Eo na Māhū o Hawai‘i: the extraordinary health needs of Hawai‘i’s Māhū

CAROL ODO*  
ASHLIANA HAWELU**

Abstract

An overview of health and social issues is presented here regarding Native Hawaiian transgenders. Perhaps due to relatively greater tolerance of gender diversity among Polynesian cultures, approximately 70% of all male-to-female transgenders in Hawai‘i are Native Hawaiian. However, the overall climate is one of discrimination and harassment such that transgenders—who tend to be under-educated, under-employed, and medically underserved—may be the most severely impacted of all Native Hawaiians. Lei Anuenue, human immunodeficiency virus (HIV) prevention program for Native Hawaiians, has provided a variety of services for transgenders, including outreach, educational workshops, support groups, HIV testing, and case management. All services are provided by peer leaders who are employed by the program. Data for this article are based on case management, including client self-disclosures and reports of peer staff who knew details of clients’ lives having shared with them both generic experiences and specific activities. Information from 100 transgender clients and their case managers indicated that the transgender health profile is far more serious than that of mainstream Native Hawaiians. For example, 74% smoke, 31% use illegal drugs (excluding marijuana), more than 50% have been involved in street or domestic violence, and few individuals over age 50 have been found during three years of outreach. To some extent, employment options limit transgenders to prostitution, drug dealing, and minimum-wage jobs. In addition, a lifestyle of multiple sex partners and lack of opportunities for stable relationships place transgenders at much greater risk for HIV, sexually transmitted diseases (STD), and other infectious and non-infectious diseases as compared to the mainstream Native Hawaiian community. Clients in this study were from O‘ahu, primarily from downtown Honolulu, Chinatown, and Wai‘anae. Future studies should compare the results of this sample to transgenders from the neighbor islands (especially in rural Hawaiian areas), as well as utilize a structured prospective longitudinal approach.

Introduction

There are many misunderstandings regarding the concepts of transgender (TG) and māhū in Hawai‘i. These constructs have direct relevance to Native Hawaiian health given the general over-representation of Native Hawaiians in this group and the at-risk health status for these individuals (e.g., acquired immunodeficiency syndrome [AIDS], human immunodeficiency virus [HIV], sexually transmitted diseases [STDs]). Associated adjustment problems include limited employment options, stress, mental health issues, substance use, and discrimination.

Given these circumstances, the purposes of this paper are to discuss the following:
1) definitions and a scheme for categorizing TGs and māhū,
2) Native Hawaiians, men who have sex with men, and HIV/AIDS,
3) needs of this population,
4) Lei Anuenue HIV Prevention Services Program,
5) exploratory correlational study, and
6) clinical and research implications.
Table 1. Toward a conceptualization of māhū within the context of biological sex, gender orientation, and sexual preference

<table>
<thead>
<tr>
<th>TG</th>
<th>MSM1</th>
<th>MSM2</th>
<th>MSM3</th>
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<tr>
<td>Self-Perception</td>
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Note: Where MSM = men who have sex with men; TG = transgender; F = female and M = male, whereby predominance is expressed by the first symbol (e.g., F/M means primarily female and secondarily male).

**Definitions and categorizational scheme**

Table 1 presents the categorizational scheme on male sexual orientation and gender identification that was derived based on historical and anecdotal observations by the authors. The chart displays four groups of "men who have sex with men" (MSM) described based on four psychosocial dimensions (i.e., self-perception, acting, appearance, and sexual preference). Our categorizational scheme refers to the continuum of visibility of MSM, with the most obvious being TGs, and the least, in terms of appearance and behavior, the masculine heterosexual-leaning males. Caution should be noted in interpreting and utilizing this organizational scheme; this is only a rough approximation of categories that include all MSM as well as male-to-female TGs.

**Men who have sex with men (MSM).** According to the Centers for Disease Control and Prevention (CDC) and other funding sources for HIV/AIDS programs, the term "men who have sex with men" (MSM) is used to identify homosexual or bisexual men. MSM are further differentiated into either gay or non-gay identified.

**Māhū.** Māhū is a term that is used in the general community, usually in a derogatory sense, referring to male-to-female TGs or very feminine-appearing men. Among the current generation of empowered male-to-female TGs in Hawaiʻi, the term māhū, or the recently coined māhūwahine (male-to-female transgender), is being embraced and used in a positive manner. The concept and practice of māhū are known throughout Polynesia; the same word occurs in Tahitian and Marquesan cultures. Parallel terms are fa'afafine in Samoan and fakafefine or fakaleiti in Tongan.

According to its vernacular use, māhū refers to a biological male who would fall under the category TG or MSM1 (see below). Anecdotally, among māhū, gender identity may be relatively fluid, and it is typical for a male to go through a transition to female, then go back to life as a man due to social or family pressure and/or due to his own perception of losing sexual attractiveness.

**Transgender (TG).** TG is defined in this article as someone who was born one sex and identifies and lives as the opposite sex. Western psychology identifies transgenderism as "gender identity disorder," differentiating among TGs as "pre-op," "post-op" or "non-op"—terms referring to the their status with regard to sex-change surgery. A transsexual is usually someone who is post-op, but the term is also used among non-op TGs in reference to themselves. Based on anecdotal observations, TGs are also referred to as "drag queens." All of their gender characteristics are more- or less feminine. TGs call themselves "queens," "girls," or "T," and use the pronouns "she" and "her" in reference to one another. They act and dress like women and live as women. It is considered taboo to have sex with females or other māhū; their sexual preference is the heterosexual male. In the larger community, there has always been a need or demand for a TG sex industry. Key informants indicated that there may be a number of reasons why otherwise heterosexual males seek out TGs for sexual encounters, among them being: (1) desire for sexual experimentation, and (2) more commonly, the desire for a "safe" homosexual experience with a male who has created the illusion of being a female.

**MSM1.** MSM1 are more transgendered (i.e., androgynous-looking and feminine-acting) than MSM2. They often call themselves "girls," and refer to each other as "she." They may be in transition—becoming TGs—but still dress as men during the workday, while at night, they may wear women's clothes at bars or public sex environments. Their sexual preference is other males.

**MSM2.** MSM2 are often bisexual in which case they may marry, have children, have aikāne (same-sex) relationships, and/or visit public sex environments. MSM2 who identify as gay are likely to be more Westernized and less likely to be familiar with traditional culture than TGs. They may also follow the gay pattern of exclusively pairing with other males. The more Westernized they are, the less likely they will have sexual relationships with women.

**MSM3.** TGs say that their usual partners are "macho" men—police officers, construction workers, athletes, and
other males. Although these partners technically fall into the MSM category, their sexual preference is female. As long as they do not establish long-term and open sexual relationships with a TG or another male, they are not harassed or ostracized by their peers. Sexual encounters with māhū are generally opportunistic and occasional.

**Native Hawaiians and HIV/AIDS rates**

*Native Hawaiian MSM rates.* With approximately 73,000 Native Hawaiian males between ages 10 and 59, and assuming a rate of 5% to 10%, we estimate 3,650 to 7,300 TGs and homosexual-leaning MSM. However, the number of MSM—men who have sex with māhū—is very difficult to estimate. Given the acceptability of bisexuality in the traditional Native Hawaiian culture (see below), the following breakdown of the estimated numbers of Native Hawaiian TGs and MSM (excluding MSM3) statewide should be considered to be conservative: TGs = 800; MSM1 = 1,000; MSM2 = 2,000; total = 3,800. On the basis of key informants, at least 70% of TGs are Native Hawaiian in Hawai‘i. Over 50% of the 80-100 prostitutes downtown and nearly all of the prostitutes in other parts of O‘ahu (outside of Waikīkī) are Native Hawaiian TGs.

*Native Hawaiian HIV and AIDS rates.* In terms of general ethnic breakdown, Caucasians have the highest incidence of AIDS at approximately 60%. Native Hawaiians have the second-highest rate at 10%, which is twice the percent of any other major Asian/Pacific Islander group. Native Hawaiians constituted 40% (n = 219) of Asian/Pacific Islanders (n = 550, including Native Hawaiians) for documented AIDS cases, and 47% (n = 102) for HIV (non-AIDS) cases (n = 218, including Native Hawaiians). It should be noted that the state Department of Health estimates that approximately 3,000 people are infected with HIV, in addition to those who have been diagnosed with AIDS. Because both TGs and MSM are categorized as MSM in the state’s AIDS surveillance reports, there is no way to determine the number or proportion of TGs reported to be infected with HIV or diagnosed with AIDS.

*Stigma and acceptance.* The question can be asked, "Why are there so many Native Hawaiian TGs and MSM who are at a greater risk for HIV/AIDS?" Legends of dual-gender deities and deities who had same-sex relationships, as well as historical records of chiefs and their male partners, suggest that transgenderism and same-sex relationships were accepted practices in ancient Hawai‘i. For example, according to traditional legends, Laka, the god/goddess of hula, was said to be both male and female. Aikane (same-sex) relationships among deities were recorded in traditional chant—as in the relationship between Wākea, the sky father, and his male lover Ha‘akaualani. Native Hawaiian scholars maintain that in the past, before Christian contact, bisexuality was the norm in traditional Hawai‘i.

Among present-day Native Hawaiians, heterosexuality is the norm. Although many TGs are reported being abused within the family, they are, on the other hand, far more tolerated in Native Hawaiian and other Polynesian societies than in the Western world. Their unspoken place in the modern Native Hawaiian family is as entertainers (hula, drag shows) or as caregivers for children and the elderly. Similar patterns are seen with other Polynesian cultures (e.g., Tahiti, American and Western Samoa, Tonga, New Zealand (Aotearoa), Cook Islands).

The Native Hawaiian historical context may also explain the apparent relative acceptance of māhū by Native Hawaiians. For Westerners, gay men are far more acceptable than TGs as evidenced by gay men’s visibility and projection of positive images—e.g. the appointment of the first openly gay man to head the White House Office of National AIDS Policy and the hiring of Stephen Herbits (who is also openly gay, as consultant to Secretary of Defense Donald Rumsfeld). For Native Hawaiians, the opposite appears to be true—i.e., māhū appear to be more accepted than gays—at least based on anecdotal observation. This attitude is perhaps seen more clearly in the prison system than anywhere else, where nearly half the inmates are Native Hawaiian. Gay men are more likely to be harassed, while māhū are valued for their feminine qualities:

> "... [the prison] is where I learned the meaning of being royalty—of being a Queen. The other inmates treated me with the utmost respect. It was in there that I would meet the most rational, most unique, and the most strong-minded people I have ever known. In a world full of hate, I found love, compassion, and most importantly unbiased judgment of who Stacia was. The only judgment came from the guards, the outside world, the real world ... I was a ‘kept’ woman, as most of the ‘girls’ in prison are ..."

**Community and Native Hawaiian health needs**

The needs of this at-risk population are great. Behaviors that put MSM and TGs at higher risk for HIV include: insertive and receptive anal and oral sex; casual sex with many partners; and exchange of sex for drugs, food, shelter, money, a ride to town, or other necessities. In addition, discrimination in the job market and gratuitous harassment from police, store clerks, and people on the street often result in low self-esteem, depression, vulner-
ability to drug use, and other self-destructive behavior. In terms of services to reduce the spread of HIV/AIDS and to provide basic psycho-social assistance, programs are needed that include outreach to the target population (including Native Hawaiian MSM), testing of HIV status, prevention counseling, distribution of condoms, and peer support.

**Lei Ānuenue HIV Prevention Services Program**

Until recently, minimal attention was paid to the needs of *māhū*, a population that plays a confined but significant part in Hawai‘i (e.g., lives of Native Hawaiian families, *hula*, entertainment, commercial sex industry). Lei Ānuenue (an ancestral symbol, literally *lei rainbow*) HIV Prevention Education Program began in 1996 with a small grant from the Department of Health STD/AIDS Prevention Branch. Lei Ānuenue is a component program of Ke Ola Mamo—Native Hawaiian Health Care System for O‘ahu. During its first year, resource materials and lesson plans were developed and a culturally appropriate HIV education program was implemented.

In 1997, a three-year award from the Centers for Disease Control and Prevention (CDC) resulted in Lei Ānuenue serving not only the general Native Hawaiian population, but the subpopulations most at risk for HIV. In Hawai‘i, these populations include MSM, intravenous drug users, and women who are partners of the first two types of individuals. The category of MSM represents over 74% of Native Hawaiians diagnosed with AIDS or HIV, and is given the most attention by funding agencies. This category encompasses all biological males whose sexual preference may be male, female, or both, but whose behavior includes having sex with men. Their gender identification may be either as men or women.

In focusing the program’s efforts on at-risk groups, Lei Ānuenue hired peer educators for both the MSM and TG populations. One of the first findings of the program was the confirmation that gay and bisexual MSM were difficult to reach. Every strategy was used to reach this group by the peer outreach worker (a gay-identified male) from canvassing public sex environments to joining Internet chat groups. Out of these efforts, several males called the office for counseling, and several small groups were organized for socializing combined with HIV prevention education. However, no MSM clients visited the office.

In contrast, the initial response to Lei Ānuenue’s TG outreach was overwhelming. During the first eight months of the TG outreach, TGs went out of their way to take the bus to the Ke Ola Mamo administrative office in the Nimitz Business Center, which is located in Honolulu’s industrial district. Management then decided to establish an outreach site in the downtown/Chinatown district in an effort to provide services in the midst of the red-light district—convenient to bars frequented by TGs and MSM. From the first week that this site was open, TGs and MSM began to drop in for condoms, counseling, and social support. Homeless clients used the office as a place to receive mail. HIV testing was a service added in January 2000. More recently, four computers were donated for clients to use to learn typing and word processing, and to write stories for the community newsletter.

With the focus on TGs (including Native Hawaiians), Lei Ānuenue tapped into focus groups and key informants to develop the following mix of services to address the needs of TGs:

- **Statewide events** (e.g., annual retreats, workshops and conferences). These events are an opportunity for networking, leadership development, and community health education.
- **Statewide HIV prevention education** (HIV 101). This program targets the general Native Hawaiian community as well as to MSM and TGs. The program has been implemented by the Native Hawaiian Health Care Systems since 1996.
- **Support groups**. These groups help clients develop survival skills in a supportive peer environment.
- **Speakers bureau**. Client volunteers assist HIV staff in making presentations to social service agencies, schools, community groups, and other AIDS-service organizations. Program staff members receive approximately 25 requests a year to provide training on sexual diversity in the context of HIV. Staff have been regular participants at national Asian American & Pacific Islander and Native American meetings and conferences. A presentation on Lei Ānuenue’s pilot study of the TG sex industry workers was made at the 1998 national Native American AIDS Prevention Conference in Minneapolis. Through the speakers’ bureau and one-on-one contact, program staff has established linkages that have greatly improved the relationship between clients and other providers.
- **Newsletters**. Volunteers produce *Diva News*, which combines HIV and other health information with announcements and other community news. Distribution is to a mailing list of more than 200 TGs and MSM,
plus State HIV Prevention Community Planning Group members and interested agencies.

- **Counseling and testing for HIV infection.** OraSure is a noninvasive alternative to blood-drawn testing. OraSure depends on samples of mucus from inside the cheeks and gums rather than blood. This technique is approved by the federal Food and Drug Administration (FDA) and is reportedly as accurate as blood tests. These tests can be performed virtually anywhere.

- **Referral for medical and legal services.** Lack of understanding among health care professionals is a major barrier to seeking medical care during the early stages of illness. For example, anecdotally, TGs tend to be reluctant to seek primary care, especially when this involves full-body exposure. To meet primary care needs, clients are referred to community health centers and other medical facilities for ailments ranging from skin infections to (a recent) heart attack. Several clients a year are also referred to legal service agencies for job discrimination, health club discrimination, police harassment, and police entrapment of prostitutes.

- **Prevention case management.** Although clients do not perceive HIV prevention as an urgent need, especially when they are confronted with survival issues, this service is the heart of Lei Anuenue’s program. The prevention case management (PCM) component is based on taking care of the whole person’s needs because these must be addressed before the client can begin to think about protecting himself or herself from HIV. The purpose is to assist individuals in identifying and overcoming barriers to reduce their risk for HIV infection and/or transmission. Services performed for clients under PCM include escort and transportation to primary care and dental clinics, the welfare office, and free legal aid. In most cases, the client is accompanied while receiving the service because the world of health and social service is unfamiliar and sometimes unwelcoming to the client. For example, one employee at the Hawai‘i State welfare office said the office did not allow male-to-female TGs to use the women’s restroom (personal communication, 1999). The length of time a client may participate in PCM before he or she has reached individualized goals varies from a few weeks to over a year. The intervention is an intensive peer-to-peer approach that involves multiple sessions in which staff members work with clients to address safety, health, and survival issues with the goal of preventing HIV infection.

Of all of the services, PCM lends itself best to data collection because it involves the completion of enrollment and assessment forms, a care plan, and a record of actions taken. The PCM data set provides an opportunity to study, on an exploratory basis, the correlates between socioeconomic, psychosocial, and health characteristics for Native Hawaiians at-risk for HIV/AIDS.

### Method

#### Participants

There were a total of 129 Lei Anuenue clients during the study period: 100 (78%) were TGs, 17 (13%) were MSM, 7 (5%) were female, and 5 (4%) were bisexual or heterosexual males. Clients ranged in age from 14 to 53, with the median being 26. For the purposes of the present investigation, only the 100 Native Hawaiian male-to-female TGs were involved in further analyses. The participants’ ages ranged from 12 and 46 years. They resided in various parts of O‘ahu—Aiea, Honolulu, Waimanalo, Hau‘ula, Kahuku, and Wai‘anae—with the majority being from urban Honolulu and Wai‘anae.

#### Measures

Data were collected based on two sources. First, the Ke Ola Mamo standard enrollment and assessment forms were used to gather basic client self-report information: gender, ethnicity, education level, housing situation, medical insurance, HIV status, and cigarette smoking.

Second, each case manager collated data on her clients according to demographics, risk behaviors, and health and social services. The estimated proportions of clients subjected to domestic and street violence, former inmate status, and substance use were based on reports of case managers who knew each client’s situation. These data were not recorded on case management files unless the issue had a bearing on a client’s care plan (e.g., if referral to substance abuse treatment was needed). Other information not routinely recorded in case files included those regarding estrogen use, sex reassignment surgery, silicone injection, and breast implants.

#### Procedures

Lei Anuenue prevention services were provided by an all-TG peer staff, each of whom was a case manager. When a new client entered, she may have requested a particular staff member to work with. If this did not occur, the first person available completed the enrollment and assessment, and provided services for the client. The outreach worker first enrolled the client and recorded information that included a health assessment, family medical history, and recordings of vital signs (e.g., weight, height, blood pressure). A care plan was then developed.
to meet the client’s individualized needs related to health, social services, and basic survival. Staff met with each client at least once a month or as determined by the client’s plan. Each client was reassessed every quarter, and each case file was “closed” when the client completed her care plans, left town, or failed to show up over a three-month period. Data were collected between the period June 1998 and December 2000.

Results

General socioeconomic, psychosocial, and health-related findings

Table 2 summarizes the findings associated with the participants’ self-reports. Overall, substantially higher rates were found for Native Hawaiian TGs as compared to the general Native Hawaiian population in nearly all of the domains: incidence of HIV (300 fold), smoking cigarettes (2.7 fold), drug use (11.9 fold), high school dropout (1.3 fold), ex-inmate (23.3 fold), homeless (24 fold), mainstream full-time employment (0.5 fold), and no medical insurance (8.2 fold). Much higher rates are presumed for sex industry workers.

Compared to TG populations on the mainland, the incidence in Hawai‘i of HIV is low. For drug use, TGS most commonly used marijuana, but also used ice, crack, and ecstasy, and abused prescribed medications. Five clients were escorted and enrolled into drug rehabilitation programs. For the general Native Hawaiian population, marijuana use is 8.9% and drug use (not including marijuana) is 2.6%. The high school drop out rate may be higher because of harassment and humiliation in the schools for TGS. Of the 100 participants, only two had a bachelor’s degree and another two had some community college education. The majority of offenses for the TGS were for prostitution and drug dealing.

In addition to the 12% who reported being homeless, 32% were provided housing assistance. Homeless clients were transported to and enrolled in the Institute for Human Services homeless shelter. Clients who had jobs were referred to Nā Kolea—a boarding house for low-income working individuals. Participants were also referred to the Section 8 program of the U.S. Housing and Urban Development (administered by the Hawai‘i State Department of Business Economic Development and Tourism). Other clients either lived with their families or shared apartments with other māhū. A few lived alone or with their boyfriends. In many cases, they were at risk for homelessness due to lack of adequate income for independent living and lifestyle issues that surfaced between themselves and their families or roommates. Clients without medical insurance were enrolled into the Hawai‘i State’s health insurance program called MedQuest.

A total of 62% of the TGS were in the mainstream workforce. All except two TGS worked at “small jobs,” making little more than minimum wage (i.e., fast food, telemarketing firm, parking lot attendant, caregiver for elderly). Clients who work take home approximately $600 a month and only two clients have a car. Over half (57%) of the TGS engaged in prostitution with 23% of the TGS doing so on a full-time basis and 34% of the TGS doing so part-time. Some of the latter also had regular jobs.

Oral health. Of the TG clients, 22% were referred to dental clinics. Free or low-income dental services are scarce, and MedQuest coverage is usually limited to treating a damaged tooth by extraction. Unfortunately, clinics do not provide for tooth replacement, which is needed by some of our clients. Needless to say, missing one’s front teeth is a major barrier to employment.

Violence. TGS, especially prostitutes, were more exposed to street and domestic violence than other Native Hawaiians. At least one TG dies of street violence every
year and many more are injured. By informal count, at least 20 TG clients have been battered by their partners since the inception of the program. The experience of being beaten/abused by parents and siblings during adolescence appeared to be a common phenomenon.

Early mortality. Native Hawaiians in general suffer from earlier mortality due to diabetes complications, cancer, and cardiovascular diseases. They have an average life expectancy of 74 years. We can only speculate about the life expectancy of TGs. It is thought that a significant proportion die before the age of 60 due to violence, depression, and/or lack of early medical care. Although no studies have been conducted, a three-year search for TGs age 50 and above found just three TGs between the ages of 50-59 years, and just one between the ages of 70-79 years. One complicating factor is that many TGs transition back to taking on a masculine appearance as they pass 40 years of age. These individuals have been difficult to locate. Therefore, estimating lifespan is problematic for TGs in Hawai'i.

Health issues related to sex change

The following issues were discussed with all clients, either individually or in group formats. Young TGs tended to have questions about hormones, silicone pumping, and sex change surgeries. The following data were reported by the peer staff.

Estrogen. Program staff indicated that approximately 70% of TGs began taking estrogen by age 20. Estrogen was dispensed by either prescription pills or injection, the latter being provided by a Honolulu physician. The effects of long-term estrogen use among TGs are not known, although users' complaints include constant symptoms of pre-menopausal syndrome (PMS), loss of muscular strength, hives, and nausea.

Silicone injection. TGs who entered pageants and who performed at nightclubs may have undergone silicone injections to enhance their physical features. Although the practice is illegal, it has always been available. Silicone imbedded in tissue can cause infection and eventual disfigurement.

Breast implants. Saline implants are common among women who wish to enlarge their breasts or who have had mastectomies. Having implants was a goal for nearly all TGs, although not many were able to afford such a procedure. Current information is inadequate in assessing the long-term safety of saline implants.

Genital reassignment surgery. The high cost of penectomy along with vaginoplasty makes such procedures prohibitive for most clients. Several Native Hawaiian TGs have undergone this surgery in Montreal, Colorado, or Thailand. Stories about complications and negative side effects include: tearing of the vaginal wall into the rectum, foul odor caused by urination through the vagina, and loss of sexual enjoyment. Although no studies have been done on the long-term effects of these types of surgeries, such techniques of surgery are promoted in the Western TG community as the ultimate solution to gender dysphoria—a viewpoint that has been almost universally adopted.

Discussion

The Lei Ánuenue HIV Prevention Services Program has "discovered" a community of individuals who desperately need access to case management and health care services. Although we may have known about TGs all along, we did not realize what their needs were until peer outreach began. People who differ from others primarily with regard to gender identification actually are at much higher risk for lifestyle diseases and perhaps early mortality than the general Native Hawaiian population, as indicated by the substantially higher rates of HIV, cigarette smoking, drug use, street and domestic violence, lack of medical insurance, and so on. Although funding is never enough to address all of the needs of this disadvantaged population, a certain amount should be set aside for services to TGs and other marginalized members of society.

In addition to relatively basic clinical implications for this at-risk population (e.g. increased services), educating health professionals and the general public on issues related to TGs and HIV/AIDS is a necessary step to decreasing stigmatization and increasing acceptance of this disadvantaged group.

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Limitations of this study included the relatively small sample size and the fact that clients were from O'ahu only. Based on "talking story" with TGs from Moloka'i, Kona, and Hilo, employment and survival may not be as critical as for Chinatown (Honolulu) TGs. Minimal information is available on TGs who live in Hawaiian communities like Miloli'i or Hāna. According to informants on Moloka'i, TGs are accepted as part of the community; they work as store clerks, waitresses, and bus drivers. Another limitation is in the mixture of data from client self-reports and case managers.

Future research should include greater representation from other communities, including those from the neighbor islands and from predominantly Native Hawaiian commu-
nities. Female-to-male TGs should also be considered as participants. A more structured, systematic, and longitudinal approach would allow for increased confidence in the findings obtained.

Although the above data showed that TGs may be, in the blunt expression of one public health educator, the “lowest of the low,” turned on its positive side, the data also indicated that approximately 70% do not take drugs (aside from marijuana). The data also suggested that the majority of TGs are willing to fight the odds—79% have completed high school despite peer harassment, and 62% work in the mainstream workforce no matter how low-paying the job. TGs are beginning to care about HIV prevention. Only two years ago, many were afraid of being tested. After counseling and role-modeling, the majority have taken oral tests for HIV antibodies. What is not shown by the data is the spirit, energy, and resilience of individuals who have survived through what is an immense personal and social challenge—changing one’s gender. These individuals represent a population that is more than willing to make a unique and perhaps invaluable contribution to society.

Acknowledgements

Gainfully employed TG individuals in professional and semi-professional settings are rare. Ke Ola Mamo has set a precedence in the Native Hawaiian community by employing three transgenders on a full-time basis. Mahalo a nui to our Board President Agnes K. Cope and Executive Director Dexter Soares for believing in us.

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References


He ukana ko ka houpo
A burden on the diaphragm
A problem in the mind