (TG Case 11 IDI)

"Her mother did not suspect that she was HIV positive but some people in the community (in KhonKaen) who asked what disease she had and she told them that she just had a lung problem." PS61403, 32 (TG Case 16 KII)

"I didn't tell anyone the result because I think that this is private. I don't tell people because I'm afraid that people will tell other people" CW50809, 32 (TG Case 22 IDI)

"I decided not go to back to Laos because there is no secret in the world there. It would be even worse there." JP10102, 27 (TG Case 23 IDI)

"Some people do not want others to suspect or know that they are HIV positive" (KIII1_HON)

"Some do not want to go back to live with their family. This is because they are afraid that their family will suspect that they are infected with HIV." (KII4_Sisters)

One of the respondents, who has a steady partner living aboard, did not tell her partner that she is HIV positive because she does not want to lose him. She knows that many couples break up because of the fear of transmitting HIV to the negative partner.

"The reason why she decided not to disclose her HIV status to her boyfriend is that she is afraid that things will change between them" PS61403, 32 (TG Case 16 KII)

Regret

Only one respondent said that she felt regret after knowing that she has HIV.

"I made a mistake and I can't go back in time to change it." TP12911, 31 (TG Case 3 IDI)

Self-stigmatization

A number of TG persons narrated their self-stigma and feelings of inward disgust after their HIV diagnosis. One TG described feeling as if she had lost her humanity.

"Although many people said that this disease is not that fatal but deep in my heart, I feel like half of myself is no longer human. I feel like I am very dirty and disgusting because of what I have" JP10102, 27 (TG Case 23 IDI)

3.4.5. Treatment initiation

3.4.5.1. Drivers

This section explores drivers of ART initiation.

Striving to stay healthy and beautiful

Most HIV positive TG persons are worried about the burdens and disadvantages associated with starting ART. They are primarily concerned about having to take drugs on time, side effects and disclosure of their HIV status to other people. However, once they have established that the benefits of treatment outweigh the burden, they wish to start the treatment as soon as possible. It is important that the TG understand that

their body will not change and they will look as pretty as they were prior to starting the treatment. They hope that the treatment can sustain their health and their lives until a cure is available.

"If I take it [ART] and the virus is less, I'd take it immediately. I won't wait… Actually, I wanted to take it because I believed that I could be cured. I still hope in my mind that in the next 4 – 5 years, a cure will be available." JP10102, 27 (TG Case 23 IDI)

Treatment cost and insurance

Positive transgender women who have health insurance such as the National Health Security scheme or the Social Security scheme are not concerned about treatment initiation from a financial perspective, but respondents who do not have any insurance at all typically are not able to, cover the costs on their own. This group usually consists of transgender migrants who have come from other countries to Pattaya to work.

*"If it's time for me to take ARV, I still don't know what to do because I have no rights here."*JP10102, 27 (TG Case 23 IDI)

Social support

Transgender women who have friends or a partner who are already on ART and who observe the benefits of treatment are more likely to be willing to start ART in the hope that they will be as healthy as their friends/partner.

"Some TG persons and MSM visit doctors for treatment by themselves because their friend suggested them to…" (KII3_Glory Hut)

Doctor's advice

Transgender women, who do not perceive themselves as having any other choice or are motivated to start ART usually do so under the advice of their doctor.

"I will fight against side-effects. I will surrender if the doctor says it's time." JP10102, 27 (TG Case 23 IDI)

3.4.5.2. Barriers: treatment initiation

This section explores barriers to treatment initiation.

Rejection and denial

Many TG persons fear that if their HIV+ status is disclosed to family members that they will be rejected because of the idea that the TG will be unable to provide financial assistance for the family. TG persons also fear rejection from family members because of the negative associations about HIV within the general population. TG persons prefer (even if aware of their HIV positive status) to ignore this extremely uncomfortable fact and continue living without initiation of treatment for as long as possible.

"Some [TG persons] may already be aware that they already have HIV. These people don't accept what they are, and don't go for treatment." CS50502, 49 (TG Case 6 KII)

"I'm just afraid that I cannot support my family. I want to send money to my mother, to make her happy." OP50609, 39 (TG Case 8 IDI)

"…sometimes I feel frustrated and I do not want to see the doctor and I want to go back to work until I die, trying my best to earn more money." OP50609, 39 (TG Case 8 IDI)

Social stigma and self-stigmatization

Many HIV+ TG persons do not want to visit health facilities nor start any treatment because they are afraid that other people, including health facility staff, would stigmatize them, causing unbearable feelings of shame.

"Some people may already be aware that they have HIV. These people don't accept what they are, and don't go for treatment." CS50502, 49 (TG Case 6 KII)

"She had abscesses all over her bottom and some part of her body (about 100 spots) but she did not want to see a doctor [to start] treatment because she felt ashamed." WB32209, 31 (TG Case 13 IDI)

Side-effects of ART

Some transgender women do not want to start ART because they have learned about or witnessed the negative side effects of ART from other people, including deterioration of physical attractiveness, dizziness, numbness, lethargy etc.

"I don't want to take ARV. I pray to be normal. I'm afraid that if I take ARV, I will no longer be pretty like I am now." JP10102, 27 (IDI TG Case 23)

"…if I start ARV, I have to take it for the rest of my life. I'm not ready" CW50809, 32 (IDI TG Case 22)

Treatment burden

Several TG articulated a resistance to initiating ART because of the of physical and life-style impacts of treatment. TG persons described not being mentally ready for the experience of regulating daily routines, changing alcohol consumption habits, and coping with the tedium and regularity of regular drug consumption. TG persons also referred to the negative consequences ART compliance has on the ability of the individual to work and generate income.

"….if I start ARV, I have to take it for the rest of my life. I'm not ready." CW50809, 32 (TG Case 22 IDI)

"I don't want to take ARV. I pray to be normal. I'm afraid that if I take ARV, I would no longer be pretty like this. If I take drugs, I have to be careful, not to drink too much alcohol and I have to be concerned about taking drugs all the time. I may even have to stop working." JP10102, 27 (TG Case 23 IDI)

Delays in health insurance registration

Thai transgender women who have a national health insurance in another city will have to wait for at least 15 days to transfer this entitlement to Pattaya city, causing delays in access to health services. Whilst this challenge to accessing services is one that can be solved (indeed most CBOs working in this area in Pattaya can assist with this process) this is an inconvenience which can (together with other barriers) prevent TG persons from pursuing ART initiation.

Job opportunity and migration

Some respondents reported that they are not ready to start ART because they intend to travel and work somewhere else as a commercial sex worker in Phuket, Malaysia, Singapore, etc.

Thai Citizenship

Some transgender women do not have their Thai citizen identification card for various reasons. This is especially common if the TG ran away from home when she was young. If they have lost their citizen ID card it will take time to prove their Thai nationality in order to have access to the national health scheme.

"There was one case of a Thai woman who left her home at the age of 10. After the process of identity/citizenship verification at the district office and she was DNA tested, then she receive treatment from Burapha University Hospital." (KII1_HON)

Ability to pay

TG persons who are not Thai nationals do not have access to free HIV treatment. Many Laotian and Cambodian TG persons living in Pattaya cannot afford to pay the treatment costs.

"There are HIV-positive foreigners [TG persons] who cannot afford the treatment." (KII2_SWING)

3.4.6. ART compliance

3.4.6.1. Drivers: ART compliance

This section presents insights associated with drivers of ART compliance.

Quality/confidential service

The most important driver of treatment compliance relates to TG persons receiving treatment within a facility that offers services in a confidential and respectful fashion that ensures the privacy of the patient and minimizes the risk of disclosure of HIV status.

> *"I go to hospital every 3 months. This hospital is very private. There are private rooms. Nobody knows what sickness each person has. There will be just one doctor and a nurse. The doctor gives me a medical certification that I actually came to hospital but the doctor will not write the details of the sickness. The doctors and health workers all speak in a polite and considerate fashion. The service is good. They respect me very much. I don't feel discriminated against at all."* CW50809, 32 (TG Case 22 IDI)

Integrated services

Simlarly, TG respondents preferred testing services which are integrated into general health services. This promotes a feeling among clients that they are the same as any other patient and not treated as a 'special' or abnormal category of client.

> *"I like the way they are providing the service. I feel like I am just a citizen. I don't think there needs to be a specialized route for this service. I want it this way so that it looks normal"* CW50809, 32 (TG Case 22 IDI)

Not feeling alone

Some respondents described feeling more comfortable and confident to access ART treatment services when they observed other TG persons (particularly TG persons of a high social status) accessing ART treatment.

> *"Some beautiful Alcazar drag queens also visit the doctor for ART at the same time as I do. I don't feel alone. It's like a personal sickness. I made a mistake and I can't go back in time to change it"* TP12911, 31 (TG Case 3 IDI)

Health

A minority of TG persons explicitly mentioned that they are more able to comply to ART treatment if they feel a strong sense of concern about their health and desire to look after themselves.

O***pportunities to schedule appointment***

One TG indicated that complying to treatment was facilitated by being able to make an appointment with a doctor on a specific day (her day off from work).

Motivation/intention

A small number of TG persons referred to fighting through unpleasant side-effects of ARV and TB drugs and complied with treatment in a effort to recover.

> *"When I took TB drugs, I got skin rashes. But I fought and never gave up at all. I intended to recover"* CW50809, 32 (TG Case 22 IDI)

Holding on for a future cure
Some TG persons rationalised complying to ARV treatment, hoping that a cure for HIV would be available in the future and they would no longer have to take medication as part of their daily routine.

Avoiding discrimination
A few TG persons described the key motivation for ARV was avoiding showing symptoms of HIV and being discriminated against.

> *"The reasons that they were willing to continue to take drugs because they all want to get better. They are afraid to become symptomatic and other people will know and they might be discriminated"* CW50602, 39 (TG Case 25 KII)

3.4.6.2. Barriers: ART compliance
This section presents barriers to ART compliance.

Social Stigma and self-stigmatization
Transgender women do not wish to visit health facilities for ART because they are deeply concerned that other TG persons in Pattaya or family members will come to know of their status. TG persons believe that if other TG persons come to know about their positive status that they will be marginalized and excluded, with negative personal and financial implications. TG persons are concerned that they will be rejected by family members because of a belief that the TG family member will no longer be able to provide for the family financially. Furthermore, TG persons believe that family members will reject them because HIV+ individuals are normatively stigmatized in Thailand. As a result, Transgender women either stop complying with ART regimens or find other sources of medication other than health facilities they are referred to where they are exposed to risk of disclosure.

> *"I have many TG friends currently living in Pattaya, who are living with HIV. There is actually a big group of them. They don't get medications in Pattaya but they come all the way to Bangkok to buy them here in Bangkok. They are probably ashamed so they don't get the drugs there."* AJ41205, 48 (TG Case 17 KII)

Unfriendly health services
Transgender women reported experiencing unfriendly health services at key health facilities (namely Banglamung Hospital). TG persons experienced impolite behaviour by receptionists, auxiliary staff and nurses. In some cases nurses abused and shouted at TG clients.

> *"I know a person who stopped treatment because that person experienced bad behaviors by the health officers."* CS32810, 36 (TG Case 9 IDI)

Unfriendly health services in public contexts

Unfriendly service is a signifcant barrier to treatment compliance among TG respondents. This barrier is amplified because this unfriendly service is typically situated in public waiting areas where other individuals (including TG persons) are also waiting. A trip to Banglamung's HIV and TB unit is therefore fraught with risk of unwanted disclosure of HIV status to other TG persons.

> *"When the clients of Banglamung hospital go to hospital on a date than which is not the day on which an appointment is made, they will not feel like going there because they don't want to get shouted at angrily by the Banglamung hospital staff. This could cause them shame because the counter is an open, and public, area. This means that other patients can and do look at them. This means that there is a risk that clients will stop taking drugs or going to pick up drugs there"*
> PB22201, 34 (TG Case 24 KII)

Side effects

Some transgender women try to discontinue their ART because they cannot bear the negative side effects of the treatment.

> *"There are some residents (of a hospice center) who do not want to receive treatment because of the side effects of ARV medicines (dizziness, their hands and feet become numb). So, they hide the medicine under their pillows."* (KII3_Glory Hut)

> *"The cases that have just started ARV are at a higher risk of stopping ARV because they are experiencing side effects, especially sex workers, since they have to work at night. They get tired easily, have darker skin and experience a range of negative side effects."* PB22201, 34 (TG Case 24 KII)

Low self-esteem

Many transgender women experience low self-esteem. The main factors informing this sense of low self-esteem include: (i) personal experiences of social marginalization and (ii) anxieties about rejection by family members. Many TG persons who have low self-esteem drop out from treatment and report not being concerned about their health or caring about their lives.

> *"But some TG persons stopped their medications. They do not care if they have to die. I also experienced this myself."* CS32810, 36 (TG Case 9 IDI)

Thai Citizenship

TG persons from Laos and Cambodia who are not Thai nationals do not have access to free HIV treatment and often cannot afford the treatment costs.

Beliefs concerning symptoms and treatment

Some TG persons reported thinking that they can stop ART when they have become healthier and no longer have the symptoms associated with HIV. When symptoms dissipate respondents described stopping ART because it was no longer necessary.

> *"There is one case of a TG who had received treatment and her CD4 increased from 1,000 to 1,200, but then she did not want to take medicine. She was sick of taking medicine. Then her CD4 dropped to 400."* (KII3_Glory Hut)

> *"Some people who get better also take alternative (herbal) medicines. But this is sometimes a scam. This can cause clients to stop ARV and only take alternative medicines because the herbal people [company representatives] make propaganda. Such cases are frequent"* PB22201, 34 (TG Case 24 KII)

Distance from residence and time at the health facility

Some transgender women do not want to spend significant periods of time travelling to the health facility and spend the whole day at the facility to receive service.

> *"Some [TG persons] do not want to go to the ARV clinic to get medicine because it takes them almost a day and it is a waste of time."* (KII3_Glory Hut)

> *"Other reasons or excuses that people refer to when stopping drugs are that they have 'no time', 'their working times are inconsistent' 'or they cannot get up and go to the hospital at the appointed time'"* PB22201, 34 (TG Case 24 KII)

> *"The reason that they don't want to go to see the doctor at the appointment time is because they said they have to work. They can't get that day off. If they do this their income for the day will be deducted by the owner. They don't want to lose their income"* CW50602, 39 (TG Case 25 KII)

3.5. Knowledge/sophistication: a cross-cutting factor across behaviours

This section explores a factor that is both a driver and barrier across all behavioural domains: the depth and sophistication of knowledge about HIV. This factor is presented as a cross-cutting factor because levels of knowledge and sophistication are strikingly low, given the high level of risk of HIV transmission for TG in Pattaya, the density of the TG population of Pattaya (and therefore potential ease of messaging to this group), and the impact that this knowledge has at all levels of the prevention and treatment cascade.

General assessment of knowledge levels

In general the TG persons of Pattaya have relatively low levels of articulated knowledge about HIV. Many TG persons had no, or very little, knowledge about HIV prior to their arrival in Pattaya.

Risk assessment: patchy and fragmented knowledge

The majority of TG persons fall into a category of actors that have a 'moderate' knowledge of HIV. For this group, HIV is considered a genuine risk that pertains to TG persons (particularly those engaging in risky sex). However, this group has patchy, incomplete and an occasionally inaccurate understanding of the sex practices, partner-choices and situations in which condoms should be used. For instance many TG persons felt that condoms should only be used for penetrative intercourse (not oral sex); or only when there are physical signs of STIs on the genitals of a sex partner.

Poor knowledge and implications

TG persons with minimal or no knowledge about HIV are more likely to demonstrate intense feelings of anxiety about getting HIV, expressions of stigma to individuals that are HIV positive, self-stigmatisation, self-hatred and desperation. These individuals tend to never have visited HCT and STI service or are less frequent users of these services. TG persons with inadequate knowledge about treatment tend to stop the treatment on their own when they become healthy.

Social support and exposure

Some TG persons are more knowledgeable about HIV prevention if they are close to someone who already has HIV knowledge. If this is the case they are more likely to practice safer sex.

> *"I was lucky to have a gay uncle to warn me to use condoms all the time. It looks good for people to have condoms. I don't understand why younger people feel ashamed to have condoms with."* OS23006, 32 (TG Case 4 KII)

Many TG persons indicate that they know more about HIV after receiving HIV education by CBOs and LNGOs involved in prevention, care and treatment messaging.

> *"Being a member at Sisters, they give more information about HIV and STIs. So, AIDS is not that easy to transmit. For instance we cannot get AIDS if we just play with each other."* SR40604, 19 (TG Case 5 IDI)

High levels of knowledge: implications

Typically, but not always, those who have correct knowledge about HIV tend to visit HCT and STI services. They demonstrate their understanding by achieving early HIV detection and treatment. TG persons with good knowledge about HIV are more competent in assessing their risk. For instance, they know that it is important to use condoms for oral sex (as well as intercourse) and with casual and transactional partners even if sex with these partner types is occasional. TG persons who are HIV positive and have good HIV knowledge are more likely to follow positive prevention strategies. We do not argue that there is a causal link between knowledge and behaviors. TG persons with better knowledge tend to be better networked to friends, peers, family members, services and sources of information. Those with better knowledge appear to be more motivated and demonstrate greater intention to be healthy.

"If we understand HIV, we don't need to be scared. Are we afraid of ghosts? If now, we're in Central Plaza, not in a temple, then there's no need to be scared. So, if you have unprotected sex, if you have wounds in your mouth, when you did oral sex, then that's when you would be afraid of HIV. But it doesn't make any sense just to get scared." OS23006, 32 (TG Case 4 KII)

"I always use condoms. Now that I know; the reason that I use is because I don't want to infect other people." SJ60908, 26 (TG Case 10 IDI)

Contradiction between knowledge and practice

Some TG persons have good knowledge about HIV but they consider themselves to not be at risk.

"I knew about HIV but I was not thinking that I would get it." OP50609, 39 (TG Case 8 IDI)

TG persons with good knowledge about HIV may engage in risky behaviours when they consume alcohol or drugs. Similarly, they may decide not to use condoms when clients offer more money for sex.

"I had no fear of infection. Sometimes I was drunk. Sometime, my clients would refuse my service if I insisted that I wanted to use condoms. I was just thinking about how I could earn a lot." SH41505, 46 (TG Case 14 IDI)

TG persons tend to practice unprotected sex if they trust their partners, feel a deep sense of commitment to the partner, or express an intense feeling of fondness for the partner. This may lead to failure to assess the risk associated with unprotected sex with the partner.

3.6. The leaky cascade

The leaky cascade: where do people go when they are diagnosed HIV(+)? What do they do?

This section explores what TG persons do after they are diagnosed HIV(+) and what barriers exist for CBOs/LNGOs in following-up clients who are HIV(+).

3.6.1. Maintaining a low-profile and avoiding stigmatising encounters

TG persons believe that both the general population and the population of TG persons in Pattaya stigmatise HIV positive individuals. TG persons feel that they will be excluded, marginalized and derided by other TG persons if they are openly HIV positive. TG persons expressed a concern about not being able to find someone to love them or anxieties about losing existing intimate partners. TG persons were fearful of losing jobs or income generating opportunities if their HIV+ status is disclosed. A large proportion of TG persons that are diagnosed with HIV in Pattaya make significant efforts to maintain

a low profile and avoid encounters with TG persons who might identify them as HIV+ and staff/volunteers of CBOs/LNGOs who are aware of their HIV positive status. In some cases TG persons disclose their status to a small number of friends but typically they avoid seeing doctors or CBO staff (particularly other TG persons) for fear of unintended disclosure.

"After I came to know that I am positive, I felt hopeless. I didn't plan anything at all. I just do my best today. I try to support my family as much as possible." SJ61908, 26 (TG Case 10 IDI)

"…they like to gossip about others within TG persons community." (KII1_HON)

"After I knew my status, life changed. It took time to recover mentally. I was stressed. This issue cannot be shared with other people." SS42007, 40 (TG Case 9 IDI)

"I try to forget this 'HIV positive' feeling, pretending like I don't have it." SJ61908, 26 (TG Case 10 IDI)

"…I am very upset because it's already too late for me to have a permanent partner or to have a true love. I feel very sorry for the opportunities that have come to me. I won't have that chance anymore. I just work, work, work and work and nothing else." JP10102, 27 (TG Case 23 IDI)

3.6.2. Avoiding Banglamung Hospital

The majority of CBOs working in the HIV arena in Pattaya with TG persons (including Sisters) refer patients primarily to Banglamung Hospital. Banglamung has a very poor reputation among TG persons and appears to lack services that ensure that clients are managed in a respectful, confidential and thoughtful fashion. Many clients of Sisters (for instance) may access treatment from Banglamung and then fall out of the treatment 'cascade' because of negative experiences associated with the quality of care.

"I know a person who stopped treatment because that person experienced bad behaviour from the health officers. They shouted. The staff are too emotional, especially [name of person removed] – a staff member in Sang Duang building (HIV and TB Unit). She's not a nurse. She's just a nurse aid but [she talks to clients] very badly." SS42007, 40 (TG Case 9 IDI)

"The nurses were terrible and shouted at me. I tried my best but I couldn't stand it anymore. I just escaped from the fire exit of the hospital. The fire exit was a dead end and was not functional. They were catching up with me, so I jumped from the upper floor. The nurse said 'why the hell did you do this? This will be really bad for the hospital's reputation.' And I said 'you mother fucking nurse' and I ran away." SS42007, 40 (TG Case 9 IDI)

"I have heard that the service at Banglamung hospital is terrible. That's why I never go there" CW50809 (TG Case 22 IDI)

"The SaengDuan building [HIV and TB Unit at Banglamung Hospital] is highly stigmatized as people give it the nickname 'HIV and TB building'. People will be highly stigmatized from the moment they enter into the building …. I have seen several cases of fighting between the hospital staff and clients. The management of the [client] flow is ineffective and chaotic." PB22201, 34 (TG Case 24 KII)

"Clients are afraid that they will have an encounter with someone they know because everyone knows that anyone waiting in this building is HIV positive. Many of them don't want to go to get the drugs here" CW50602, 29 (TG Case 25 KII)

3.6.3. Leaving Pattaya

Many TG persons who are HIV positive leave Pattaya routinely for a range of reasons. TG persons have either committed/ are accused of committing a crime and leave to evade the law enforcement authorities. TG persons often find themselves in deep debt and flee Pattaya as a means of evading creditors. Some wish to be with their families for a range of reasons. Some TG persons feel ashamed to remain in Pattaya once they are diagnosed HIV+. The vast majority of TG persons who leave Pattaya have no incentive to disclose the location to which they are moving, given that they wish to maintain secrecy over their status.

"…Some may have done something illegal and fled from Pattaya….Some may be in heavy debt and fled away….Some people, after testing positive, disappeared from Pattaya." CS50502, 49 (TG Case 6 KII)

3.6.4. Short-term visitors and mobile livelihood trajectories

Some TG persons who are students plan to stay in Pattaya for a short period. They go back to their hometowns for a number of reasons. Usually either a school break or better job opportunities elsewhere pull students away from Pattaya. Finally, when they cannot earn satisfactory income in Pattaya they move elsewhere or back to their hometowns.

"I came to Pattaya without knowing anything at all. I just needed a job. I came with friends but when we arrived, we didn't get any work because we were not pretty and I was not confident because I was not beautiful either. No place accepted me for a job. So, I went back (home)" JP10102, 27 (TG Case 23 IDI)

3.6.5. Imprisonment

Many TG persons are detained in prison for criminal acts or alleged criminal acts. For many, livelihoods exist within the shadow economy of the commercial sex industry in Pattaya. Arrests, extortion, and arbitrary punitive measures by law enforcement agencies are not uncommon in Pattaya.

"Out of 10 people, who got tested positive, I usually only find 4 of them again. This is probably mostly due to them having done something illegal and they got arrested." CS50502, 49 (TG Case 6 KII)

3.6.6. Changing phone numbers

TG persons often change phone numbers. Phone numbers are changed because TG persons are trying to evade creditors, former employers who are unhappy with the individual, TG persons with whom the individual has an ongoing conflict etc. We hypothesise that some TG persons change phone numbers when they are diagnosed HIV+. Whilst no TG persons explicitly referenced this it is a fair assumption that given the fear of disclosure that changing mobile numbers would be an effective strategy in avoiding contact with CBOs/LNGOs that know the status of the TG.

"We could not reach some HIV-positive TG persons by phone, as they tend to change phone number very often." (KIII_HON)

3.6.7. Foreign migrant labourers

A proportion of TG persons in Pattaya are migrant labourers from Laos and Cambodia. This group of TG persons are working in Thailand illegally, and they do not have the same access to insurance and the health care system that Thai TG persons have. Once they are diagnosed HIV+ by CBOs/LNGOs it is difficult to track individuals who maintain a low profile and high degree of invisibility and who earn their livelihood in mobile and unstable ways.

"…I went to double check at Chonburi hospital. I went there by myself. Everything was so difficult because I'm an alien in this country. There was nobody who would help me there. I decided not go to back to my country because there is no secret in the world there. It would be even worse there…" JP10102, 27 (TG Case 23 IDI)

3.6.8. Informal procurement of ART

It is not possible to establish the scale of the phenomena but one TG KI respondent who lives in Bangkok presently (but used to live in Pattaya) stated that a large number of TG persons obtain drugs through a well-known and reputable hospital in Bangkok with the help of brokers based in Bangkok. These TG persons remain in Pattaya but obtain drugs from elsewhere.

3.6.9. Out-migration for international sex work

A number of TG persons in Pattaya travel to Singapore for a month, on tourist visas. In Singapore they work as sex workers on a short-term basis. Typically, they pay brokers and pimps for the cost of the travel to Singapore, accommodation and a commission, sometimes paid in kind in sexual services. The sex worker will arrive in Singapore and work until the debt is paid off. Often TG persons are deported by Singaporean authorities before the end of the one-month visa.

3.6.10. Barriers to treatment initiation and compliance

Many of the barriers to follow-up are interlinked with the barriers to treatment initiation and compliance. These barriers are discussed in detail in other sections of this report. For instance, TG persons often know of their HIV status but delay initiation of treatment because they do not want to have to take pills on a routine basis. TG persons may fall out of the cascade having initiated treatment because the staff at Banglamung hospital is rude and the risk of disclosure to other TG persons is high. When these (and a multitude of barriers) to treatment initiation and compliance are faced by TG persons, the individual also typically falls out of contact with CBOs/LNGOs who are attempting to follow-up on the client.

4. KEY FINDINGS

Program design. PSI/Thailand's support to Sisters provides HCT and follow-up support and services for TG persons diagnosed HIV+. This study finds that testing and treatment services for the TG population in Pattaya that are provided by TG persons are not appropriate for all the TG target audience. TG persons accessing services need to be guaranteed that other TG persons will not come to know about health and treatment seeking behaviours related to HIV, STI and TB.

Avoiding disclosure. TG persons in Pattaya typically invest considerable amounts of time and energy to avoid disclosure of HIV+ status to other TG persons. TG persons reported perceiving themselves to be at risk of disclosure when visiting hospitals with specialised units offering HIV and TB services or when undertaking counselling at CBOs/ LNGOs providing HCT.

Stigma among TG persons. TG persons in Pattaya provide support to each other and interact with each other in a number of domains (how to find clients, how to increase the transactional value of yourself in the arena of sex work, beautification, cosmetics, clothes and sex-reassignment surgery). However, TG persons in Pattaya do not divulge their innermost, private thoughts linked to anxieties about health (including HIV, STIs, TB). Indeed, TG persons broadly discussed how social practices of gossiping ensure that any TG that is HIV+ whose status is disclosed will be talked about and marginalised, stigmatised and excluded (both socially and with regard to livelihoods/income generating-opportunities).

TG persons and the cascasde. When TG persons are diagnosed HIV+ very few of them leave Pattaya to return to their homes (typically in North and North-Eastern Thailand). The majority of TG persons remain in Pattaya maintaining a low profile and avoiding CBOs, LNGOs, friends, acquaintances and other actors who might know their status. Many TG persons also migrate away for other sex work opportunities, are incarcerated in prison or change their mobile phone numbers. The trajectories of TG persons that are HIV+ constitutes a profound challenge to an organisation like PSI attempting to develop a coherent M&E/MIS which tracks TG persons after HIV testing, and which seeks to follow-up HIV+clients, primarily because TG persons aim to maintain a low-profile concealing their status and whereabouts.

Delaying testing. Many TG persons engage in risky sex for several years and experience the symptoms of HIV for long periods of time without undertaking testing. Several TG persons narrated being extremely sick before undertaking testing.

Gossiping, stigma and quality of services. Testing, initiation of treatment and compliance are behaviours that have negative associations among the TG persons of Pattaya. All behaviours face a large number of barriers. Three barriers are priority

barriers within all three behavioural domains include: (a) social practices of gossiping among the TG community in Pattaya; (b) high levels of stigmatisation among TG persons with regard to HIV and TG persons with HIV; (c) the existence of a number of key health service providers in Pattaya that are not designed to, and do not offer a service, which provides a confidential, quality and respectful service for TG persons in Pattaya.

Social structure and social capital. This study was premised on the notion that TG persons exist within a hierarchical social structure in which senior TG persons might be leveraged programmatically to message to and influence younger TG persons with regard to a range of important behavioural domains (condom use, HCT, initiation of ARV, compliance etc). Some TG persons described a social hierarchy between TG persons. Some TG persons described examples of social support to one another. Social support is typically functional rather than emotional. TG persons almost never talk about their anxieties, concerns and issues if related to personal and private issues and particularly if they relate to health. The majority of TG persons described vivid examples of their life experience, which suggest that they live an isolated and atomised existence as lonely individuals rather than as social actors in a hierarchy or community. What TG persons have in common is their gendered identity and geographical location. It is not correct to consider TG persons to be living in a community of social actors with a clearly understandable social structure. The social relations between TG persons are much less uniform and constant across socio-professional domains and contexts than was understood at the study design phase of this research process. Social marketing programs premised on leveraging senior TG persons to influence younger TG persons would not therefore reflect an underlying social reality or structure nor be effective in catalysing behaviour change.

5. RECOMMENDATIONS

PSI/Thailand is supporting Sisters which offers HCT to TG persons within the context of a Drop-In Centre specifically focused on TG persons living in Pattaya. Many TG respondents described feeling uncomfortable undertaking testing and accessing treatment in a context in which other TG persons might come to know that the TG is either HIV+ or has concerns about her status. This concern constitutes possibly the most significant barrier and challenge to PSI/Thailand and Sisters with regard to behaviour change amongst this target group. It is recommended that Sisters strengthen their services by offering mobile testing and provide services by non-TG peers to remove the experience from the risk of gossip. TG persons seeking testing and treatment will be attracted to services that are designed for their needs, but are not executed/offered by fellow TG persons. A fellow TG as an HCT counsellor is viewed as a potential 'leak' disclosing the status of the TG to the broader TG population.

Providing treatment through hospitals does not always provide the confidentiality that TG persons require in order to avoid disclosure of HIV positive diagnosis among the TG community of Pattaya. It is recommended to **provide treatment through private general health providers that are mobilised within the framework of a Social Franchise network.** These general health providers offer a multitude of health services that are not specifically HIV/STI-related. TG persons would be able to access services from such providers without fear of being observed by other TG persons. TG persons would feel more comfortable accessing services without fear of unwanted disclosure of their HIV status. Accessing care through such providers would have a range of other benefits. Actors operating on a profit motive might be more incentivised to provide a polite, quality service in comparison to some state providers (which in some cases have an extremely negative reputation among TG persons). Moreover, such providers would be more easily accessed by TG persons, which would reduce one barrier to accessing testing/treatment, inconvenience resulting from distance and time to travel to hospitals.

TG persons are uncomfortable approaching staff within Sisters and other CBOs about testing and treatment fearing unwanted disclosure. **Provide confidential mobile phone-based and social media-based counselling and advice about condom use, testing and treatment.**

Auxiliary and administrative staff in large hospitals (such as Banglamung) are described by TG clients as rude, insensitive, and lacking in skills that would provide a springboard for quality service (i.e. service characterised by confidentiality, privacy and respect). **Conduct training/capacity building with auxiliary and admin staff (nurses, receptionists etc) in government hospitals. Focus on the following areas: (i) practical approaches to treating clients with respect; (ii) interpersonal skills; (iii) confidentiality and privacy.**

Banglamung hospital HIV and TB unit is poorly designed and managed. **Conduct advocacy to Banglamung hospital where TG persons go for testing and treatment. Provide advice in the redesign of schedules and service unit physical design to maximise privacy and confidentiality and minimise risk of disclosure.**

Many TG persons are delaying initiation of treatment for very long periods of time well after CD4 counts have dipped below threshold levels at which point treatment could start. Many TG persons have an extremely negative brand association with the behaviour of treatment initiation and compliance. **Conduct generic promotional campaigns to remove misconceptions about the negative experience of ARV treatment and emphasise the benefits of early initiation and compliance of treatment. Focus messaging on the benefits of ART helping TG persons to stay healthy and maintaining a healthy appearance. Emphasise that this will avoid early signs of symptoms of HIV (which provides a tactic for avoiding disclosure and stigmatisation). Emphasise the benefits of ART in providing a platform for continued reliable livelihoods strategies and income generating opportunities.**

One of the most significant barriers to starting treatment and compliance relates to concerns about disclosure of status within the TG community itself. **Find creative ways to help TG persons build greater levels of social capital, trust, and confidence in each other and to develop networks of social support. Supporting organisations such as Sisters is an effective approach to building social capital.**

On the whole, TG persons do not experience themselves to be living in a community or hierarchical TG social structure. **Social Marketing Programs should not therefore be designed/initiated to influence or message to younger TG persons via older TG persons given that there is limited evidence that this social structure exists in reality and this approach would not catalyse behaviour change.**

6. ANNEX

6.1. References

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