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The gendered technostate: transnational health flows, local inequalities

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Dissertation

**THE GENDERED TECHNOSTATE:
TRANSNATIONAL HEALTH FLOWS,
LOCAL INEQUALITIES**

by

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B.A., Bryn Mawr College, 2010

Submitted in partial fulfillment of the
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DEDICATION

*For my family,
who instilled in me a desire to learn
and responsibility to challenge the status quo.*

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Perhaps one of the most confounding revelations that came from my 2017 fieldwork in Thailand was that, although I had never felt more alone, I simultaneously remained connected to the support and wisdom of so many people. It was only through the physical distance – a supposed absence – that I became abundantly aware of how deep an impact my communities have had on me. While I take full responsibility for any errors in this dissertation, the work is also a conglomeration of and testament to the immense generosity, care, and thought of family, friends, colleagues, and mentors throughout the years I worked on this. Their influence on me and this work is incalculable.

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**THE GENDERED TECHNOSTATE:
TRANSNATIONAL HEALTH FLOWS,
LOCAL INEQUALITIES**

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ABSTRACT

This dissertation analyzes how medical tourism in Thailand impacts and involves kathoey, a Thai third gender group. As the Thai state launched in 2016 an economic plan centered on technological growth and medical tourism, kathoey entertainers – many who have undergone gender-affirming surgeries – are being used as a symbol of medical technologies to attract foreign currency and potential medical tourists. Their work in the entertainment industry also contributes to national rebranding efforts by shifting Thailand’s historical reputation as a sex tourist hub to one of medical expertise and professionalized labor. Through the concept of the gendered technostate, I show how states, gendered labor, and technologies are co-constructed via technologically-enhanced gendered labor, that is both produced by and contributing to state agendas. Within the context of state-led efforts to advance technological growth and medical tourism, I illustrate how local people co-construct a global medical market, affording the nation

new levels of prestige. The dissertation analyzes local health effects of medical tourism, developing the sociology of trans-national health, a framework which accounts for the political and economic aspects of health and health care across borders of sex, gender, and nation. The project elucidates the cultural economy of medical tourism and the local gendered relations that undergird transnational health practices. It demonstrates how transgender people are incorporated into the state as professionalized citizens, thereby illuminating the role of the state in producing and legitimizing bodies to become particular configurations of sex, gender, and labor.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
APCASO	Asia Pacific Council of AIDS Service Organizations
APCOM	Asia Pacific Coalition on Male Sexual Health
CBO	Community-Based Organization
CLMV	Cambodia, Lao PDR, Myanmar and Vietnam
DSM	Diagnostic and Statistical Manual of Mental Disorders
FDA	Food and Drug Administration
GDP	Gross Domestic Product
GFAN-AP	Global Fund Advocates Network-Asia Pacific
HIV	Human Immunodeficiency Virus
ICD	International Classification of Diseases
ILO	International Labor Organization
IMF	International Monetary Fund
IRB	Institutional Review Board
IT	Information Technology
JCI	Joint Commission International
LGBT	Lesbian, Gay, Bisexual, Transgender
MOPH	Ministry of Public Health
MSM	Men who have Sex with Men
NGO	Non-Governmental Organization
NIC	Newly-Industrialized Country

PEP	Post-Exposure Prophylaxis
PREP	Pre-Exposure Prophylaxis
SDG	Sustainable Development Goals
STS	Science and Technology Studies
TAT	Tourism Authority of Thailand
TRT	Thai Rak Thai
UHC	Universal Health Coverage
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
WHA	World Health Assembly
WHO	World Health Organization
WPATH	World Professional Association of Transgender Health

CHAPTER ONE: INTRODUCTION

During the summer of 2008 as a college undergraduate, I volunteered with a Miami-based organization that addressed Lesbian, Gay, Bisexual, and Transgender (LGBT) youth suicide through education and outreach. In developing a presentation about sex and gender diversity worldwide, I reached a stumbling block in my research: the only images I could find of *kathoey*, a Thai third gender group, were as glamorous cabaret performers and beauty pageant contestants, often with visible surgical enhancements. Why were these the dominant representations of *kathoey*, and how had medical technologies altered not just *kathoey*'s embodiment but also their labor outcomes? What did *kathoey*'s visibility mean for a middle-income country such as Thailand, once known for sex tourism - but now broadcasting *kathoey* entertainers on a global stage?

These questions first led me to Thailand in 2009, when I volunteered with an LGBT health organization and developed initial ties with community members, and again in 2015 and 2017, when I conducted dissertation fieldwork and interviews. This project draws on fourteen months of ethnographic and interview data collected during 2015-2016 and 2017-2018, as well as primary and secondary analyses of sources related to medical tourism and the *kathoey* entertainment industry.

Throughout that time, the Thai government has promoted economic policies to convert the country to a "medical hub" for foreigners in a process known as medical tourism, or health-related travel. After earning \$1.8 billion dollars from health and wellness tourism in 2015 (Oxford Business Group 2017), and while treating around 2 million foreign patients a year (Kasikorn Research 2017), the government of Thailand

launched in 2016 an economic plan explicitly centered on technological advancement and medical tourism called “Thailand 4.0” (Toomgum 2016). While a medical tourist can travel to Thailand for treatments such as dental implants or a knee replacement, the country first became known as a destination for gender-affirming surgeries¹, touting world-class surgeons at a fraction of U.S. prices (for example, vaginoplasty costs around \$12,000 at a top clinic in Thailand, compared to over \$30,000 in the U.S.).

Alongside the growth of medical tourism, many kathoey have found work in the entertainment industry, including cabarets and beauty pageants; this work often involves accessing gender-affirming surgeries to become emblems of “ultra-femininity,” LGBT diversity, and the “amazing wonders” of Thailand on a global stage (Aizura 2009, 2011:154; Jackson 2011:35-36; Käng 2014:424). While kathoey often “spend considerable time and money drawing on medical technologies to realize their ideal of feminine beauty” (Jackson 2011:36), they have also helped advance medical tourism by working in gender surgery clinics, teaching patients how to apply makeup during their convalescence, and appearing on private clinic websites (Aizura 2009, 2010, 2011; Enteen 2014). As sex, gender, and sexuality are augmented worldwide through “national varieties of capitalism” (Jackson 2009:364), how does the state-driven medical tourism industry impact such gendered transformations in Thailand?

The objective of this dissertation is to analyze how kathoey’s labor roles and health outcomes are connected to technological growth, medical tourism, and the Thai

¹ Gender-affirming surgeries refer to procedures that modify genital and non-genital characteristics, including breast augmentation, nose reshaping, or Adams Apple shaving. While procedures labeled “aesthetic” or “cosmetic” overlap with gender-affirming surgeries, transgender people may choose to use the surgeries to affirm their gender identities.

nation-state, both economically and politically. The dissertation addresses the following questions:

- 1) How and why has Thailand become a site for both kathoey entertainment and medical tourism?
- 2) How might medical tourism and kathoey entertainment contribute to the nation-state's global prestige and nation-branding efforts?
- 3) How does the global commodification of gendered technologies reshape sex, gender, labor, and nation?

I argue that medical tourism is a technology of the nation-state that transforms gendered bodies and labor roles, elucidating various effects and dynamics related to the global commodification of health and medical technologies more broadly. Medical tourism and kathoey's labor also construct new alternatives for Thailand's reputation and prestige on the global stage, as local gendered labor roles are assembled by and shaping transnational health flows – with deep impacts on the nation-state.

Firstly, the dissertation focuses on labor within the context of transnational technological flows, expanding research about gender and labor in the global economy (Hoang 2015; Lee 1998; Manalansan 2003; Mohanty 2003; Namaste 2004; Otis 2011; Peterson 2011; Salzinger 2003; Thayer 2001). Scholars have analyzed how the gendered division of labor is integral to state development projects (Hoang 2015; Lee 1998; David 2015; Yen 2014), and this dissertation elucidates the “sexual politics of global capitalism” (Mohanty 2003:141) by showing how kathoey's labor is connected to national and transnational shifts in technologies and medical tourism. I build on the

transnational feminist aim to deconstruct states and nations by “unraveling their material and cultural linkages with sexuality and gender” (Puri 2005:138), and by analyzing how and why kathoey’s labor has impacted, and is altered by, medical hub policies of the nation-state. The dissertation adds to research about how cisgender and transgender² women have not only facilitated economic growth, but also symbolized and advanced the image of the nation (McClintock 1995; Hoang 2015; Balogun 2012; Ochoa 2014; Tsing 2009). At its core, the project demonstrates how capitalist transformations have “become entangled with the experiences of workers” (Tsing 2009:151), underscoring how national policies oriented toward medical tourism and privatized health care can reshape gendered labor dynamics.

Secondly, the dissertation adds to research about health inequalities in a global era by analyzing the unique health issues that arise for kathoey as medical tourism transforms health care settings, resources, and practices. Recent scholarship has begun to analyze health and health care amidst globalization (Bakhtiari, Olafsdottir, and Beckfield 2018; Casper and Simmons 2014; Conrad and Gallagher 1993; Conrad 2005; Harris 2013, 2017b; Heimer 2007; Noy 2019; Olafsdottir 2007), which is characterized by the “global flows of capital, bodies, and other resources” (Casper and Morrison 2010:S128). However, little sociological research has focused on medical tourism as an example of medical consumerism and global health care transformations, nor has much research

² “Transgender” is an umbrella category that refers to people whose gender identity does not conform to their anatomical sex (Valentine 2007). To avoid ascribing Western theory and language to gender-diverse people throughout the world (Jackson 2009; Najmabadi 2013), I use the term “kathoey” to respect Thai linguistic and cultural nuances, while acknowledging its meaning and use is both contested and changing. When referring to both kathoey and Thai transgender men, I state “transgender people.”

focused on how medical tourism impacts health care access and health outcomes for local people. Rather than view health from a biomedical paradigm that centers on the individual (Geist et al. 2015:4), the dissertation develops a *sociology of trans-national health*, a framework which analyzes the political and economic aspects of health and health care across borders of sex, gender, and nation. The framework adds to recent sociological research that has analyzed health in the context of global development (Harris 2017a, 2017b; Mojola 2014; Noy 2019). It contributes to a “critical political economy of global health” (Birn, Pillay, and Holtz 2017) by focusing on social, economic, and political aspects of health, and expands our understandings of how health intersects with sex and gender worldwide (Casper and Morrison 2010; Mamo and Fosket 2009; Mojola 2014).

Thirdly, the dissertation demonstrates how medical tourism and kothoey’s labor concurrently contribute to the brand and cultural wealth of the nation. The nation, conceptualized “as a discourse of *identity and allegiance*, as a political and social project of *spatial representation*, and as a producer of *value and values*” (Aronczyk 2013:13-14, italics in original), creates a brand that commodifies culture and land. Additionally, research on the “cultural wealth” of nations has focused on “the reputational attributes and cultural products of [a] nation” (Bandelj and Wherry 2011:7). While scholarship has focused on the relationships between nations, medicine, science, and technologies (Harding 1993; Jasanoff 2004; Ong 2010), less work has focused on medical tourism as a process that redefines the nation-state (for exception, see Holliday et al. 2017). Nor has research analyzed how medical tourism contributes to a nation’s cultural wealth. With

Thai government branding projects seeking to erase the “blot” of the commercial sex trade (Centeno et al. 2011:40; see also Nuttavuthisit 2006), the dissertation centers medical tourism *and* kathoey’s labor as interlinked contributors to the nation-state’s rebranding efforts and its cultural wealth, demonstrating new relations between gendered labor, medical tourism, and the nation-state.

Through observations, interviews, and primary/secondary analyses, this dissertation analyzes kathoey’s labor and health outcomes, tracking their lived experiences against the broader backdrop of technological expansion, medical tourism, and the shifting nation-state. The simultaneous growth of the kathoey entertainment industry alongside state-sponsored medical tourism initiatives warrants deeper analysis of how local sex, gender, labor, and health outcomes are linked to the political and cultural economy of medical tourism.

In this introduction, I will provide a brief historical overview of the political and economic growth of the Thai nation-state, situating why medical tourism in Thailand offers a critical lens to understand sociological questions related to gender, health, labor, and globalization. I will then provide a summary of the unique elements of Thai sex, gender, and sexuality in a national and transnational context. This overview is followed by a background on the theoretical perspectives of the dissertation, followed by a discussion of the methods used. I then conclude with a summary of each chapter.

Background

Thailand 4.0: On and Beyond the Nation-State

Thailand is one of the first and most successful medical tourism destinations in the world, and is also unique for its gender-affirming surgery niche, which sees transgender people traveling from various countries. This section provides a brief background on the political and economic trajectory that has led to Thailand's role as a medical hub. It contextualizes the development of biomedicine in Thailand, and demonstrates why the country is a productive site to analyze transnational health flows in relation to the nation-state and local people.

Although Thailand was never colonized, some have argued that imperialist or neocolonial relations have shaped the economic and political arrangements of the state (Herzfeld 2012; Jackson 2007; Wilson 2004). Thailand's relationship with the global economy can be described as "semi-colonialism" (Jackson 2007: 344), or "crypto-colonialism" in which relations of power are often concealed (Herzfeld 2012). For example, to avoid colonization, Siam³ signed unequal treaties with Europeans and Americans (Jackson 2003:8), stipulating that Siamese law was "equally civilized" to its Western counterparts. In addition to shaping the import-export business, since the 19th and 20th century European society has also influenced the Thai legal system, public discourse, and elite culture (Wilson 2004). Such laws also had profound impacts on Thai sex, gender, and sexuality, as I discuss in the next section.

³ Thailand was renamed from Siam in 1939 under fascist policies of Field Marshal Phibun Songkhram (Jackson 2007:344n2).

Biomedicine was first introduced in Thailand through imperialist relations (Puaksom 2007). For instance, western medical treatment for cholera arrived in 1822, while printing technology helped inform Thai elites of Western science and technologies (Puaksom 2007:314). Presbyterian physicians from the U.S. transported biomedicine to Siam in 1828, with the first medical school opening in 1889 at Siriraj Hospital; beginning in the 1920s, the Rockefeller Foundation assisted in “upgrading medical education” in Thailand (Suwanwela 1996:401). While Pasteurian medicine was introduced in the middle of the 20th century, Puaksom (2007) argues that its adoption was imbued in state governmentality between 1850 and 1950. For Puaksom (2007:313), the “germ created a nation,” as government officials ensured people were practicing hygiene through clean clothing, and abandoning aspects of “low culture” (*watthanatham tam*) (Puaksom 2007:312). Without practicing this medical “rationality,” the Thai nation-state could not “belong to the world of civilized nations and would struggle to survive” (Puaksom 2007:334). Adopting dominant, Western norms of science and medicine was imperative for the Thai nation-state to become “civilized” (Puaksom 2007).

In 1835, the American missionary Dan Beach Bradley “demonstrated the magic of Western medicine” as he treated 3,500 patients for smallpox, reportedly performing his surgical methods in front of live crowds (Puaksom 2007:314). King Mongkut drew on Bradley’s theories to discount Thai traditional medicine. In contrast to biomedicine, Thai traditional medicine, which views health and healthcare holistically, is a 2,500-year-old tradition rooted in Buddhism (Lindbeck 1984:24), and has been used to describe healing with “prescientific” practices (Techatraisak and Glesler 1989). Thai traditional medicine

utilizes systems of metaphors without classifying direct etiologies of disease, as well as concepts of person, mind, and body (Cassaniti 2017). The emphasis on *khwaan*, or the spirit of a person encased in the body, opposes biomedical systems that isolate bodily systems and parts, as the spirit is “recentered” by spirit mediums, who provide care through song and ritual (Cassaniti 2017). The development of biomedicine in Thailand is thus rooted in forms of colonialism, echoing other scholars’ assertions about the linkages between science, medicine, and national power (Decoteau 2013; Hamilton et al. 2017; Harding 1993).

Military involvement has guided economic industries, medicine, and labor in Thailand. For instance, the U.S. Military Assistance Program (MAPS) funded various military aid agreements in Thailand beginning in the 1950s, and between the years of 1950 and 1987, the U.S. gave Thailand more than \$2 billion in military assistance. Plastic surgery was developed in Thailand during the Vietnam War, when foreign military personnel were stationed in the country and Thai doctors were trained in such techniques, which formed a technological foundation for medical tourism (Wilson 2011). In addition to seeing the development of plastic surgery, the Vietnam War was also a time during which the sex and entertainment industry became institutionalized, when approximately 50,000 foreign military personnel visited Thailand for “rest and recreation” (Manderson 1995; Wilson 2011). While polygamy and sex work⁴ previously existed in Thailand, the Vietnam War sparked the development of the foreign-oriented sex market as venues

⁴ The phrase “sex worker” delinks people from the “identity” of prostitution, instead relocating attention to the “income-generating activity” (Kempadoo 1998:3).

emerged and the sex industry expanded beyond brothels to include massage parlors, dance halls, and other environments (Manderson 1995).

Structural adjustment policies in the 1980s shifted Thailand's exports from agricultural to industrial, increasing foreign investments and expanding the tourism industry (Boonchalaksi and Guest 1994). Prime Minister Thaksin Shinawatra's business-driven government (2001-2006) sought to promote economic recovery by urging the growth of the domestic economy/capital, relying on local labor forces to perform various kinds of work. The Thai Rak Thai (TRT) national party created policies that introduced a "flexible and skilled labour force" to create a "globally competitive capitalism" (Brown and Hewison 2005:354). Specifically, the TRT sought to diversify markets and develop new niche industries, stressing "an innovative, knowledge-based and productive economy" to foster both foreign and domestic growth (Brown and Hewison 2005:354, 359). The fusion of public-private initiatives also spoke to the state's need to "meet the challenges of regional and global competition and to develop a more knowledge-intensive economy" (Brown and Hewison 2005:367). As the initiatives have reoriented Thailand to the global economy, Thailand's national identity has also grown alongside economic shifts, particularly in becoming a Newly Industrialized Country (NIC); for instance, the values of economic development, including "bourgeois consumption, economic performance and global personhood" have become "stamped onto Thai identity" (Reynolds 2002:14).

After the 1997 Asian Financial Crisis, the first medical tourism policies were initiated as the "national solution" crisis (Wilson 2011:10). Private Thai hospitals were

sold to foreign partners, and Thai hospital executives began to market services to foreign patients to stay afloat. An International Monetary Fund (IMF) Letter of Intent not only tightened monetary and fiscal policy, but also privatized state enterprises and enhanced foreign investment (Brown and Hewison 2005:354). Structural adjustment packages from the IMF put a “straightjacket on government spending” (Harris 2017a:253), and led to foreign investments and privatization of hospitals along with tax incentives (Turner 2007; Supakankunti and Herberholz 2011:148).

Broadly, tourism plays a large role in the Thai economy (Glassman 2004:132), directly contributing 9.2 percent to the total Gross Domestic Product (GDP) (TAT 2017). Thailand is marketed to foreigners by “commodifying its culture and tradition” (Reynolds 2002:13). The Thai nation is self-hailed as the “Land of Smiles,” embedded in the broader region of Southeast Asia, whose institutionalized brand is “Southeast Asia: Feel the Warmth.” Historically, Asia has been commodified and sexualized through the process of tourism “within the political economy of global relations and derives its market value from the general commodification of the ‘Orient’ as well as the commodification of leisure and pleasure” (Manderson 1995:310). Asia is constructed as a site for satisfaction, relaxation, and access, while dominant discourses, from both within and outside of the Thai nation-state, have represented the country as a land of “infinite warmth” (Morris 1997:61). Tourism relies on gendered images, as “[f]eminine beauty – and masculine for that matter – feature in the formal and informal export of images of Thailand to attract tourists and investment and to engender a favorable opinion of the

country in the perceptions of foreigners” (Reynolds 1999:270). Gendered bodies are thus imbued in the Thai tourism economy and nation-state more broadly.

In 1998, the Tourism Authority of Thailand (TAT) launched a campaign called “Amazing Thailand” to market culture, the environment, and shopping opportunities – and to pivot the reputation of the country from a destination for sex work (Chon et al. 1993 as cited by McDowall and Wang:362). In recent decades, the TAT has also rebranded the often-sexualized image of massage parlors to emphasize skilled workers and cultural traditions (Nuttavuthisit 2006:28). And in 2013, the TAT also began promoting a campaign called “Go Thai, Be Free,” targeted towards LGBT travelers, and signaling the importance of the “purple baht,” or the LGBT tourism industry in Thailand (Jackson 2011:22). How does the brand and identity of the nation continue to shift as Thailand becomes both a medical hub and destination for LGBT tourists? And how do such shifts incorporate and impact local people?

While this dissertation focuses on Thailand, we see through the study of medical tourism and kathoey’s labor roles that the nation-state is not in isolation, but instead connected to broader regional and global flows – from global trade agreements to Instagram hashtags. There is no such thing as a spatially-bound “Thailand,” but instead a state that is related to others instead of a “unitary or homogenous entity” (Glassman 2004:18). Research has analyzed how Thailand has become “transformed and internationalized as part of the process of capitalist internationalization” (Glassman 2004:156), yet less work has focused on the relationship between medical tourism, the nation-state, and local people. Given the unique moment of Thailand’s recent medical

hub policies and the nation-state's ongoing "transformation through capitalist industrialization" (A. Brown 2004:1), it is increasingly important to understand how Thai political and economic growth is connected to medical tourism, and how this then impacts Thais on the levels of gender, labor, and health. Within the context of the globalized, ever-changing Thai nation-state, I now offer a brief background on local conceptions of Thai sex, gender, and sexuality.

Thai Sex, Gender, and Sexuality

Scholarship on gender/sexuality in a global era has demonstrated how local forms of LGBT and queer⁵ identities have arisen and shifted amidst increased globalizing forces and market changes (Altman 1996; Boellstorff 2003, 2005; Jackson 2009; Valentine 2007). Analyses of Asian queer cultures combine an attention to various scales, including: local specificities ("the premodern"), national bureaucracies and markets, and the global (particularly global capitalism) (Jackson 2009). Research has identified the importance of the national scale, particularly "national varieties of capitalism" (Jackson 2009:364), to queer autonomy and sexual cultures. Similar to other queer or transgender groups worldwide, Thailand's preexisting gender diversity saw great changes with capitalist transformations and printing technologies, which were catalyzed in the 1970s

⁵ Queer can refer to sex and gender diversity, and its meaning changes across international settings, as queerness cannot be generalized across cultures (Jackson 2009:364). Queer can also stand in as a descriptor for that which "unsettle[s] assumptions and preconceptions about sexuality and gender and their inter-relationship" (Altman 1996).

(Jackson 2010; Jackson 2009:363), warranting more research on how the technological transformations of Thailand 4.0 impact Thai sex, gender, and sexuality.

In addition to capitalist influences, another theme in research on globalization and gender/sexuality is hybridity, or how local and global influences merge and transform, as opposed to a monolithic Western culture taking over “traditional” sex/gender norms, falsely read as static or non-agential. Instead, formulations of sex, gender, and sexuality in the phase of global capitalism is a highly dynamic process in which “new forms of cultural difference exist alongside international commonalities” (Jackson 2009:359). As the current formulation of kathoey is entirely different from its “traditional” form (Jackson 2009), the Buddhist Vinaya text identified four main sex/gender categories: males, females, *ubhatobyanjanaka* (hermaphrodites) and *pandaka* (males with non-normative anatomies or sexual preference) (Jackson 1998). *Kathoey* are described in ancient Buddhist texts as paying back their karmic debt for adultery or other sins in a past life (Jackson 1998:3). Sex, gender, and sexuality are not separate terms in Thai, but rather collapsed together, with scholars arguing it is best to think of “eroticized genders” in Thailand (Jackson 2002). For example, one cannot be a “gay man” because “man” already implies heterosexuality (Ojanen 2011). Although scholars have argued that western influence on sex/gender labels is “undeniable” in Thailand, the “kathoey” category is distinguished from English terms such as “transgender” and “drag queen” (Jackson 2000). Kathoey have also been referred to as “*phu-ying kham-phet*” (transgender woman), “*sao prophet sorng*” (or “second kind of woman”), and the explicitly derogatory English coinage of “ladyboy” (Jackson 2009). As many as one in

every 180 people in Thailand may identify as kathoey (Winter 2002), who can work in shops, rice fields, or as boxers, gaining public visibility in media and everyday life (Pravattiyagul 2018:21).

While Foucault (1990) described how homosexuality was invented in a Western context via social institutions such as medicine, scholars have demonstrated that this was not the case in Thailand (Jackson 2009; Käng 2014). Instead, broader regulatory norms on Thai sex, gender, and sexuality – targeted towards cisgender people – led to the visibility of gay people and kathoey. Gendered codes of dress, which emerged in a royal decree in 1941, emphasized that Thais should dress “in accordance with civilization” (Peleggi 2007:73), adopting particular gendered ways of dressing to appease Western tastes. For example, Käng (2014:424) found:

The Thai state proffered and enforced sexual differentiation as a means to show its civilizational status and to resist colonial encroachment. In particular, the androgyny of Thai women in Western eyes compelled the state to require their feminization in dress, hair, and behavior.

In addition, state media control and censorship shaped representations of gender minorities (Käng 2014; Fuhrmann 2016). Käng (2014:425) has addressed how kathoey have often appeared in the media as “comic, criminal, or tragic,” but with the toppling of Thaksin’s government in 2006, “there has been an explosion of more balanced and humane representations” (Käng 2012:480). The construction of sex, gender, and sexuality in Thailand are thus linked to governmental regimes that asserted codes and regulations amidst broader global relations.

Beauty contests for cisgender Thai women and kathoey have historically been tied to government and nation, what Wuen (2005:34) describes as part of a “nation-building

strategy” that attempts to “reconstruct a Thai identity and culture based on new-found feminine beauty, promote and authenticate it, while at the same time, appear to the rest of the world as modern, civilized and essentially, Western.” Although the notion of appearing simply “Western” is more nuanced, as I will discuss in Chapter 2, Thai cisgender and kathoey beauty pageants have historically been used to invoke and present national identity. National beauty pageants have served as sites through which gender and citizenship are conveyed on a global stage, both in Thailand and other parts of the world (Balogun 2012; Ochoa 2014). For instance: “The Miss Alcazar and Miss Tiffany’s Universe showed that not only can kathoey mimic femininity to good effect, they can also epitomize the ideal Thai woman. To be successful in a beauty contest was to be a successful kathoey. And a beautiful, successful kathoey should be a source of national pride” (Wuen 2005:8). With such institutionalized relationships between gendered bodies and the nation-state, what is at stake for local people – particularly kathoey – as the Thai nation-state expands both medical tourism and LGBT tourism initiatives? How can scholars better understand sex, gender, and sexuality in a global era by considering local people’s relations to national policies and transnational flows?

This dissertation adds to research on the political economy of global queering by underscoring how medical tourism – a local, national, and transnational process – impacts and involves queer people worldwide. While the capitalist market has provided space for new trans identities to “form around the commodification of modern norms of feminine beauty” (Jackson 2009:360), less work has shown how medical tourism – a state-led and private initiative – impacts the material and cultural landscape for queer and trans people

in medical tourism destinations. What new tools emerge and where, and how do increased flows of medical technologies through medical tourism augment gendered norms and ways of being? I argue that medical tourism is a project of the Thai nation-state that incorporates and impacts kathoey on various levels. The focus on medical tourism as a national capitalistic industry highlights how global queerness is related to state agendas, private industries, transnational health flows, and local specificities.

Literature Review

There is little question that people, objects, and information are connected in an almost borderless fashion amidst globalization, involving various cycles of economic, political, and social relations and a rapid growth of new technologies (Arrighi and Silver 2001; Sassen 2006; Wallerstein 1974). With globalization as a key factor in political, cultural, and economic changes, this dissertation draws on theories of gendered labor and technologies, medical tourism, medicalization, and nation-branding and cultural wealth.

Gendered Labor and Technologies

Gender is constructed through various social processes, and the workplace is a key site through which unequal gender relations take place (C. Connell 2010, 2014). States, as conglomerates of “structures, discourses, and practices” (Puri 2014:345), structure and depend on labor roles that are differentially assigned to cisgender and trans people within a global order (C. Connell 2010; David 2015; Manalansan 2003; Mohanty 2003; Namaste 2004; Peterson 2011). The term “gendered labor” has been used to

distinguish the global divisions of work based on gender, with most research focusing on the roles assigned to cisgender women (Moghadam 1999:379). Recent research on “purple-collar labor” has also shown how specific roles and inequalities also emerge for transgender people in the global economy (David 2015).

Technologies are “both a source and consequence of gender relations” (Wajcman 2010:149), and are also integral to work (Cross 2012; Guevarra 2015; Robertson 2010). Labor is often made of and augmented by technologies, such as cotton plants in India (Ramamurthy 2004), telephones in global call centers in the Philippines (David 2015), or female-appearing robots that perform housework under the Japanese government’s technology-driven domestic policy (Robertson 2010). Research has spotlighted workers’ intimate and embodied relationships to technologies (Cross 2012), such as cisgender female bar hostesses in Vietnam who have used “technologies of embodiment,” including skin lightening cream and plastic surgeries, to strategically enact new formulations of gender, class, and race, appealing to various clients and gaining social/economic capital (Hoang 2014:517). Technologies of embodiment may take many forms and shape labor in a multitude of ways – including for people in the U.S. who use Botox for economic and social capital (Berkowitz 2017), those in Brazil who want to “work better” by having plastic surgery (Edmonds 2010:8), or for cisgender and transgender women in Venezuela who access plastic surgery to appear in national beauty pageants, representing their country’s beauty, modernity, and technological achievements on a global stage (Ochoa 2014). In sum, technologies, which are both made of and

making gender relations, also augment labor roles, which then facilitates economic and political shifts for the nation-state.

Yet, we know less about the context of technologies of embodiment, such as why certain tools emerge in particular places and for whom – especially as state policies throughout the world target technological growth and medical tourism. Why are some tools more dominant or desired in the workplace? While the transgender body in a Western context has been viewed as a “product of medical science” and “technological construction” (Stryker 1994:84), how are global shifts in medical tourism remapping transgender people’s experiences with technologies and labor worldwide? Little has been said about how transgender people throughout the world may interact with medical technologies in correspondence with their labor roles, or how these augmented labor roles then impact the nation-state and global economy.

In the Thai context, much research has described the co-constitutive relationship between sex, gender, sexuality and the economy. Reflecting trends in U.S. homosexuality, in places such as Bangkok, “a body of national capital precedes the emergence of modern queer bodies” (Jackson 2009:368), as nationally-specific forms of capitalism produced new queer cultures globally. As Wilson (2004) has described: “Thailand’s economic growth has been underwritten by women’s labor in raising rice and food, caring for families at home, selling goods in markets, and providing services for the tourist economy in restaurants, shops, and go-go bars” (Wilson 2004:21). Wilson’s analysis of the “intimate economies” of Bangkok describes how women interact with

historical shifts in capitalism and neoliberalism⁶ in Thailand. Wilson defines capitalism as “an economic system oriented to ‘the market’ (ultimately a global market) that uses money to measure value, pay people for work or debts, and conduct exchange” (Wilson 2004). Wilson examines “the complex interplay between these intimate social dimensions and plural economic systems in a context shaped by transnational capitalism” (Wilson 2004:11). Jackson’s (2009) work on Thai gender/sexuality in the era of global capitalism analyzed how market shifts interact with queer subjectivities. How, then, are gendered labor roles changing with the advent of medical tourism, technological growth, and LGBT tourism campaigns such as Go Thai, Be Free? This dissertation illuminates the black box, or context surrounding, kathoey’s use of technologies of embodiment, demonstrating how their gendered labor is connected to technological growth, medical tourism, and the shifting nation-state.

Along the lines of Irving’s (2008) call to expand research beyond a transgender individual and consider political economic conditions, I examine the “connections and circuits” linking local people to state institutions (Grewal and Kaplan 2001:672), such as medical tourism. For Grewal and Kaplan (2001), tourism is inherently imbued in issues related to imperialism, power, orientalism, and ethnocentrism, raising further questions about how medical tourism involves and incorporates new forms of gendered power relations. I build on scholarship that analyzes how local people intersect with the political economy of tourism – and particularly queer or LGBT tourism (Cantu 2002; Käng 2010;

⁶ By neoliberalism, I draw on Henisz et al’s (2005) description as policies that “encourage entrepreneurship, investment, and long-run economic growth through reduction in subsidies, tax reform, tax cuts, stabilization of the money supply, the free flow of trade and capital, and... the market-oriented reform of state-owned industries” (Henisz et al. 2005: 873).

Puar 2002) – by drawing out the gendered elements of medical tourism, its relation to LGBT diversity campaigns, and to kathoey’s gendered labor.

The project contributes to our understandings of gender, labor, and globalization by analyzing how kathoey interact with and represent medical technologies and the transitioning nation-state on a global stage through their work in the entertainment industry. Amidst Thailand 4.0 and Go Thai, Be Free, the project delves into how kathoey’s labor, health, and social outcomes are connected to broader political and economic shifts, shedding light on the gendered and technologized elements of gendered labor and the nation-state. I now turn to research on medical tourism as a significant process for sociological inquiry.

The Sociological Significance of Medical Tourism

Medical tourism, or health-related travel across borders, offers a profound window to analyze how globalization and health care markets interact – particularly as privatized medical markets impact and involve local people in destination countries in uncharted ways. The term “medical tourism,” while widely debated, captures the process of traveling across borders for health or medical services (J. Connell 2006). People have traveled across borders for health services since ancient times (J. Connell 2011), but medical tourism in the 21st century bundles partnerships between national governments and private businesses, encapsulating new trends in health care commodification, practice, and delivery. Medical tourism may include a range of services from spa treatments, dental implants or heart transplants, and may also include niche industries

such as reproductive tourism, stem cell tourism, and “death tourism,” in which people go abroad for euthanasia (J. Connell 2006).

With an attention to the movement and flows of culture, economies, and technologies, medical sociologists have identified the current era of health care and medicine as “stratified biomedicalization,” defined as an “increasingly complex, multisited, multidirectional processes of medicalization, both extended and reconstituted through the new social forms of highly technoscientific biomedicine” (Clarke et al. 2003:161; Clarke et al. 2010:41). Yet, less work has analyzed how shifts in biomedicalization and medical tourism ripple beyond the United States, limiting our understandings of the global aspects of these processes. Despite medical sociologists’ calls to “decenter the west” (Bell and Figert 2012:781) and analyze the “shifting engines” of health and medicine in a global era (Conrad 2005), research in the field has not yet focused on the process of medical tourism and its relationships to global health outcomes and economic/political arrangements. Medical tourism encapsulates new formulations of health care commodification, privatization, and medical consumerism, in which health care and medical technologies are bought, sold, and traded (Starr 1982; Timmermans and Oh 2010).

Given the growing role of commodification and consumerism within medicine and health care delivery, the “successful splicing of the tourism and health sectors” is an especially important site of sociological analysis and intervention (Bookman and Bookman 2007:95). As Turner (2010:444) has argued: “Medical tourism reveals the shape that medicine takes when it is commodified, subjected to international competition,

and subsumed within a global market economy.” The industry encapsulates how “health care, traditionally perceived in large part as a public good for patients in need, has turned into an international commodity that can be traded, marketed, and used to generate revenues for the government and private health sector” (Kanchanachitra et al. 2012:82). Medical tourism therefore speaks to sociologists’ interest in how the growth of “medical markets” and global commodification of health care has shaped how health services and medical technologies are bought, sold, and disparately accessed throughout the world (Almeling 2007; Bell and Figert 2012; Reuters 2015).

Although economists and business scholars conduct “SWOT” – or Strengths, Weaknesses, Opportunities, and Threats – analyses of medical tourism analyzing the industry from a material perspective (Wong et al. 2014), I build on the work of economic sociologists such as Almeling (2007), Guseva (2008), Mears (2011), Hoang (2015), and Zelizer (2011), to underscore the gendered “cultural economy” of medical tourism. This perspective shows how medical tourism is not a rational economic market involving just linear supply and demand factors or “push” and “pull” trends (John and Larke 2016). Instead, medical tourism intersects with local bodies, cultural norms, institutional hierarchies, and gendered divisions of labor.

Medical tourism also has distinct health consequences for foreign patients and local people. For instance, medical tourism can create or exacerbate public health care disparities for local populations by causing a “brain drain,” where doctors specialize in private treatments for wealthier clients and abandon public hospitals and local patients (J. Connell 2011; Pocock and Phua 2011; Turner 2007). It has also been shown to cause a

“crowding out effect,” wherein foreigners cause health care prices to rise and locals can no longer afford care (Pocock and Phua 2011). Some have critiqued medical tourism research for focusing mostly on Western/European travelers, eliding its impacts on local people in destination countries (Whittaker and Leng 2016). These occlusions have the potential to reproduce the hierarchies and divisions in knowledge production that sociologists have been diligent to critique (R. Connell 2006; Harris and White 2019).

Overall, there is a lack of in-depth research about the lived experiences of people in medical tourism destinations on the levels of labor and health outcomes. How might medical tourism impact the availability of health resources for Thai people, and especially local queer and trans people? What does medical tourism in Thailand reveal about the ways in which gendered medical technologies are developed, commodified, and differentially accessed for people throughout the world? In highlighting the health inequalities created by medical tourism, the dissertation identifies how “science (re)produces differences and stratifications among people” (Thompson 2005:51), as well as “the uneven distribution of new knowledge and technology” which shapes health disparities worldwide (Link 2008:373-74).

Lastly, medical tourism has implications for the identity of nation-states, a theme largely unexplored in research. Technologies and medical science have changed the symbolic identities of nations, such as the case of plastic surgeries in South Korea contributing to “medical nationalism” (Holliday et al. 2017), as doctors export aesthetic ideals of the nation. Yet research has sparsely focused on how medical tourism impacts the prestige and identity of nations. In this way, the dissertation also provides a gendered

perspective to world-systems scholarship, which frequently elides the role of gender relations in the contestation over power relations (Wallerstein 1974; see Ramamurthy 2004 for critique). We gain new insights about the relationships between nation-states, technologies, and medical science (Carroll 2006; Harding 1993; Jasanoff 2004) by considering medical tourism as a process that impacts not just local people, but also the nation's identity and reputation on the global stage.

Medicalization of Sex and Gender

Much research on the social construction of disease builds on the work of Foucault (1976, 1990), who identified the medical system as a key institutional site through which societies are managed. Foucault argued that populations are constructed, regulated, and disciplined through institutions such as medicine, terming this “biopolitics,” which involves “an explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations” (Foucault 1990:40). A biopolitical perspective on sex and gender focuses on how state regulatory regimes manage populations, resulting in “biopower,” which involves disciplining the body to ensure its “integration into systems of efficient and economic controls” (Foucault 1976:138). Research has also shown how hygienic practices have also recently blended with neoliberal reforms of self-discipline, a form of public health that entails personal responsibility, terming this “biocitizenship,” which involves personal practices that distinguish healthy citizens from those who are not (N. Rose 2007), and encapsulates the merging of health/medical governmentality and neoliberal subjectivity.

Using the lens of biopower, research has shown how gendered medicine and health care do not exist in a cultural vacuum (Pitts-Taylor 2009:122), drawing attention instead to the “historical, cultural, and political innards” of medical technologies in a global setting (Casper and Morrison 2010:123). Of particular concern is how biomedical technologies remake human bodies to create alternative “biosubjectivities” (Casper and Morrison 2010:126). With science and medicine affected by and embedded in social, economic, and political processes (Brandt 1987:5), research has specifically unveiled how sex and gender are constructed and managed through medicine over time and across place (Laqueur 1990; Reis 2009). Research has focused on cases such as male-pattern balding, obesity, Human Papilloma Virus vaccinations, and cosmetic surgery to illuminate how precise shifts in institutionalized medicine and medical power have produced disease, and how that reflects and shapes gendered cultural norms (Casper and Clarke 1998; Conrad 2005; Mamo and Fosket 2014; Pitts-Taylor 2009; Turner 1996).

Feminist medical sociology has also drawn from Science and Technology Studies (STS) to further show the interaction between bodies, technologies, cultural norms and discourses, and scientific/medical institutions (Casper and Clarke 1998; Rapp and Ginsburg 1995; Haraway 1989). A feminist STS approach “views women’s bodies and the technologies used on/in them as woven tightly into governmental practices, such that technologies and women are (re)configured” (Casper and Clarke 1998:82). Research on the development of the pap smear (Casper and Clarke 1998: 82), for instance, used a “social-worlds analysis” to demonstrate the importance of biomedical professional

groups, funding flows, women's health groups, and non-human technologies (e.g. pap smears or classification systems) in addition to cultural discourses.

According to Judith Butler (1993:7-8), individuals in a Western context are interpellated, or produced as male and female subjects through medical care, which “shifts an infant from an ‘it’ to a ‘she’ or a ‘he’...” Medical processes and technologies have thus intervened on and constructed physical and social elements of sex and gender. Sex was “invented” in the 19th century as the Western medical institution classified normal bodies based on the genitals. Locating the “gonadal sex” as the primary site for inspection and intervention, European doctors at this time labeled persons with indeterminate sexes as “hermaphrodite,” “hybrid,” and “unfortunate monstrosity” (Reis 2009). The “age of the gonads,” from 1871-1915, classified “true hermaphrodites” as those whose bodies contained both ovarian and testicular tissues (Dreger 1998). Doctors’ cultural logic of femininity, masculinity, and binary sex rejected the possibility for hermaphroditism or an “infinitely malleable continuum” of sex and gender (Fausto-Sterling 1993:21). Instead, Western medical practices have affirmed a binary ideal and “cultural need to maintain clear distinctions between the sexes” (Fausto-Sterling 1993:21).

While cosmetic surgeries technically overlap with some of the procedures sought by transgender people, research has analyzed how transgender people are distinctly impacted by medical norms and health care oversight (Bornstein 2013; Fausto-Sterling 1993; Feinberg 2001; Reis 2009; Roskam 2008; Spade 2003; Stryker 1994). Historically, meanings of “transgender” have been partially constructed through medical

interpretations as Western medical institutions have often intervened on non-normatively sexed and gender non-conforming people (Fausto-Sterling 1993; Reis 2009). For instance, the classification of gender dysphoria as a psychological condition categorized by the Diagnostic and Statistical Manual of Mental Disorders (DSM), a handbook used by the American Psychiatric Association, describes transgender experiences as “strong desires to be treated as the other gender or to be rid of one’s sex characteristics, or a strong conviction that one has feelings and reactions typical of the other gender” (DSM-V). As coding and classification has been necessary for trans and gender non-conforming people to access health care services and qualify for insurance reimbursements, these trends also speak to “the diffusion of biomedical categories” (Conrad 2005) in non-Western countries. Outside of medical sociology, research has focused on the vast “burden and needs” of transgender people throughout the world, especially as medical institutions classify their experiences as illness and health care and social supports are often inaccessible (Reisner et al. 2016). As of May 25, 2019, the World Health Assembly (WHA) of the World Health Organization (WHO) will no longer list trans-related diagnoses as mental health disorders, possibly signaling the beginning of global depathologization of transgender people.

Yet, less research has analyzed how medical tourism restructures norms, institutions, and practices related to sex, gender, and beauty, or how people interact with medical technologies as transnational health care shifts take place worldwide. It is also important to expand sociological research on health and medicine to include non-Western countries - not just because they are understudied, but because empirical knowledge of

phenomenon such as medicalization and the social construction of sex and gender is diminished when people in only some geographies are included in the analysis. This dissertation thus explores how and why particular medical technologies have become the “right tool” (Casper and Clarke 1998:82) for kathoey, particularly amidst shifting political and economic conditions such as Thailand 4.0 and Go Thai, Be Free. How does medical tourism contribute to people’s new engagements with gendered medical technologies worldwide? Given that health care and medicine are key sites in which sex and gender are defined, pathologized, and regulated, how does medical tourism impact these processes for local people in destination countries?

Despite the project’s focus on kathoey’s gendered labor, health, and embodiment, it is important to note that gender is constructed for all people, and surgeries are just one facet of gendered technologies. Gender-affirming surgeries are not always desired, nor do they imply an endpoint in a person’s transition. Viewing the body as a “sociocultural artifact” (Grosz 1994:115) and the “inscribed surface of events” (Foucault 1984:83), I contextualize kathoey’s use of gendered technologies against broader social processes that structure gender for all people. Transgender people and kathoey are not exceptional for accessing technologies of embodiment, as cisgender and transgender people use various technologies for different purposes, including scalpels, glasses, walking sticks, haircuts, or hearing aids. Given that kathoey’s gendered embodiment and beauty “often requires the utilization of modern medical technology such as hormones, Botox, and surgery” (Käng 2014:424-25), the project underscores how and why such embodied

ideals have formed by contextualizing technological expansion and transnational health flows, such as medical tourism.

Nation-Branding and Cultural Wealth

The dissertation builds on scholarship that has analyzed nations as “imagined communities” (Anderson 2006), which are constructed through the process of nation-branding (Aronczyk 2013). Since World War II, state agencies and private partners have used corporate brand management techniques to define a “national form for a range of profit-generating purposes” (Aronczyk 2013:11). Relatedly, countries with “tarnished international reputations” can strategically accumulate cultural wealth for economic and symbolic gains (Bandelj and Wherry 2011:7). For instance, Rivera’s (2011) work on the Croatian government’s rebranding after the Croatian civil war evokes theories of stigma management to demonstrate how nations recover their reputations. In this dissertation, I focus on two recent and intersecting processes in Thailand that I argue advance the nation’s cultural wealth and branding efforts: medical tourism and kathoey’s gendered labor.

Nation-branding seeks to “to make the nation *matter* in a world where borders and boundaries appear increasingly obsolete” (Aronczyk 2013:3). The process of nation-branding “retains an image of what it means to be nationally competitive and nationally effective *for* globalization (Aronczyk 2013:10), as it “maintains and perpetuates the nation as a container of distinct identities and loyalties, and as a project for sovereignty and self-determination” (Aronczyk 2013:5). The goal of nation-branding is to increase

economic growth, democratic communication, and launch new levels of national visibility and credibility (Aronczyk 2013:3). Resources are divided within public institutions for this purpose, as nation-branding constructs a “cosmopolitan center” that is “nationally competitive and nationally effective for globalization” (Aronczyk 2013:10).

Research has analyzed the ways in which medicine and science contribute to national prestige (Ong 2010), with potential to augment the brand or image of the nation. For instance, nation-states are made of and making technologies, including medical science (Carroll 2006; Jasanoff 2004; Winchakul 1994). Biotechnologies have vastly expanded in Asia, contributing to Asian wealth and political prestige (Ong 2010). Ong (2010:16) wrote:

Having laid the foundation for capitalist development, Asian states are turning to biotechnologies as a mechanism of regeneration, not only of the economy and of the people, but also of national prestige.

Ong (2010:7, 3) has referred to the process as “biotech nationalism,” in which Asian state leaders have become “dazzled by the economic, social, and political gains that can stem from developing scientific expertise and knowledge”, as they use biotechnology “to overcome past humiliations and to restore national identity and political ambition.” However, less work has analyzed how medical tourism augments cultural wealth or nation-branding processes (for exception, see Holliday et al. 2017).

As various state governments have also enacted policies and initiatives to advance medical tourism, it is important to consider how medical tourism, formulated by both national policies and private industries, then impacts the boundaries, brand, and cultural wealth of the nation-state. This dissertation adds to work on science, medicine and the

state by showing how medical tourism impacts and reifies global hierarchies of medicine and a nation's cultural wealth. It argues that Thai medical expertise – particularly in the field of transgender health – redefines Thailand's cultural wealth and the global health landscape, as health care sites in a middle-income country become internationally-accredited for high quality care.

While Aronczyk's (2013:18) work features nation-branding campaigns that include sexualized images of women, the analysis does not extend to how gender is deployed (and constructed) through the process of nation-branding. Additionally, research on cultural wealth has sparsely focused on gender relations. Work in this field has also suggested that cisgender women's work in tourism activities may be a reason to support cultural tourism in places such as Mayotte, France, as the former French president said that women's social and professional integration serves to "reduc[e] gender inequalities," as their work allows women to "be integrated into the market world" (Regnault 2011:169). On the other hand, Puar (2002) has called attention to the gendered labor politics of tourism, describing tourism as "the way in which the state enables neocolonialism through the labor of poor women of color" (Puar 2002:127). Gender is also integral to the nation, as McClintock (1997) has argued that women "are typically constructed as the symbolic bearers of the nation," standing in for and reproducing nationalist ideologies (McClintock 1997:92). Ochoa (2014) offers important contributions in discussing how and why cis and trans women in Venezuela stand in for the nation, showing how gender is "sutured" into state processes to become part of a national imaginary. Yano's (2011) work on Japanese-American flight attendants hired by

Pan Am has shown how stewardesses became “ideal hostesses,” and were integral to the corporate branding of Pan Am within the context of U.S. imperialism post-World War II. Transnational feminist research has therefore demonstrated how cisgender and transgender women are tied to processes of nation-branding as gender is assembled in the national imaginary.

Research on nation-branding and cultural wealth raises generative questions about how local people, such as kathoey, catalyze cultural wealth and new conceptions of the nation through medical tourism, gendered labor, and technologies. Medical tourism and kathoey’s professionalized, desexualized labor represent new and intersecting waves of economic and political growth for the Thai nation-state. With LGBT rights now seen as a global marker of modernity (Butler 2010; Duggan 2002; Puar 2002), the dissertation extends scholarship that has analyzed the ways in which local people intersect with the political economy of tourism, demonstrating how kathoey help champion LGBT diversity as a political discourse that is incorporated into both medical tourism and nation-branding (Aronczyk 2013:108).

Medical tourism and kathoey’s gendered labor help advance the nation’s brand and cultural wealth, particularly by disassociating the nation from sex work and HIV/AIDS. I show how kathoey serve as symbolic brands of Thai medical technologies, LGBT diversity, professionalized citizenship, and public health, contributing to the economic and cultural wealth of the nation and redefining its brand on the global stage. The dissertation also demonstrates how nation-branding and cultural wealth incorporate local people and exclude others based on race, class, HIV/AIDS status, gender, and

citizenship (Cantu 2002; Käng 2010; Moussawi 2018; Puar 2002). With national policies advancing technologies and medical tourism, how is cultural wealth amassed, and rebranding accomplished, through both medical tourism and gendered labor?

Theoretical Approach

Assemblage Theory

The dissertation uses assemblage theory, a comprehensive theoretical and empirical toolkit, in order to analyze how people interact with and construct technology, culture, and health care markets in increasingly complex and interconnected ways.

Assemblage theory spotlights the roles of technologies, nonhuman actors, and scientific tools which are “situationally constructed” through various social actors, institutions, and technologies, particularly as scientists and medical authorities pursue social interests (Fujimura and Clarke 1992:5). It allows researchers to “discover and analyze a complex social system by building it from the ground up” (Castellani and Hafferty 2005:5).

Assemblage theory analyzes the “conglomeration of material technologies, infrastructure, institutions, collective, and discursive relationships that have arisen with the movement of technoscience and biomedicine across the world” (Collier and Ong 2005:4). In this view, science and medicine are affected by and embedded in social, economic, and political processes (Brandt 1987:5). Technologies are not just culturally-neutral objects, but instead “hybrid assemblages of knowledges, instruments, persons, systems of judgment, buildings and spaces” shaped by “certain presuppositions and assumptions about human beings” (H. Rose 1996:26). Related to actor-network theory, the assemblage

approach highlights the importance of both “human and nonhuman actants within scientific and technological networks” (Epstein 2008a:169). Thus, cultural beliefs and social dynamics are embedded in the emergence of scientific tools and medical technologies. Conceptualizing the “circulatory systems or economies” of science allows research to map various connections between health and medical objects, culture, and markets (Thompson 2005:51 as cited by Epstein 2008a:171).

Medical tourism can be conceptualized as a “transnational health assemblage” that bundles state and private initiatives, technologies, cultural discourses, and various industries (J. Connell 2011; Holliday et al. 2015; Ormond and Kaspar 2018; Wilson 2010). This perspective has shown how formal and informal networks such as trade agreements, travel agents, and cultural discourses impact medical tourism. For instance, in a study about “cosmetic surgery tourism,” Holliday et al. (2015) made visible the unseen connections between people, technologies, institutions, and discourses in Europe and East Asia. Through multi-methods research involving interviews and observations, they drew on Arjun Appadurai’s (1996) concept of *scapes*⁷ to argue that “beautyscapes” signal “how beauty practices, ideas, and ideals shape and are shaped by encounters with particular locales” (Holliday et al. 2015:302). The medical tourism assemblage redefines the role of the nation-state by enabling new public-private partnerships. Medical tourism relies on a variety of stakeholders, including “patients, providers, insurance agents,

⁷ Appadurai (1996) analyzed how global shifts involve *ethnoscapes* (flow of people), *mediascapes* (flow of images, such as in popular media, news outlets, and guidebooks), *technoscapes* (flows of technology), *financescapes* (flows of money) and *ideoscapes* (flows of ideology).

medical tourism facilitators, transport providers, tour operators, government agencies and hotel groups” (Herberholz and Supakankunti 2013:6).

As an assemblage, medical tourism redefines the boundaries and functions of the nation-state. Thai state agencies also collaborate with private institutions such as hospitals and the Private Hospital Association, signaling new relationships among state and non-state actors. For instance, in Thailand, the Ministries of Commerce, Department of Export Promotion and Ministry of Health collaborate with private hospitals (Pocock and Phua 2011), and the TAT has partnered with Royal Orchid Plus airline to offer medical tourism packages. Medical tourism illuminates the “[m]utual dependence between the nation and the private corporation” (Aronczyk 2013:23), which assembles various industries such as hospitality, food services, and the airline industry. In 2010, the state had also launched a new organization called Thailand Medical Tourism Cluster, which created a “Medical Tourism Cluster Map” to detail the extensive coordination between state and private organizations.

The dissertation focuses on local people’s convergences with medical tourism, demonstrating how the industry is made by local people, global processes, objects, cultural norms, and internal conditions. This shifts us from a top-down or strictly materialist approach, instead demonstrating gendered, cultural elements of a global medical market. By showing how kathoey’s work in the entertainment industry is linked to the growth of medical tourism, the project highlights local elements of a “global” phenomenon. The assemblage approach, when applied to medical tourism, illuminates how the industry is shaped by and impacting historical events, policies, technologies,

institutions, and different actors. Kathoey are highlighted as key actors whose own experiences are impacted by and also augmenting transnational health flows and the Thai nation-state.

The Gendered Technostate

Bridging research from transnational feminisms, sociology of science, and gender studies, I introduce the concept of the *gendered technostate*⁸ to analyze how nation-states, technologies, and gendered labor are co-constitutive. I conceptualize the nation-state as comprised of state bureaucracies (e.g. the Ministry of Public Health), and as an “imagined community” of the nation (Anderson 1991). Through this concept, I demonstrate the co-construction of nation-states, gendered labor, and technologies via technologically-enhanced gendered labor, that is both produced by and contributing to national agendas and a national image. The concept accounts for the creation of gender at local, national, and transnational scales, illuminating the black box, or underlying processes, around the interlinked processes of gender, labor, technologies, and the nation-state. Within the context of state-led efforts to advance technological growth and medical tourism, I illustrate how local people co-construct a global medical market and the nation-state.

The gendered technostate exploits health, economic, and social inequalities to reinforce governmental power and authority, while private health industries profit from

⁸ The first use of the term “technostate” was in the context of education (Taylor 1968); while related to the “techno-scientific state” (Uttam 2006), my conceptualization of the gendered technostate distinctly brings gender into conversation with the relationship between technology, labor, and the state.

both foreign currency and local workers. The gendered technostate accounts for new roles of the nation-state, as it develops public-private partnerships with private industries to advance medical tourism and technologies. Rather than take for granted that certain technologies just exist, we can instead track their connections to local people, state processes, private industries, and transnational flows such as medical tourism. The concept merges an attention to local people's gendered labor, national policies, and transnational technological flows to understand the political economy of sex and gender across various scales.

The gendered technostate therefore underscores how people throughout the world take on new forms of gendered labor roles alongside national policies that expand technologies and privatize health care. It extends to women in the Information Technology, or IT, industry in India who represent a "respectable femininity," in a changing national culture (Radhakrishnan 2009); to government policies that train and export nurses in the Philippines (Masselink and Lee 2012); to bar hostesses in Vietnam who use eyebrow pencils or scalpels to embody the nation and facilitate foreign investment (Hoang 2015). The gendered technostate broadens our view of the locations and types of technologies that alter people's ways of being and working. Whether a telephone in a global call center, which causes people to use a different tone of voice (David 2015), or a cotton plant that evokes the "agility" of a young girl's body (Ramamurthy 2004:759), the gendered technostate allots cultural and material agency to technologies – as actants – that have the potential to augment one's gendered ways of being and work outcomes. Technologies have unique economic, cultural, and political

constitutions and origins. With the growth of technologies in and outside of global workplaces, new gendered configurations then have the potential to contribute to the nation-state's economic and political growth.

Data and Methods

Epistemological Orientation

The dissertation draws on methodologies and ethics of feminist standpoint theory, which grounds people's experiences as having distinct authority (Smith 2005). In demonstrating how power relations shape research questions, the feminist framework often opposes a positivist approach by acknowledging how the researcher is embedded in the study with institutional and personal biases, highlighting the institutional technology of knowledge production as "people became the objects of investigation and explanation" (Smith 2005: 335). Feminist standpoint theory draws on ethnographic methods to create an "alternate to objectified subject of knowledge of established social scientific discourse" (Smith 2005:328). My aim is to privilege the voices of people often excluded from mainstream research and discourses with my interviews (Hill Collins 2000:259). As a white, cisgender woman from the United States, I remained reflexive about how I was interpellated everyday as a racialized, classed, sexed, and gendered subject throughout my fieldwork, archiving comments about my body shape and size, my hair, my way of sitting or talking, my style of dress, my food choices, or even the yoga mat I carried. These interactions and utterances lent great insights into the daily construction and regulation of racialized, classed, citizen-based, sexed and gendered embodiment.

Transnational feminist scholars have rightly critiqued the common Western feminist approach of exoticizing and patronizing Third World women, described as the fetishization of the Other (Steinbock 2013; Najmabadi 2013; Valentine 2007). Within Thai studies, van Esterik (2000) has called attention to the tendency of Thai gender studies to focus on women, prostitution, and sex tourism and Wilson (2010) grapples with the hyper-representation of women in sex work in her analysis of go-go bars. Further, hegemonic feminist approaches to sex, gender and sexuality often assume a white, Eurocentric lens, which collapses and overwrites the differences between women (and transgender women) across classes, genders, sexualities, nations, and cultures (Sandoval 1991). It is problematic to collapse a homogenous experience of gender or sex, and by bundling the diverse practices into one umbrella category (e.g. “woman” or “feminine”), research often “obscures the diverse geographic locations, meanings, and politics in which such practices are embedded...” (Walley 1997:429). As an alternative, both feminist standpoint theorists and global theorists suggest researchers acknowledge the diversities that exist throughout the world rather than seeking or creating a “unified doctrine” of knowledge (R. Connell 2006:262)

Reflective about how global inequalities are embedded within social scientific research, writing from the “metropole” or Global North also has the potential to reproduce power dynamics by engaging in “gestures of exclusion” and “grand erasure,” which involve rarely citing theorists from the “colonized world” and occluding colonial experiences and social processes (R. Connell 2006). Global sociology can aim to manifest as a “conversation among many voices” while feminist standpoint theorists also

echo that dialogue becomes a humanizing approach to including the voices of people often excluded from mainstream research (Hill Collins 2006:259). Research can also illuminate the cultural, social, and lived “common differences” between people across locations (Mohanty 2003:244).

Ethnography and Interviews

Global ethnographic research integrates an attention to political economic and macro social structures and everyday lived experiences (Boellstorff 2005:20).

Ethnographic research can unveil nuances of social life and “subterranean processes” that are not entirely obvious upon first glance (Burawoy 2009:60). For instance, Thayer’s (2001) work describes a community in Sertão, Brazil, which is often thought of as unaffected by globalization, yet she argues how they do in fact engage with global processes, particularly economic liberalization and democratization. By demonstrating the importance of a group often ignored, Thayer (2001) intervened in hierarchical narratives of globalization which might occlude local people and issues. In a similar way, Seidman’s (1999) work emphasizes how local practices rather than international donors institutionalized new meanings of gender in South Africa.

The dissertation draws on 14 months of fieldwork in Thailand, mostly conducted between January 2017 and February 2018. The fieldwork took place in the Bangkok Metropolitan Area, Nonthaburi, Phuket, and Pattaya, which are prominent sites for medical tourism and/or cities in Thailand with large populations of kathoey. I used a grounded theory approach to collect, code, and analyze data simultaneously (Glaser and

Strauss 1967). To understand Thailand's complex web of medical and entertainment tourism, I conducted and transcribed 59 interviews with the participants listed below, who were recruited through formal and informal networks (see Appendix for Interview Schedules).

33 kathoey 2 owners of a kathoey cabaret 1 creator of a kathoey beauty pageant 7 health care professionals 2 private hospital CEOs 6 officials from the Ministry of Public Health 1 executive from the Tourism Authority of Thailand 3 civil society members 1 representative from a United Nations-related agency 2 medical tourism stakeholders 1 medical tourist

Table 1. Interview Participants

Between 19 and 44 years old, average age of 27 9 held bachelor's degrees 2 held master's degrees 7 university students 10 graduated high school 1 graduated middle school 4 did not report educational background 19 reported working full-time jobs Average income: 16,500baht/month (around \$500 US, which is \$300 less than the average monthly income in Thailand).

Table 2. Kathoey Demographics

All interviews were recorded for accuracy and edited slightly for grammar and coherence. All participants are referred to in the text by pseudonym; in keeping with Thai cultural norms, I use pseudonymous nicknames rather than full first names.

I visited various health care sites – both public hospitals serving mostly Thais and private clinics geared towards medical tourists – as well as health care facilities in Singapore and Malaysia to better understand the regional dynamics of medical tourism. I observed several kathoey entertainment venues, treating the shows as a text to be analyzed (Manderson 1995), while spending hours backstage with performers in cabaret venues in Bangkok and Pattaya. I attended several LGBT activism events in Bangkok and participated in three regional meetings related to kathoey health and social rights, which were sponsored by local, regional, and international organizations. I triangulate the observations and interview data with analyses of state policies, publications about Thailand 4.0, and media reports. Building off of research on the discursive construction of medical tourism (Turner 2007), I analyzed medical tourism marketing materials appearing on blogs, private hospital discourses, and from state agencies. These sources provided a multifaceted view of medical tourism.

Dissertation Outline

Chapter 2 demonstrates the co-construction of technologies and kathoey's labor, showing how technologies impact kathoey's labor roles, while their work also augments local and global demand for technologies. This chapter elucidates kathoey's unique relationships to technologies of embodiment, and how their ideals of sex, gender, and labor are tied national policies that expand technological growth and private industries, such as health care sites and the entertainment industry. It also demonstrates how medical tourism incorporates the TAT's LGBT tourism campaign, "Go Thai, Be Free," in which

kathoeys also play important roles. Within the context of broader societal and employment discrimination, the chapter sheds light on how kathoeys' aspirational job outcomes are hinged on accessing technologies of embodiment, describing their pressures to be and appear as certain types of women. It also focuses on kathoeys' exclusion from public spaces and resistances to discriminatory stereotypes, highlighting their strategies to improve their social outcomes. By arguing that kathoeys perform display work (Mears and Connell 2016) to help foster medical tourism and advance the country's image as LGBT-friendly, this chapter contributes to research on gendered labor and the nation-state (Balogun 2012; Hoang 2015; McClintock 1997; Ochoa 2014; Radhakrishnan 2009; Ramamurthy 2004; Vijayakumar 2013), by underscoring how kathoeys' work is impacted by and contributing to national policies and initiatives that transform the country to an LGBT-friendly medical hub.

Chapter 3 focuses on the health implications of the gendered technostate, analyzing kathoeys' experiences with health care against the backdrop of medical tourism. It proposes a new framework, *the sociology of trans-national health*, through which to analyze the interplay between sex, gender, health, and nations. Amidst kathoeys' pressures to access surgeries for economic and social gains, this chapter analyzes how kathoeys navigate internal brain drain, the crowding out effect, and public and private health care settings in Thailand alongside the growth of medical tourism. It also develops the concept of *invisibilized uncertainty*, a type of medical uncertainty characterized by data hierarchies that exclude or collapse certain populations globally. Chapter 3 identifies kathoeys' hormone access, public health inequalities, self-stigma and

internalized oppression, and health care activism and resistance, particularly amidst the state's allocation of resources to medical tourists. Increased medical consumerism and national policies to expand technologies take place in the gendered technostate, with great impacts on local health and bodies. By accounting for the political and economic conditions of global health – whether related to air quality (Slini and Pavlidou 2016), lake ecology (Mojola 2011), or chemical exposure (UNDP 2011) – the sociology of transnational health extends our understandings of how national and transnational trends impact local people's health, particularly across lines of sex and gender.

Chapter 4 analyzes how the gendered technostate rebrands itself and accumulates cultural wealth through technologies and gendered labor. I first analyze the importance of medical tourism to a nation's cultural wealth, focusing on Thailand's reputation for gender-affirming surgeries. Thailand's role as a global provider for gendered medical technologies demonstrates how scientific and medical hierarchies are reshaped throughout the world (Harding 1993), while also reifying international standardization efforts (Kowalski 2011; Quark 2012; Timmermans and Oh 2010). The chapter also argues that kathoey in the entertainment industry promote the image of Thailand as professionalized and detached from HIV/AIDS, contributing to its rebranding campaigns and cultural wealth through kathoey's sanitized public health status. Kathoey must manage their own behavior and public image as the nation's face changes on the global stage, demonstrating the micro politics of nation-branding, and how local bodies overlap with cultural wealth. The chapter adds a gendered dimension to studies on cultural wealth and nation-branding, demonstrating the importance of medical tourism and gendered

labor to the nation. Alongside material shifts in technology, labor, and embodied health outcomes, the gendered technostate focuses on how nation-branding and cultural wealth are gendered and technologically-enhanced processes involving local people.

Chapter 5, the conclusion, discusses the research and policy implications of the gendered technostate. For the Thai case, the chapter will suggest state policies to: target employment discrimination; regulate gender clinics; expand universal health coverage to include transgender people's access to hormones and HIV/AIDS testing; and train medical professionals in clinical/cultural transgender health competency. The conclusion will offer suggestions for future research, including directions for work on globalization, gender, and health.

This dissertation builds on the theoretical insights and empirical strategies of medical sociology and gender studies to analyze transgender people's health outcomes and labor inequalities within the context of medical tourism, parsing out the intimate connection between nation-states, gendered bodies, and daily life. In doing so, it endeavors to answer: How might sociologists analyze and improve the health and life outcomes for people amidst shifting transnational health flows, and particularly queer and trans people who face inequalities globally?

CHAPTER TWO: The Gendered Economy of Medical Tourism

In Bangkok, Thailand, I shopped for groceries in a multilevel commercial complex with an entire floor dedicated to upscale beauty clinics offering lip injections, Botox filler, and other aesthetic services. The clinics featured plush sofas and decorative chairs, and often there were representatives standing outside distributing discount fliers. It became an everyday reflex for me to either smile and accept the papers, folding them in my pocket, or simply keep walking, eyes set ahead to the produce aisle. According to the *Bangkok Post* (Thepbamrung and Ruffles 2013), over half of Thai cisgender women access services in local beauty clinics, while “six pack” surgeries on cisgender men have recently become popular to etch the appearance of abdominal muscles (Kamolvattanavith 2019). With Bangkok providing access “to the consumer products that allow for greater gender differentiation” (Käng 2014:422), Thai cisgender and transgender people incorporate a variety of tools – including clothing, hormones, eyebrow pencils, or a scalpel – to embody their ideals of sex, gender, and beauty. Yet economic pressures and industries also guide people’s choices to access particular technologies (Edmonds 2010; Hoang 2015; Ochoa 2014). This chapter analyzes how kathoey’s labor has shifted amidst the state-led growth of medical tourism, and the growth of the “purple baht,” or the LGBT tourism industry (Jackson 2011:22). While kathoey are considered “queer cultural warriors” (Jackson 2011:37) and postmodern beauties (Aizura 2009; Käng 2012, 2014), this chapter shows that they are simultaneously used to signify medical technologies and LGBT diversity to thereby advance medical tourism and the goals of the nation-state.

Rich scholarship in transnational feminisms and global sociology has analyzed the gendering of labor in the global economy, yet less work has analyzed the technologies with which people interface amidst changing economic, cultural, and political conditions (Hoang 2015; Lee 1998; Manalansan 2003; Mohanty 2003; Namaste 2004; Otis 2011; Peterson 2011; Salzinger 2003; Thayer 2001). Research has also focused on the roles of local people in the tourism industry (Cantu 2002; Puar 2002). Although medical tourism involves other local industries, little research has shown how medical tourism alters local labor roles. Nor do we know much about how medical tourism augments the local landscape for health care access and medical services.

This chapter illuminates the black box, or context, surrounding kathoey's use of technologies of embodiment, demonstrating how their gendered labor is connected to technological growth and state processes to expand medical tourism, particularly the "internationalization" of gender-affirming surgeries (Jackson 2011:37). I argue that kathoey's work in the entertainment industry is both affected by, and supports, technological growth and medical tourism in Thailand, while also helping to position Thailand as an accepting place for LGBT travelers. Kathoey's labor intersects with the LGBT tourism industry and medical tourism, demonstrating the gendered elements and cultural relations embedded in the medical tourism industry, and the nation-state more broadly.

In this chapter, I elucidate the concept of the gendered technostate, delineating the specific expectations of gendered labor for kathoey, how their work is connected to technological growth, and how it supports the intersecting state agendas for medical

tourism and LGBT tourism. To understand how kathoey are deployed to promote medical tourism, I first examine what prompts kathoey to access the medical services that draw in tourists from across the globe. I then analyze how kathoey's work in the entertainment industry is a form of display work (Mears and Connell 2016), helping to advance not only medical tourism, but also LGBT tourism. This is then followed by an analysis of kathoey's experiences and inequalities in the workplace, and their resistance to such constraints.

Becoming a Woman in Thailand 4.0

At Calypso Cabaret in Bangkok, Thailand, the figure of Marilyn Monroe appears on stage clad in a silver sequin dress, high heels, and a blonde wig. Two men donning black masks and business suits drape diamond bracelets and necklaces upon the eager Marilyn, as she marvels at the sparkling jewelry. The performer fervently lip-syncs "Diamonds Are a Girl's Best Friend," and "Material Girl," enactments of Western femininities and cosmopolitan consumption.

The kathoey entertainment industry is a dominant site of the production of feminine beauty, and one in which surgeries are typically employed to achieve such norms. Kathoey cabarets and pageants are often sponsored by Bangkok clinics, which offer performers and contestants free and reduced services such as breast augmentation.

Rose, a cabaret performer at a prominent venue in Pattaya, said:

We got sponsored by some beauty clinics for our performers to access surgeries. They also provided us gift vouchers. In the past, [the cabaret] organized numbers of beauty pageants and other beauty events, which have always been sponsored

by several beauty clinics, both in Pattaya and Bangkok. You know? Some of the clinics even sponsored us with free services. They allowed us to select one [performer] to receive their free service. Our task was to select candidates for them. Then, the clinic would select the best out of the best from those selected candidates.

Beauty clinics may benefit by branding themselves with kathoey performers, while surgical technologies are a foundation that undergird the stage itself, making it possible to embody Thai ideals of beautiful women, and become successful entertainers. Nana, a beauty pageant creator, also said that her pageant has received sponsorships from beauty clinics offering free breast augmentations for some contestants, as well as makeup and skin cream sponsors. The material connections between medical venues and the kathoey entertainment industry demonstrates how technologies enhance the work that kathoey do.

Several kathoey cited the entertainment industry as a source of their ideals of embodiment. Kitti explained: “The role model of transgender beauty nowadays is [pageant winner] Poy Treechada... if you are an ugly trans, you need to have money, to get many surgeries, to have all the house, cars, and every asset. You need to look high-so. For me, I think beauty is look[ing] like a beauty queen or actress.” Kitti’s role model Poy famously underwent gender-affirming surgeries and won national and international kathoey pageants in 2004. Kitti also evoked the importance of appearing “high-so” – a phrase that captures class and consumption – as a component of the right look. Financial status is thus coupled with norms of beauty and womanhood, as pictured in cabarets and beauty pageants. In a documentary about Poy, she is shown as living the “It Girl” life, which involves eating in top restaurants and wearing designer clothing. In the film, Poy stated: “I need to look after myself always, because I have a lot of brands to represent.”

Kathoey entertainers also represent a culture of consumerism, demonstrating linkages between sex, gender, and classed embodiment. Oom said she wanted to be a cabaret performer after visiting Pattaya when she was younger and seeing performers with feather costumes: “I had a dream to become a show girl because it is a very beautiful job.” Oom’s childhood memory of feather costumes and glamour informed her career path in the cabaret. While Thai cisgender women were once valued for raising children and inheriting land, Whittaker (1999:57) found that “social status, power, and prestige are aligned with economic success and consumer goods.” The attainment of social capital and consumption practices now help define cis *and* trans womanhood, with fashion and luxury items a main component symbolized in entertainment venues. According to the description of the Aphrodite Cabaret Show on the official TAT website, performers wear “gowns dripping with diamante” (Tourism Authority of Thailand, n.d.). The cabaret’s emphasis on extravagant fashion represents kathoey’s class-based consumption practices, which are part of kathoey’s gendered embodiment, economic success, and social belonging.

While growing one’s hair long, having soft skin, wearing makeup, and taking hormones were often mentioned as features of being kathoey, 72 percent of the kathoey respondents had also accessed some form(s) of feminizing surgery (and four did not report). Several kathoey who had not yet had surgery said they were actively planning to undergo procedures. Just as many cisgender women and men in Thailand do most kathoey defined beauty through technologically-enhanced traits such as a V-shaped face, a defined nose, big eyes, and double eyelids. This “pan-Asian aesthetic ideal” (Hoang

2014:517) is, many interviewees noted, the dominant look in the entertainment industry because of South Korean aesthetic influences; some even became medical tourists themselves through travel to South Korea for related procedures. One cabaret was sponsored by Gangnam Clinic – whose tagline is “Original from Korea” – located in the shopping area of Siam Square in Bangkok. Others mentioned that the Philippines was a preferred destination for surgeries to widen the hips. This highlights some of the regional cultural flows, with images and booking services traveling borderlessly through Facebook Live and Instagram – as well as the fragmentation of medical specializations. In Thailand, for example, a TAT executive told me the country is best for surgeries “from the chin down.”

Gan, who worked in the television industry and said that Poy was her ideal of a beautiful woman, defined beauty and womanhood in direct relation to surgeries. She said that to be a beautiful woman: “You have to have many plastic surgeries, both face and body. I got a chin surgery five years ago. I didn’t have a [prominent] chin.” Gan emphasized that augmentation through plastic surgeries is necessary to achieve simultaneous norms of sex, gender, and beauty. By defining her chin, she was able to produce a look more aligned with her notion of a beautiful woman. Similarly, Egg, a cabaret performer, explained that altering her body was key. She said: “[When I was young,] I wished I could grow long hair, have my breasts augmented, and sexy hips as other women have. And the most important is I want to be seen as a beautiful woman, you know?” Long hair, a key facet of female embodiment, was mandated by King Rama VI (1910-1925) to differentiate men and women in accordance with western norms of

civilization (Pravattiyagul 2018:98), demonstrating how governmental practices have become embedded in everyday understandings of sex and gender. Today, technological augmentation – whether surgical or hormonal – allow kathoey such as Egg to achieve the physicality of “other women.” Egg also implied that there are unified expectations of sex and gender, since it is desired to obtain features that “other women have.”

In this way, binary norms of sex and gender have also informed kathoey’s experiences with surgeries. Kitti said: “Surgery can help transgender people look like a woman... It is like a correction of the places that are like a man.” Her comment implies that there are particular ways to look like a man or woman, with surgery helping kathoey pass as women. Similarly, Bee distinguished between body parts that appear male and “not beautiful,” in contrast to body parts that are more “womanly,” and therefore smaller. She said:

Surgery can help us fix the inferior parts of our body which are not beautiful, like, eyes, nose, mouth, and chin. It can help our looks become more womanly. Whichever body part still looks like a man, we can do surgery to make them more small. Like the face, I can do Botox to make my face smaller, to look more like a woman.

Bee emphasized that there are “inferior” parts of the body, signaling negative associations or values assigned to features that appear more male and/or masculine.

Kathoey’s emphases on “fixing” and “correcting” the body demonstrates how technologies of embodiment, such as surgeries, become integral to kathoey embodying their gendered ideals. While kathoey often mentioned that they still accepted kathoey who do not “pass” as women or beautiful, the majority of respondents stated that passing

as a beautiful woman was important to them. I return to the theme of the sex/gender binary embedded in medical interventions in the next chapter.

Appealing to audience members' varied ideals of beauty was also important for performers' success on stage, and receiving tips after the show. Kathoey cabaret performers also acknowledged that the mostly-international audiences of cabaret shows required different embodiments of beauty. Show numbers included song and dance in Hebrew, Persian, Chinese, Vietnamese, Russian, K-pop, Korean folk, and jazz, requiring that performers embody different nations through costume, dance style, and gestures. San, who played the role of Ariana Grande in a cabaret show in Pattaya, remarked that beauty is subjective and geographically-situated, as she does not believe she is beautiful by Asian standards. She said: "People like different types of beauty. For me, I know that I am not an Asian type [of beauty], for sure. I may look more beautiful if I lived somewhere in western countries." While her hair was pulled back in a high ponytail and her winged eyeliner mirrored that of Grande's trademark look, San believed her type of beauty is null in Thailand, and she must be strategic in how she appeals to certain audience members. Her beliefs reflect the "spectrum of possibilities of beauty that each culture subscribes to" (Mears 2011:255), with various "waves of social excitement" becoming instantiated across time and place (Mears 2011:256).

In addition, smaller features and body size are said to belong to women. At the downtown Bangkok yoga studio I attended in an upscale high-rise building, signage outside of the women's locker room designated a weekly meal plan for studio-goers, suggesting that one consume around 800 to 900 calories a day. These bodily standards

often meant that Thais read me as fat (sometimes touching my stomach and remarking “*uan*,” Thai for “fat,” usually with a lighthearted laugh), and I was asked over six times in one year if I was pregnant. With intimate knowledge of the ways in which societal frames interpreted my body size, kathoey also spoke to the negative associations with fat or larger bodies. Piim, a cabaret performer born and raised in Bangkok, said: “I need to choose outfits that... don't make me look too big...[Being a] woman for me is small, soft, [things] like that.” Emphasizing the need for a small body, Piim strategically wore clothing that supports this value. Non also spoke to her experiences taking diet pills, after gaining weight from hormones, and causing herself to vomit after meals.

I did not observe any overweight performers in the cabaret shows I attended in Bangkok, but the cabaret show in Pattaya featured one overweight kathoey, who played the role of a jester. Upon exiting the stage after one of her acts, she dramatically bumped into the wall, eliciting applause and laughter from the audience as her body was cast as cumbersome, inconvenient, and inherently comedic. In addition, a beauty pageant specifically for kathoey called Miss Jumbo Queen awards winners the title of “Daughter of the Elephant,” and involves raising awareness for elephant protection. The pageant awards the contestant “who best exhibits the characteristic of an elephant by virtue of her grace, elegance, and size” (Reuters 2005). The pageant not only fetishizes fatness, but also dehumanizes its contestants by linking them with elephants. Becoming a mainstream beauty pageant contestant involved managing one’s weight, and Gan remarked that joining a beauty pageant would require her to go on a diet. She said: “I want to join Miss Tiffany [Pageant] as well, but I have to lose weight first. Most contestants are skinny;

there is not a single fat person.” A desire to be and appear small undergirds many kathoey’s outfit choices and diet, reflecting global, regional, and local cultural frames that prize thinness (Bordo 2004; Kwan 2009).

Kathoey have made decisions to access surgeries within the context of an entertainment industry that promotes particular norms of sex, gender, beauty, and embodiment. Their beliefs about what constitutes a woman’s and man’s embodiment is an instantiation of transnormativity (Vipond 2015), which upholds binary sex and gender tropes (Garrison 2018:633). These narratives also reflect dominant biomedical paradigms of binary sex and gender, a theme to which I return. I now discuss how kathoey entertainers strategically access surgeries, which then allows them to perform display work, serving as brands of medical tourism and LGBT diversity.

Surgeries on Stage

All but one of the cabaret performers and beauty pageant contestants interviewed had undergone some forms of gender-affirming surgeries, and they unanimously agreed that the surgeries were essential to their livelihoods. In a focus group with four performers at a cabaret in Bangkok, I can still hear the resounding chorus of performers fervently agreeing that their careers were enhanced because they had surgeries (“*Chaiiii*” – “yes” – they exclaimed, all in unison). For instance, Pinky said she had her nose augmented to build a more prominent bridge, specifically to succeed in Miss Jumbo Queen Contest. “I have to use my nose for work,” she said. Linking her nose to her work performance, Pinky emphasized that surgical decision-making was tied to her work on

the beauty pageant stage. A more defined nose comes to feel mandatory for success at work.

Double eyelid surgery is often described as a means to “Westernize” the body or achieve norms of cosmopolitan beauty. Bee however, also defined it as a practical decision to support her work as a performer in the cabaret:

We do surgeries on our face and body because we are performers. People see my face first. In addition, it helps me [put on] make up easier. If I have only single eyelids, it will be much harder when we stick on the artificial eyelashes. So surgeries are very important for being a performer.

Linking surgeries to her work as a performer, Bee’s use of makeup and false eyelashes were visibly enhanced by double eyelid surgery. Her appearance and performance in the cabaret necessitated her use of technologies. Creating double eyelids was not just about appearing white or Western for Bee; instead, surgeries were also a necessity of her work.

Nana, now a creator of a kathoey beauty pageant, experienced how facial surgeries allowed her to gain entry to work in the cabaret. She explained:

Personally, I dislike surgery. But in the past, I wanted to work at Calypso [Cabaret] but I failed all seven times that I applied. Then I started to wonder why they don't accept me. Then I decided to do surgery on my face. After that I went to apply again. That day there were a total of thirteen applicants, and only I got accepted. So [surgery] is important for my life.

Nana’s job prospects in the cabaret, she recalled, hinged on access to facial surgeries.

Nana’s experience demonstrates that kathoey do not access these surgeries simply to please their own aesthetic sensibilities – rather, they feel pressure to conform to this beauty ideal in order to find employment.

To succeed in the cabaret, several performers said that breasts were the most important feature, particularly since they could not be hidden. According to Naw: “It

helps when we are wearing costumes. It can make me more beautiful – like a woman – when wearing a show costume. It also can complete my confidence.” Breasts added to Naw’s personal confidence and also enhanced her appearance in costumes, signaling the ways in which performing often requires technological augmentation. Oom agreed that breasts made the biggest difference for performers, and said: “If you have breasts, it can be a symbol of sex that you are a woman. For genitals, we can use an outfit to conceal it. But for the show costume, the top part is revealed a lot. So, I have a feeling that [having] breasts is the most important.” Similar to Egg’s expectations about the bodies of “other women,” breasts were aligned as a visible “symbol of sex” that created an outward appearance of womanhood and enhanced performers’ confidence and appearance on stage.

Seemingly personal decisions to access surgeries are shaped by gendered labor demands, as the success of performers who have surgeries influences other kathoey to get surgery. Gender relations are thus made in the workplace, while “ideas of attractiveness are organizationally produced and situated in place” (Mears 2011:11), in settings such as cabarets and beauty pageants. Kathoey’s relationships to work and surgeries also reveal how “organizational demands shape and promote conventional gender expectations” (Geist et al 2015:6), enhancing our understandings of gender and the workplace (C. Connell 2010, 2014; Mears 2011; Schilt and Connell 2007). I now discuss how kathoey’s work feeds into the global demand for medical tourism in Thailand, as they perform display work to become brands of both medical technologies *and* LGBT diversity on a global stage.

Display Work

Ali is a short-haired queer-identified American woman who works as a medical tourism facilitator for a startup company in Bangkok. We were drinking pour-over coffees at an artisanal café in the qualifiedly hip district of Ekkamai, where she also lives. As the aroma of fresh roasted coffee fills the air, Ali described the level of openness and understanding regarding sexuality that she has personally found while living in Bangkok. She asserted that this is part of the reason that the transgender medical specialization has emerged in Thailand, stating: “People come here not just for [genital reconstructive surgeries], but because there is [LGBT] community.” She said she believed that Thailand’s reputation in the LGBT community is well-established because of kathoey. She said:

You’ve seen the ladyboys, you’ve heard the jokes, you know all of that. You know [about] cabaret shows. You can be a little old lady from a small conservative town and you’ve probably heard about a ladyboy in Thailand. This is not an ideal format, but at least – hey, you kind of know this is a place you can be this person and not be killed or chased, and in some ways welcomed.

The figure of kathoey entertainers has informed the desires of medical tourists, such as Kali, a transgender medical tourist from New Zealand. She said that the reputation of kathoey helped her make her decision to travel to Thailand for surgeries, stating: “I definitely think Thailand is very LGBT-friendly... [I]t influenced my decision because they’re known for trans people and sex changes.” Transgender medical tourists may be drawn to Thailand for surgery because of a preexisting foundation of LGBT tolerance publicized through kathoey. Just as airline industries displayed “multiracial, multinational

reach in terms of personnel and destinations” (Yano 2011:107), kathoey in the entertainment industry and broader tourism industry demonstrate not only the medical techniques of Thai surgeons, but also the country’s apparent openness to LGBT people.

Kathoey are not just symbols of Thai beauty who sing and dance on stage; they are also used to sell medical tourism. For example, the promotional pamphlet “Thailand is a Global Center for Sex Change Operations,” available on the TAT’s Medical Tourism Portal website in the mid-2000s, included a photograph of seven kathoey beauty pageant contestants juxtaposed with a list of gender-affirming procedures offered. In interviews, Thai state officials explicitly link kathoey and Thailand’s growing economic prosperity via its reputation as a medical tourist hub. Pravat, an official from the Ministry of Public Health (MOPH), stated: “You can see in some touristy places like Pattaya or Phuket, transgender people are superstars – they are celebrities – so we are quite open to that.” His comments affirm that the country is known as an accepting place for transgender people due to kathoey’s prominent entertainment roles in tourist hubs. Images of kathoey beauty queens appear on private hospital websites, as doctors are wedged between the winners.

In response to a question about the popularity of Thailand as a destination for gender-affirming surgeries, Nin, another MOPH official replied: “[T]he transgender in Thailand: they win the competition like the beauty queen, and if you see them they are very beautiful, so I guess Thai doctors have a lot of cases to practice on! *[laughs]*” In this speculation, Nin drew on the success of kathoey performers as evidence of Thailand’s excellence in gender-affirming surgeries. Similarly, Prameth, an executive from the TAT,

admitted that kathoey play a significant role in advertising medical tourism. He concluded that: “In terms of [medical tourism] promotion, maybe we have an advantage from the reputation of the Thai ladyboy or Miss Tiffany Show. They can prove what is made by the Thai doctor.” State officials acknowledged how kathoey entertainers discursively symbolize Thai medical technologies, helping to advance medical tourism. This is exemplified in online discourses about medical tourism, such as a blog post entitled “Just Why Do Many Transgender Girls Head to Thailand for Surgery?” The author, Christine B. from Canada writes that “many foreign transgender girls are captivated by the beauty of [Thai transgender] women in cabaret shows and the like” (TG Forum 2015). These comments show how kathoey’s technologically-enhanced gendered labor contributes to the local *and* global demand for surgeries in Thailand, advancing medical tourism and the goals of Thailand 4.0. The dominant image of kathoey cabaret performers has become bundled into the decision-making of medical tourists.

Kathoey contribute to the medical hub – not only through their roles in clinics (Aizura 2009), or their display work advertising technologies in the entertainment industry – but also through their public image as “queer cultural warriors” (Jackson 2011:35). They represent and advance Thailand’s brand as tolerant and LGBT-friendly, demonstrating how the nation-state’s medical tourism agenda intersects with cultural narratives around sex, gender, and sexuality. Part of the cabaret branding strategy involves not only marketing kathoey as stunning and beautiful, but also highlighting their gendered difference. One cabaret website states: “We are neither ladies nor boys, but naturally born individuals, although different from the natural norm. CALYPSO-

performers are THAI TRANSGENDER ARTISTS.” The capitalized emphasis on kathoey’s gender, as well as the designation that they are “neither ladies nor boys,” designates that kathoey’s gendered embodiment is part of the spectacle of the show. Kathoey’s gendered embodiment is advertised for its uniqueness, with their “differen[ce] from the natural norm” functioning a main component of the cabaret. According to another cabaret’s website, “this production and it has nothing and yet everything to do with being TRANSGENDER, because of who we are and what we do.” Kathoey’s gendered difference is folded into their cabaret roles, centering Thailand’s prominent “institutionalized third gender” (Käng 2014:424) and conveying an openness to foreign audiences.

Kathoey’s display work transcends the boundaries of the Thai nation, appearing virtually and transnationally to circulate the technologically-enhanced “looks” of performers, as well as the notion that Thailand is an LGBT-friendly destination. For instance, kathoey are distinctly marketed by the TAT for their work in the cabaret, with the agency’s website selling tickets to Calypso Cabaret and Miss Tiffany. As Käng (2014:424-25) summarized, kathoey cabarets are “commodified by government and private agencies for tourists to demonstrate the ‘amazing’ character of Thainess, an exotic place with an institutionalized third gender.” In 2010, Miss Tiffany Cabaret in Bangkok was lauded by the TAT for a Tourism Award, and cabarets and kathoey are also featured on the Go Thai, Be Free website. According to several kathoey cabaret performers, the TAT sponsors their performances in other countries, such as the Philippines, Indonesia, India, Vietnam, Malaysia, South Korea, Singapore, Australia, and Russia. These events

are facilitated by the Royal Thai Embassy, which arranges kathoey's travel documents and arrangements. The TAT's Go Thai, Be Free webpage lists kathoey's work in cabarets, restaurants, and hotels, and as "ladyboy captains" on a boat tour of the Similan Islands, as part of the country's LGBT-friendly appeal. Kathoey cabaret shows are also incorporated into Thailand's Pride events, exhibiting LGBT diversity in a global queer circuit.

Cabaret websites market performers as "[p]assionately fighting prejudices," with the cabaret a "live stage for transgender artists and performers to express their minds, their thoughts, their feelings in a highly professional way, to continue the unique and different form of show entertainment, which CALYPSO presents today." While I return to the discourses of professionalism in Chapter 4, the emphasis on performers being able to convey their thoughts and express their minds – as well as the emphasis on the "unique and different" type of entertainment they provide – highlights how kathoey promote Thailand's LGBT diversity. The cabaret is not only a site where kathoey perform display work by advertising medical technologies, but also a location in which they represent LGBT acceptance. These narratives may then inform the decisions of LGBT tourists to seek Thailand as a medical destination.

In the cabaret websites and in other interviews, kathoey are also referred to as uniquely gifted. For instance, some respondents stated that kathoey are naturally more artistic than cisgender people, making them uniquely positioned to succeed in the entertainment industry. For Fin, a costume designer of a cabaret show and kathoey herself, she believed kathoey have a more "sophisticated" psychology, stating:

[Kathoey's] creativity is extraordinary and overwhelming compared to straight people. You know? You can just kindly ask them whenever assistance is needed especially in terms of the artistic creativity. My statement might not [apply to] transgender and homosexual people as a whole but I can see this gift in most of them. What I said does not mean that straight men and women are not skillful but I want to point out that I have this kind of feeling while I am working with transgender people.

Beliefs about kathoey's innate artistic skills, attached to their gendered embodiment, are bundled into their work in the entertainment industry. Similar to how girls in cotton plants are “embodied as disciplined, laboring subjects through their extraordinary suitability” to move between plants, kathoey are seen as naturally creative and artistic.

The nation-state's advancement of medical tourism is therefore linked to the TAT's LGBT tourism campaign, demonstrating the connections between medical tourism and intimate lives in Thailand. Ali remarked:

As a member of the LGBT community, you already know about Thailand, and now you're looking to have this major [gender-affirming] surgery. You do some research – hey, where are the specialists, where are facilities, where is it legal, what does it cost?.. Thailand, the same [LGBT-friendly] place - look at that.

The dominant image and publicized work of kathoey performers have helped establish Thailand's reputation as both technologically-advanced and LGBT friendly, discourses embedded in the medical tourism industry.

Thailand's reputation for LGBT tolerance is explicitly bundled into the medical tourism industry. In a Thai magazine on medical tourism, which was initially sponsored by government agencies, the cover reads, “Quick Sex,” with a subtitle stating: “Crossing Barriers: Thailand's transgender surgery attractions include first-class transgender surgeons, third-class prices, and a tolerant culture.” In addition to the cost-savings and “first-class” medical expertise, the magazine promoted the “tolerant culture” of Thailand,

signaling the convergence of medical tourism with global norms of diversity, multiculturalism, and LGBT acceptance. Some attributed Thailand's openness and acceptance of LGBT people directly to the kathoey cabaret. For instance, Dr. Wirun said: "In general, I think with the growth of the trans community in Thailand, it makes the society more liberal in this sense – although not as liberal as many western countries – but we have a lot of pageants." In this remark, kathoey beauty pageants have helped liberalize Thai society (although this liberalism has not surpassed Western countries).

Scholars have asserted that is imperative to analyze "diversity within the structure of capitalism" (Tsing 2009:172), particularly how workers "endorse projects of identity that move them beyond (as well as, of course within) the limitations of their workplaces" (Tsing 2009:172). As queer and homosexual acceptance have become symbols of a country's "development" and "modernity" (Butler 2010; Duggan 2002; Puar 2002), kathoey represent this strand of Thai development on the global stage. Kathoey contribute to the country's reputation as welcoming of diversity, and serve multiple roles in advancing the nation-state. They do so specifically by becoming brands of medical technologies and icons of an LGBT-friendly Thailand. The broader reputation of kathoey can help establish Thailand as an LGBT-friendly destination, which then informs the demand of medical tourists. The spectacle of kathoey's gendered difference coincides with Garland-Thomson's (2005) analysis of freak shows in which she demonstrated that "freaks were profitable performers" and "monstrous bodies were a type of prodigy" (Garland-Thomson 2005).

Much like global supply chains incorporate cultural diversity (Tsing 2009:171), Thailand's role as a medical hub incorporates narratives of tolerance and local LGBT diversity, while also drawing on the work of kathoey in the entertainment industry to represent medical technologies. Kathoey entertainers serve as "brand enhancers" or "walking billboards" for products, services, or norms (Zeithaml and Bitner 2003:318 as cited by Warhurst and Nickson 2009:390). Kathoey perform purple-collar labor (David 2015) on stage, engaging in "display work," in which their job is not just to make their bodies available for visual consumption (Mears and Connell 2016), but also to capture tourist attention and foreign currency and showcase medical technologies. Kathoey contribute to the national economy through their performance work, advancing both medical tourism and LGBT tourism, industries which overlap. In light of their service to expand medical tourism and LGBT tourism initiatives, I now discuss the broader context of kathoey's employment experiences and disparities.

Workplace Inequalities and the Glass Ceiling

Limited economic opportunities and workplace discrimination has led many kathoey to turn to entertainment as their most viable source of income. Many kathoey described how they were denied work on the basis of gender, were told by employers to cut their hair and dress like a man, gossiped about in the workplace, or made to use the men's restroom at work. Kathoey spoke of their experiences being denied work on the basis of their gender. Jin, who won the swimsuit portion of Miss Tiffany Beauty Pageant,

experienced what she calls “human rights issues” in the workplace before she was crowned. When she applied to work at a cargo company, she said:

[Employers] think that *sao praphet sorng* are the cause of adulteries within the workplace. I was told that *sao praphet sorng* are very talkative thus they may cause quarrels between other female employees or whatsoever. They don’t hire *sao praphet sorng*... They didn’t want to hire me because they were afraid I would cause problems at work. They didn’t even let me prove that I could work. They chose to not hire me from the beginning.

Jin specified that stereotypes about kathoey pervade the workplace, and she was not given a chance to work because of these beliefs. Despite the fact that Jin embodied dominant norms of beauty – which earned her a prominent pageant title – her looks did not afford her workplace equity.

Similarly, Fan said her gender became an immediate question when she applied for an internship at a warehouse. She said: “At the beginning, I was asked whether I would be able to work on this shift or not because the recruiter foresaw that I might not be appropriate for this position according to my physical appearance...” Bin has also experienced how some companies do not accept transgender people. She described:

There is one place which has just been newly opened located around Pin Klao area and I heard a rumor that they accept employees of all genders. I asked a friend of mine to provide me more information regarding the recruitment process. Later, I went to this place for the pre-screening interview but my application was eventually denied according to my gender. I was told by the recruiter that it is unclear for transgender people... whether they are man or woman and what kind of uniform should they be given.

Bin was denied work on the basis of the employer’s uncertainty on which uniform to give her, underscoring the institutionalized gendered norms⁹ that exclude trans people in the

⁹ Following King Bhumibol’s death in October 2016, debate ensued over whether toms should be able to wear pants and kathoey dresses to the Grand Palace to pay respect, despite a national dress code that only

workplace. Relatedly, the World Bank Report (2018:4) found that 23.7 percent of Thai transgender respondents were told at work to use the toilet according to their birth sex, which was also the case for Pai, when she said a janitor forbid her from using the women's restroom at work.

In addition to being rejected from jobs or internships because of their genders, several kathoey were told by employers to cut their hair and dress like a man. Denny said: "I once applied for a job at fast food restaurant. They forced me to cut my hair short like a man or they won't accept me. There are conditions like this everywhere, even nowadays." Pai echoed this experience, stating: "When I applied for job they also forced me to cut my hair and [said I] can't wear makeup." Kathoey's gendered embodiment was erased by employers, replaced with essentializing rules that they perform the gender assigned at birth and designated on their legal identification cards.

The International Labor Organization (ILO) report (2014:xiv) also found that 40 percent of Thai transgender respondents experienced harassment or were ridiculed at work, including jokes, gossip, or insensitive comments (ILO 2014:xiv). These types of experiences were substantiated by Apple, who works as a food vendor in a large Bangkok shopping complex and said: "I was still directly criticized and gossiped [about] regarding my physical appearance as a transgender woman, but I tried not to be mad at them." Apple tried to overcome her feelings of anger towards those with whom she worked,

assigned pants to cismen and skirts to ciswomen (Mahavongtrakul 2016). Prior, in 2015, Bangkok University announced that toms and kathoey could wear pants and skirts, respectively (Winn 2015).

emphasizing how personal responsibility to control one's emotions takes precedent over larger institutional change such as workplace discrimination laws.

Kathoey's experiences being rejected from jobs, told to dress like a man, refused entry to women's restrooms at work, and as the target of gossip or ridicule may explain why kathoey are "opting out of mainstream jobs" (ILO 2014:xiv). This can also serve as a context for why kathoey may find liberation, acceptance, and employment in the entertainment industry. The entertainment and beauty industries were hailed as occupational goals for several kathoey, who spoke to their desires not just to look like entertainers, but also to become a cabaret performer or enter a beauty pageant. May, who works as a clerk in a motorcycle dealership, said: "I think jobs [in the entertainment industry] in Pattaya are the most sought after... It's very hard to get into it. You have to be very beautiful." In order to work in the most "sought after" industries of beauty or cabarets, May emphasized that beauty is key. Apple agreed, stating: "I think I can say that 100 percent of transgender women want to be a cabaret actress... as well as the beauty pageant." Bee echoed that she thinks participating in the beauty pageant "is the greatest goal for most of Thai transgender people. If not a beauty pageant, we would try our best to get as close as we could to work in the field related to the beauty."

Dao said she recognizes that many kathoey have failed in their goals of becoming entertainers due to their appearances. She said: "I trusted that becoming a cabaret actress is the supreme goal for most of the transgender women, but most of them failed to follow this pathway because of their appearance." With sex/gender normativity and appearance serving as barriers or gateways to employment, the workplace is a site in which gender is

managed, evaluated, and disciplined. Fai, who works at an LGBT nongovernmental organization (NGO), mentioned that there are limited job options for kathoey who do not pass as women or as beautiful:

As a transgender, if you can change yourself to look like a woman totally, society will admire you... And there are only few spaces for us to show our capabilities - for example, the beauty pageant.... Due to little space for success, I thought that I needed to become more beautiful in order to gain success.

Fai spoke to the inherent demand for “becom[ing] more beautiful” due to employment constraints, implying certain steps or tools are necessary to “look like a woman totally.” Fai’s remark reflects what the Bangkok Post (Thongnoi 2015) deemed a “glass ceiling” on kathoey’s employment, a trend that has been documented in reports by the World Bank (2018), Asia Pacific Transgender Network (Winter et al. 2018), and the International Labor Organization (2014). Gender conformity is the main route to success, as workplaces are rife with “institutional policies and rules or negative attitudes among officials towards alternative sexuality” (ILO 2014:89). Nana also emphasized this point, stating that despite social acceptance for kathoey, norms of beauty still limit job opportunities, as she said: “Even though there are more options but those come with the condition of appearance. The one that isn’t beautiful still have limited options.” Social acceptance more broadly is also dependent on one’s beauty. Kathoey such as Chip and Ari agreed that beauty is a “social value.” Ari said: “If you are ugly transgender, you are a clown. People can [treat you badly], they can dehumanize us as what they want. But if you are beautiful, people will talk to you very softly. I experienced [this] myself, because I’m not beautiful... If you want to be accepted by society, you have to look great. And trans women [are] always pressured, so they need to come up farther than others.” Chip

added: “If I am beautiful, boys will treat me like a princess, but if I am ugly, they will see me as a clown or terrifying person.” Beauty is both a gateway to economic success as well as social belonging.

According to the ILO (2014:43), kathoey, as well as masculine-presenting homosexual women, called *toms*, face the most barriers to employment and discrimination in mainstream jobs. The report found:

Acceptance is high only in a few narrow, stereotypical spheres assigned to transgender persons, for example, in entertainment as cabaret performers or beauty pageants, in the beauty industry as make-up artists and sales in cosmetic department, and in a few service jobs such as public relations. They feel they have little or no place in public life and are excluded from mainstream jobs, particularly official and civil service jobs.

Bee affirmed this finding, stating that although she believed kathoey are good workers, they often “struggle to get a job in some fields, such as bureaucrats and other conservative jobs.” Mainstream or bureaucratic jobs are often deemed inaccessible by kathoey, especially those who do not easily “pass” as cisgender women.

Although the ILO report describes the “ghettoization of employment” for Thai trans women, who are often relegated to “stereotypical jobs” in the cabaret, as makeup artists, cosmetic sales, and public relations (ILO 2014:xiii), for some kathoey, even these jobs have barriers. Wan said: “When I applied for a job in one of the makeup companies, they said that if I’m kathoey they won’t accept me and I have to go to the main branch. So I was thinking if they [were] going to accept [me], why not at both places? And this made me feel really bad.” Wan’s confusion that one makeup store branch would not accept her demonstrates the uneven application of discrimination laws such as the 2015 Thailand

Gender Equality Act¹⁰, a law that Parcharin said has “yet to be extended and tested. The mechanism is still weak.” Thus, even in the “stereotypical” settings in which many kathoey work, kathoey might still be barred.

Similarly, while the cabaret websites emphasize full freedom of expression, for Fan, participating in a singing contest when she was younger proved painful, as the contestants were divided by sex. Fan said:

I remember once I was onstage dressing up fully like a girl, audiences were recklessly laughing at me. That is why I think that my gender hinders my singing talent and I opted not to continue on this path. It was my bad experience embedded deeply in my mind and created a phobia. I decided to give up [singing] and never return onstage again ever since.

While the beauty and entertainment industry might be seen as a space of acceptance for Thai trans women, Fan’s rejection at a singing contest speaks to a broader lack of acceptance for trans people. Even if kathoey are believed to be more artistic and creative than straight people, as Fin reported, kathoey have been cast as outsiders due to their genders, even in those roles or workplaces in which they are seemingly most accepted such as performance spaces or makeup stores.

Research has shown how social inequalities are also embedded in these Thai economic shifts, such as gaps in income. Glassman (2004:153) asserted:

The Thai economy has not experienced growing income disparity and socio-ecological problems *in spite of* rapid economic growth; rather it has these problems precisely *because of* rapid growth, and the Thai state has in fact made the very processes that produce income disparity and socio-ecological disamenities the cornerstone of its growth strategy.

¹⁰ The law prohibits discrimination against “persons whose expression differs from the sex by birth” (Winter et al. 2018:21). The Committee on Consideration of Unfair Gender Discrimination has seen six cases settled for trans people as of October 2018 (Winter et al. 2018:21).

This chapter demonstrates how such inequalities are particularly gendered and unique as technologies and medical tourism advance. While kathoey helped align Thailand as a destination for medical tourism and LGBT tourists, they still live in a social context in which “failures” of their own femininity or beauty have distinct and severe economic consequences. Even though kathoey symbolize Thai medical surgeries, and the country’s apparent openness and LGBT-friendliness, I now discuss how they do not always benefit from the reputation of LGBT diversity.

The Boundaries of Go Thai, Be Free

As opposed to narratives that the West is the source of modernity and queer liberation, Thailand is framed in dominant discourses as a “queer paradise” (Aizura 2011; Käng 2014), championed by the public image of kathoey. Yet research and activist networks have long complicated the “myth of the Thai gay paradise” (Jackson 1999). As the previous sections have described kathoey’s display work and pressures to access surgeries amidst broader employment discrimination, kathoey are also prohibited from public spaces due to broader discriminatory practices. Ali noticed these contradictions, stating: “It’s not until you stay here longer that you learn that there was a pride parade and the government shut it down.” While local LGBT activism has catalyzed new waves of LGBT political participation, kathoey expressed how they themselves are not treated the same as foreign tourists in public spaces. For instance, Jin, a beauty pageant winner who embodies dominant norms of sex, gender, and beauty was not allowed into bars because she is kathoey. She recalled a time when she visited Bangkok, stating:

When I go out or go to the bars, they check my ID and as soon as they realize that I am *sao praphet sorng*, they don't let me in... There are many places around Bangkok. You can absolutely check it out. I wish I could stand up for the *sao praphet sorng* to obtain equal rights. We also want to go out and be able to have fun just like other people. There are many places [that discriminate] like Sukhumvit and Khao San Road. I was just in Khao San the other day. I was just an ordinary tourist who wanted to go out but because I'm *sao praphet sorng* I was not allowed in the club... I was told that *sao praphet sorng* cause problems, quarrels, and fighting. That's what they said.

Jin experienced inequalities in local settings, as LGBT acceptance is afforded more to foreigners than Thais – even though she herself is a tourist visiting Bangkok from an outside province. Discriminatory beliefs about kathoey permeate public spaces, as Mo stated:

Perhaps, they might have experienced some substandard behaviors by transgender women which caused them a phobia against us and led them to escalate regulation with transgender women in particular. We do not even exactly know either. In order to nip something in the bud, they ultimately decided to forbid all trans people to be allowed inside their places.

Kathoey are forbidden from certain spaces, demonstrating how the Go Thai, Be Free brand does not apply to their experiences. San also specified that laws target kathoey, stating: “The fact is that all genders could be a troublemaker, but we, transgender women, were particularly discriminated.” The direct targeting of kathoey in public spaces demonstrates that they are not always free to appear in certain spaces.

While Thais might appear to welcome LGBT foreigners – as marketed in Go Thai, Be Free promotional videos with young Thai school-children high-fiving a gay couple – respondents also spoke to how being transgender was not accepted by Thai families. For instance, Dr. Wirun said:

I think at the moment for transgender people they are much more accepted by the Thai people in general than ten, twenty, thirty years ago. Although if you were

parents, you don't want your children to be transgender. Although you are open to others to be [transgender], but of course for your own [children], it's not very acceptable for parents.

Thai people may still exhibit negative associations in having transgender children. This demonstrates that dominant world-culture narratives – such as those of LGBT inclusion – are not always completely localized, even if they are picked up in state discourses for global consumers. On the one hand, LGBT diversity is advertised in Thai tourism campaigns and for medical tourists, yet it is also a detriment for local people in various settings.

LGBT acceptance is also gendered and classed. Ali recognized a hierarchy of foreign LGBT tourists – with gay men with money at the top of what she describes as the “totem pole.” She said: “As a gay man and someone with money, this is a home away from home.” The politics of LGBT exclusion was echoed by Patcharin, a founding Thai LGBT activist, who mentioned that the tourism industry caters towards wealthier white gay men. The company that creates Go Thai, Be Free marketing materials states that its ad campaigns target a particular group, including:

otherwise hard-to-reach audience of internationally-minded, men of achievement in their respective fields, who are constantly seeking inspiration. They are worldly trend-setters, opinion-leaders and early-adopters, looking for ways to complement their lifestyles. Like the community they're part of, they are mature, individual and adventurous men who naturally fuse both style and substance. Moreover, they have the means to pay for it, but expect exceptional quality and service in return.

The company's description addresses men, echoing the sentiments that LGBT tourism is mostly focused on gay men with designated spending capabilities.

Kathoey cabaret performers who traveled through TAT-sponsored initiatives – such as tours in other countries – also spoke about how they have issues more generally in airports when crossing borders. San said:

We also have problems in some countries at immigration procedures... the Philippines is also [problematic] but not too bad. In Indonesia, they looked at us and just like, ummm, not so good. But anytime we traveled with Thai Tourism Authority, we faced less problems. I think we traveled under some kinds of diplomatic immunity to some extent.

While the TAT may extend a form of “diplomatic immunity” to kathoey workers, kathoey do not regularly move through institutions such as airports with ease, only accessing this form of treatment when actively working for the state. According to San: “When I go some countries by myself or with my boyfriend like in Japan I got to talk with immigration officers. It takes me more time to explain with them, like passport is the problem... Here in Thailand they still [indicate the name title] so the immigration will be confused when I go to their country, [asking] like which sex you really are?” Kathoey’s legal identification cards pose issues as they travel, and demonstrate how openness and acceptance are not readily available when they cross borders.

The inequalities resulted from medical tourism and LGBT diversity campaigns resonate with other nation’s diversity campaigns, in places such as Beirut (Moussawi 2018) and Mexico (Cantu 2002). For instance, the discourses of “gay-friendly Beirut” have been complicated for marginalized queer people from Beirut, particularly those who are working-class or gender non-normative (Moussawi 2018:176, 182). Modernity and cosmopolitanism, it is argued, are represented by the openness to middle and upper class gay and lesbian tourists – and yet gay-friendly spaces are classed, gendered, and

racialized (Moussawi 2018:182). Government discourses of LGBT acceptance and incorporation are often based on consumerism and otherizing those who do not conform with dominant ideals of race, class, nationality, and gender (Moussawi 2018).

Resistance and Agency

Sociologists have long been concerned with questions related to the “structuring structures” of society (Bourdieu 1984:170) versus personal agency (Pitts-Taylor 2009), specifically in the domains of sex, gender, and health (Bird and Reiker 2008). The range of thought has been wide, perhaps encapsulated on one hand with Mary Wollstonecraft (1792) who asserted that cisgender women are socialized to beautify themselves in a societal prison. She wrote: “Taught from infancy that beauty is woman’s scepter, the mind shapes itself to the body, and roaming round its gilt cage, only seeks to adorn its prison” (Wollstonecraft 1792:58-59). Yet scholars have adapted a more fluid and flexible notion of agency, empowerment, and exploitation. For instance, in the context of supply chain capitalism, there are often overlaps between self-exploitation and external, or superexploitation, of laborers, who both demonstrate efficiency and provide labor at lower costs (Tsing 2009:171). Peterson (2011) spoke to the conception of agency for the Filipina transgender, or *bakla*, performers in the entertainment venue he studied. He wrote: “[F]or all of the agency that employment in Amazing Show may offer, performers remain situated in a transnational labor market where their skills and cultural competencies have value because they are inexpensive to purchase” (Peterson 2011:590). The global capitalist system makes available, naturalizes, and underpays the *bakla*’s role

as entertainers. Thus, there are tensions and contradictions in local agency in an era of national and global capitalist transformations.

Despite the pressured nature of employment in and outside of the entertainment industry, some kathoey were savvy about the possibilities to benefit from the system. Oom acknowledged that breast augmentation was important for her success on stage, but took a more pragmatic approach to these embodied demands: “I want to succeed in my life – get a house, car, and savings. Because we are transgender, we won't have children to take care of us when we are getting old... I will do everything to escape poverty. I don't want my life to be difficult in the future.” Working in the cabaret proved a viable option for Oom to secure a comfortable and financially-sound future.

For kathoey, passing as “real” and “beautiful” women and participating in the formal economy has become a means of resistance against discrimination, despite institutional barriers. For many interviewees, the entertainment industry has promoted a positive image of transgender women, and enhanced the lives of performers. This speaks to kathoey’s agency and resistance to use technologies of embodiment for personal fulfillment and economic and social capital. In addition to economic gains, the cabaret provided a sense of liberation and personal fulfillment for some by allowing kathoey to showcase their confidence and appearance. San underwent genital surgery, rhinoplasty, and breast augmentation as a cabaret performer. She said:

When I was young, my appearance was non-normative and strange compared to other friends of mine, which caused me to be bullied sometimes... Now, I stand tall in the middle of [the cabaret] stage surrounded by a round of applause from audiences... Though it was difficult sometimes, this is who I was meant to be and this is me.

San emphasized she was once bullied because her appearance was once “non-normative and strange” but she was supported by audiences and proud of who she is. Not only do kathoey find economic gains through the cabaret, but also experience greater social acceptance and exhibit resilience in the midst of challenges to be who they are “meant to be.”

More broadly, working in the cabaret or appearing in a beauty pageant was a means of resisting discriminatory stereotypes about kathoey, who were historically cast as jokers, sex workers, adulterers, and thieves (Pravattiyagul 2018:19; Interview Data). The entertainment industry also mediates stereotypes of Thai trans women, serving as a site of resistance and liberation. Despite Thai trans women’s “subjection to commodified notions of feminine beauty,” Jackson (2011:36) stated that Thai trans women have “skillfully manipulated the country’s mass media to promote positive images of their claimed feminine status and to achieve an increasingly recognized place in Thai society.” While this strategy of respectability has significant drawbacks as a strategy of liberation (Spade 2015), it nonetheless allows individual kathoey to survive or even thrive in their circumstances with a sense of dignity and economic possibility. Self-exploitation and superexploitation (Tsing 2009), or that which takes place from outside, can occur simultaneously. People using a technology can “challenge and renegotiate its meanings and materiality, adapting or domesticating it for use, and opening the way to divergent interpretations” (Wacjman 2000, as cited by Cross 2011:122). Kathoey sometimes find empowerment in the entertainment industry, and using technologies of embodiment offers a way to access work and social acceptance. Rather than romanticizing and

simplifying the idea that employment access is a human right, kathoey enter the entertainment industry in an unequal global economy. They uphold hierarchical norms of technologically-enhanced feminine embodiment and gendered labor, while at the same time, find both resistance and agency in this setting.

Conclusion

In the gendered technostate, people interact with various technologies that can “give gender” (Meadow 2011; Ward 2010) and “give sex” (Davis et al. 2016), processes that encapsulate how gendered embodiment – especially for trans people – are constructed through relational acts, and often medical interventions. As medical interventions and technologies expand through national policies and private industries, this chapter has analyzed the role of gendered technologies and gendered labor in catalyzing and sustaining medical tourism and the nation-state. It has shown the origins and implications of kathoey’s gendered labor on the interrelated projects of LGBT tourism and medical tourism. Kathoey performers are used to facilitate a dominant image of Thai femininity for medical tourists (Aizura 2009, 2010, 2011; Enteen 2014) and kathoey alike. They often perform aesthetic labor, or “the mobilization, development and commodification of embodied dispositions” (Witz et al. 2003:37) by embodying technologically-enhanced femininity. The organizational context of the entertainment industry – and increased growth and commodification of particular technologies of embodiment – informs the broader regulation and ordering of bodies (Hanser 2005; Otis 2011; Mears 2011; C. Connell 2010). Sex, gender, and beauty are therefore

“organizationally produced” (Mears 2014:1340) through both the entertainment industry and growth of medical tourism. Kathoey’s display work, as brands of technologies and LGBT diversity, demonstrates the “cultural economy” of medical tourism that not only involves rational price comparisons or shorter waiting lists, but also reflects the importance of “connected lives” (Zelizer 2005), or intimate social relations and networks embedded in economic actions (Guseva 2008). Medical tourism is a gendered cultural economy, intersecting with national policies, LGBT tourism campaigns, and private health industries, as it bundles the work of kathoey as surgical stars and symbols of LGBT diversity.

As technologies become increasingly commodified through medical tourism, gendered labor is also refashioned. This is a key element of the gendered technostate: technologies shape gendered labor, while gendered labor shapes the desirability and commodification of technologies. Kathoey are not just entertainers, but are also symbols of Thai medical technologies used to sell medical tourism and promote Thailand as a destination for LGBT diversity. The LGBT tourism campaign, Go Thai, Be Free, is linked to the medical tourism industry, as Thailand’s reputation for LGBT diversity helps boost its reputation for transgender medical tourists. This demonstrates the ways in which seemingly separate industries – medical tourism and LGBT tourism – are actually connected, as social ties and cultural processes – namely gendered labor – help constitute medical tourism.

In the gendered technostate, people interface with technologies – and in this case, use technologies of embodiment – in direct relation to their job outcomes, performance,

and economic success. Kathoey spoke to the ways they used various technologies – such as makeup, clothing, Botox, hormones, or breast augmentations – to meet certain standards of sex, gender, and beauty, as well as perform work in and outside of the entertainment industry. The findings suggest how binary norms of sex, gender, and sexuality are imbued in and shaping workplace experiences for transgender, gay, bisexual, and lesbian people (C. Connell 2014; Schilt and Connell 2007). These norms limit kathoey’s economic and aesthetic possibilities, and also contribute to the global medicalization and pathologization of trans and nonbinary people, reinforcing binaries of gender that do harm to trans, nonbinary, and cisgender people alike.

What is particularly insidious about this process is how it naturalizes narrow gendered possibilities and puts the responsibility for achieving this rigid standard of beauty squarely on the shoulders of kathoey themselves, many of whom struggle to get by. For all the wealth they bring into Thailand, kathoey are rarely wealthy themselves, yet they are expected to find the money for surgical procedures. The “winner take all” (Mears 2011:4) entertainment industry facilitates the illusion of wealth and LGBT acceptance through kathoey celebrities, while masking the minimal earnings of the vast majority of performers, and the employment discrimination experienced by kathoey more broadly.

This chapter has also shown how state investments in medical tourism and Go Thai, Be Free incorporate and constrain kathoey’s gendered labor and embodiment. It has elucidated kathoey’s role in promoting Thailand’s reputation as LGBT-friendly, thereby advancing both the medical hub and the nation-state’s Go Thai, Be Free initiative.

Kathoey's relationships to labor and technologies demonstrate how transnational health flows coalesce in local people and their labor, highlighting a political economy of transgender (Irving 2008) connected to national markets for technologies, as well as the various inequalities and resistances that arise in the era of medical tourism.

The gendered technostate sheds light on fundamental sociological concerns about how the state extracts value from technologically-enhanced bodies, and how people become seen and legitimized by achieving certain standards of sex and gender – both in and out of the workplace. In the case of kathoey, limited economic opportunities and the expectations of the entertainment industry shape and constrain shared understandings of acceptable embodiments of gender. By ascribing agency to and contextualizing the use of technologies – whether scalpels or makeup – the gendered technostate affords a more nuanced perspective to how gendered embodiment is augmented through technologies in the workplace, contextualizing where, how, and why such technologies have emerged through both national policies and private industries. In the next chapter, I examine how kathoey's experiences with health and health care have shifted within the context of medical tourism, explicating the health inequalities that emerge in the gendered technostate.

CHAPTER THREE: Transnational Health Flows, Local Inequalities

One of Thailand's largest islands is home to several internationally-accredited hospitals and clinics, and Dr. Somchai, one of the first gender surgeons in Thailand. Dr. Somchai was trained by Dr. Preecha Tiewtranon, the first gender surgeon in Thailand, who first performed surgeries in a public hospital in Bangkok. In a taxi from the airport to the hotel, I drove past a van that was plastered with an advertisement for a world-famous kathoey cabaret show located on the island. The mobile billboard travelled down the tree-lined highway, a reminder of how kathoey's display work is conducted even off the clock.

Dr. Somchai works in a multi-million dollar plastic surgery center owned by one of Thailand's largest private hospital networks. Of around 2,000 patients a year, the clinic sees 60 percent arriving from Europe, America, Australia and New Zealand, and 20 percent from within Thailand – the remaining percentages, a staff member told me, have not been calculated. Forty-five percent of the patients utilize a medical tourism agency to book their services, demonstrating the role of facilitators in providing almost half of the clinic's patient-tourists. As surgeries have become a globalized medical commodity through the expansion of medical tourism, what are kathoey's experiences with health care and medical technologies, in both public and private settings, as medical tourism has expanded? How does the gendered technostate – with its emphasis on technologies and technologically-enhanced gendered labor – impact embodied health outcomes for various people?

This chapter demonstrates the implications of national policies that expand medical tourism on the local accessibility of health care and medical technologies, underscoring the distinct impacts for local transgender people. It develops a *sociology of trans-national health*, a framework which accounts for how global political and economic conditions transform health and health inequalities for people across lines of sex, gender, and nation. The approach is twofold: it is inclusive of people beyond binary categorizations of sex and gender, while also attentive to transnational flows, mobilities, and movements within and beyond the nation-state. The sociology of trans-national health allows us to “decenter the nation as a primary site of identification” (Ochoa 2014:13), by showing how regional and transnational flows circulate within and beyond a nation’s borders. As the nation is comprised of “multiple spatialities and temporalities” (Sassen 2000:215), the sociology of trans-national health incorporates a transnational lens to highlight “the changing roles and nature of the state” as it relates to health care systems, access, and outcomes (Zanini et al. 2013:10).

The chapter begins with a historical account of the growth of medical tourism, followed by an analysis of internal brain drain and the “crowding-out effect” on kathoey, and accounts of their experiences in public health care settings. This is then followed by an analysis of the international norms related to transgender embodiment that are instantiated through medical tourism. I then address how gaps in global transgender health data manifest in medical uncertainty, developing the concept of *invisibilized uncertainty* to situate how missing global health data and epistemic hierarchies influence clinical encounters. The chapter analyzes the impact of invisibilized uncertainty not only

on health care practices, but also on universal health coverage (UHC). It parses out elements of kathoey's self-stigma, and demonstrates how transgender health care activism and resistance take place, ending with the implications of the case for research on health and health care amidst globalization. The chapter thus demonstrates how national shifts in technologies and gendered labor, which characterize the gendered technostate, have significant impacts on health outcomes for local people.

The Waves of Medical Tourism

As I walked into Dr. Somchai's plastic surgery center, I couldn't help but notice my own reflection gleaming onto the immaculate floor. Recessed lighting created a warm atmosphere unlike any hospital I had visited before – a calmer and more sophisticated tone than the standard fluorescent bulbs. A concierge desk, which hovered in the center of the large lobby, was peppered with fliers about procedures, and guidebooks on local attractions. I was approached by an employee who wore a business suit, nametag, and a smile. She asked me where I would like to go and knowingly handed me a bottle of water as I shuffled through my paperwork. Whisked to the elevator, I arrived in the lobby of Dr. Somchai, where I was almost instantly greeted with breasts.

Breasts. There were silicone and saline breast implants placed on every table for one to paw, press, feel, and examine. I spent what I deemed an appropriate amount of time surveying the devices, until picking up a copy of the hospital network's own publication. The cover featured an image of a white woman with eyes closed, and black dashed lines drawn across her chin, mouth, and cheek. A white-gloved hand held a

marker, completing a dashed arch over her left eyebrow. The woman's face was complacent, her mouth neither curved to a smile nor a frown. Perhaps she was already anesthetized, sleeping, imagining and accepting the marks drawn by the detached, glove-bearing hand. The publication featured mostly English articles, with a few written in Thai, including topics about cosmetics, online shopping, and cardio exercise. My own curious consumerism piqued as I started to Google the holistic health benefits of cordyceps capsules, a mushroom derivative featured in an advertisement. Before I could click "Purchase," Dr. Somchai appeared before me wearing a white coat, his hands interlaced in front of him.

I had read reports about Dr. Somchai published on his website, which described his bedside manner and positive demeanor. Seated in his light-filled office with lush green trees outside the window, he first told me how he began in the field of gender-affirming surgeries as a medical resident in 1987, when he trained with Dr. Preecha at the public health care setting of Chulalongkorn Hospital. To continue practicing surgeries, he moved in 1991 to the island because, he said:

[It] is a tourist destination, like Pattaya or Bangkok, so there is a transgender community who is gathered together to do their career – to do their job in the entertainment business – this theater full of transgender [women] packing together. And they're a very good show, elegant show. I think [the cabaret here] started at the same time, or maybe one year before, I moved [here] – so there is a demand for surgeries among Thai transgender [women] living [here].

Relocating to the island, where he said a high concentration of kathoey lived and worked in the entertainment industry, allowed Dr. Somchai to first practice gender-affirming surgeries. He mentioned the "elegant" quality of Simon Cabaret, subtly differentiating the performances from sexualized entertainment – a theme I discuss in the next chapter. With

kathoey entertainers as his initial client base, Dr. Somchai recalled that there was no legal regulation at the time on gender-affirming surgeries, or medical requirements to qualify for surgery. Using his own discretion, he said he performed around 60 surgeries a year on kathoey, working with the techniques he had learned from Dr. Preecha.

Dr. Somchai described what he calls the “waves” of medical tourism, and his distinct place in the arc of cascading events. The first wave of medical tourism, he asserted, started with foreign patients visiting Dr. Preecha for gender-affirming surgeries. “Medical tourism originates with sex change,” he told me bluntly. Dr. Somchai continued: “This is the truth – this is the fact – and I’ve seen this evolution.” Two major factors emerged: the 1997 Asian Financial Crisis, and the introduction of the Internet in Thailand in 1998.

Before the 1997 Asian Financial Crisis, Dr. Somchai explained that foreigners seeking gender-affirming surgeries visited Dr. Preecha at Bumrungrad Hospital. “After Dr. Preecha, then it’s me,” he said, explaining what he calls the second wave of medical tourism. Before the Internet was introduced to Thailand in 1998, Dr. Somchai said that “very few” foreign transgender women contacted him for surgeries, who may have learned about him from their peers and word of mouth. Dr. Somchai said his services became part of a larger strategy of a hospital executive to attract foreign patients:

I was advised by the director of this hospital to launch my own website about plastic surgery to offer to the foreigners to come – either the general cosmetic surgery or gender reassignment surgery. My website started on January 1, 1998 and was the first medical website in Thailand.

Dr. Somchai recalled that six months after launching his website, the first Swedish patient contacted him for surgery. “That was the start,” he said. “Then people contacted

me through the Internet, through my website, and the longest waiting list of mine at that time was two years.” Most of his patients, he said, came from the United States or Japan at this time.

In 2002, Dr. Somchai said that state officials from the MOPH and provincial health offices held meetings with him and hospital executives, inviting media along to publicize his practice.

When I start to offer [surgery] for foreigners, during the Thaksin government – Thaksin, like every ministry, has a strategy to bring business back to Thailand. Also, the Ministry of Health at that time came to visit. They have a policy that if anybody or department related to Ministry of Health have any strategy to improve the economy of Thailand – especially to draw more foreign currency to Thailand, to let them know. So at that time, the Chief of the provincial health office came to see me and ask me to give some interview about [surgery] that I offer to foreigners and offer [the interview] to the Ministry of Public Health in 2002.

The media interviewed and observed Dr. Somchai, who said he made headline news. “Oh, it’s like a bomb,” he recalled, expressing the beginning of the global demand for gender-affirming surgeries in Thailand.

Medical tourism emerged in Thailand from local, regional, and global conditions. It is, as MOPH official Dr. Van said, a “home-grown industry,” developed from government policies and local actors. While economic analyses (Wong et al. 2014) might focus on mostly external consumer demands (e.g. Western or wealthy patients), medical tourism in Thailand began from local people’s demands. How, then, does medical tourism impact local people’s health outcomes? I now discuss aspects of internal brain drain and the crowding-out effect on kathoey.

Brain Drain and Crowding Out

Medical tourism has been shown to cause an internal brain drain in destination countries, or a movement of health care professionals from the public to private health care sector, typically for higher wages (Pocock and Phua 2011). Civil society members, state officials, and health care providers all expressed concern about medical tourism, particularly its internal brain drain effects. According to Dr. Arun, a gender surgeon in a public hospital who also performs surgeries in the private setting:

Thailand is not a well-developed country. Our people still need doctors, nurses to take care of them. If you're talking about medical tourism, you have to spend tons of money on the doctors to take care of [medical tourists]. What about your country? What about the Thai patients? So, it means you need more doctors, you need more nurses, you need more medical personnel in this field.

According to Dr. Arun, medical tourism has put a strain on the number of doctors who take care of local people. He conceded: "So anyway, it's the way of our world, so now we need more doctors." Dr. Arun spoke to the trend of "doctor-poaching" (Cohen 2011:185), which typically refers to the medical migration of health care workers from developing countries to those more resourced. However, in Thailand it speaks to a process in which private hospitals will pay back doctors' medical school loans so they do not have to do mandatory service in the public sphere, particularly in rural areas.

Wattana, a Thai publisher of a medical tourism magazine, further described doctor-poaching, stating: "The secret of the success [of medical tourism] is you grab all the doctors at all costs... [Private hospital executives] are starting to recruit - they recruit from the rural areas." He went on to impersonate the negotiation between private hospital executives and doctors, playing the role of the hospital executive. He said:

‘Don’t work for rural [areas] far away from your family. Live in Bangkok. When you live in the rural [area], you work in the border – your wife suffer, your children suffer, please come to Bangkok Hospital, come to Bumrungrad. I pay off your debt. How much you owe them? I pay them back. You work for me, I pay you double what you earn now.’ So they move. This is a bad strategy of the hospital owner, but they are still doing it legally [laughs]. Legally... See? And you make money.

Doctor-poaching by private hospital owners results in issues related to local access to health care, particularly for Thais in rural areas seeking specialized services. Wattana reflected on these disparities:

But what happens if you are living on the outskirts in poor provinces and you have a heart problem and you need operation? There’s no place for you. If you have a heart problem and you are poor, you queue up. The doctors here, especially the heart specialists, they serve international patients - they don’t serve Thai. We take good care of the international patient. Take your time, spend your time in the government hospital for a morning – Siriraj, Rama [Hospitals] – you see my people suffer, queue up... We don’t have that much heart doctors in this country. We have enough, but most of them have been moved to serve the Arab patients, the Myanmar patients, the rich Chinese. So we don’t have heart doctors left for our people.

Wattana asserted that heart specialists might no longer serve rural people, instead choosing to work with international patients. Although private hospitals have developed foundations to offer heart surgeries to rural people to close some of the gaps in access, there remains concern about local access to such care.

But how does an internal brain drain then impact kathoey, specifically? With international demand for gender-affirming surgeries increasing as a result of media publications, his website, and initiatives from state and private hospital executives, Dr. Somchai said he went from first performing 60 surgeries a year on kathoey to 100 surgeries a year on foreigners. This reversal of clientele, from Thai to foreign transgender women, is emblematic of a larger trend toward catering primarily or exclusively to

medical tourists. In a study of six Bangkok clinics offering gender-affirming surgeries, the number of foreign patients undergoing the surgeries increased from 5 percent between 1985-1990 to 90 percent in 2010-2012 (Chokrungruanont et al. 2014), signaling the way in which foreign clients crowded out the local market, as medical tourism policies ensued. Similar to what Dr. Somchai shared, other research has found that the initial Thai patients at gender clinics were kathoey cabaret performers, who first requested procedures from local doctors and spread word about services during their travels or migration (Aizura 2009; Chokrungruanont et al. 2014; Wilson 2010).

Within his luxury plastic surgery center, Dr. Somchai explained that his prices have changed dramatically from the time he began offering surgeries to kathoey in the 1990s until the present. He smiled as he recalled: “I remember in the beginning we charged patients, about 20 years ago, probably [\$2,000], and right now it’s about [\$12,500].” The price increased roughly 400 percent over a time spanning the Asian Financial Crisis, during which the value of Thai currency plummeted. With his patient population reversing from Thai people to foreigners as the costs of his surgeries skyrocketed, I asked him where kathoey can access surgeries now, if not at his clinic. His answer was immediate and straightforward. He told me: “Then they go to cheap surgeons, like Dr. [Bank] at [Nuun] Clinic. There is a handful of Thai plastic surgeons and general surgeons who offer very cheap [vaginoplasty]... They offer simple [vaginoplasty] at a cost like [\$2000].”

I was surprised by his unfettered utterance of Dr. Bank at Nuun Clinic. These were proper nouns I had learned that many wanted to avoid. I had read about Dr. Bank’s

notorious lack of safety standards from international news reports, and had pored over the clinic's one-star reviews on Facebook, which describe the place as "run-down" and a "mortuary." Wattana told me he had denied the clinic's request to be featured in the publication, refusing to sell them space for an advertisement because of the clinic's extremely poor quality. "It's a hell," he warned me.

I had decided to wait until just about the end of my fieldwork to visit Nuun Clinic back in Bangkok. Perhaps it would have been more helpful to visit earlier and note any immediate contrast between Dr. Somchai's clinic. Yet, with many interviews and site visits remaining, I had a sort of prescience that spending time at Nuun Clinic might have somehow filtered the rest of my interactions, observations, or experiences in Thailand. I was both trying to forget the descriptions I had heard and "clear my bias," and also readying myself to face an anticipated disparity. For whichever reasons, and for better or worse, I waited.

Nuun Clinic is located on a busy four-lane street in central Bangkok. Its front door was adorned with a poster for a kathoey beauty pageant, signaling its formal sponsorship of the famous event. Inside the clinic waiting room, 12 people were seated when I arrived, while a Thai soap opera played on a television screen. At the front desk were three people behind large stacks of paper; they did not look up when anybody entered the clinic. The walls were covered with several more beauty pageant posters and a poster of four kathoey flight attendants for a now-defunct Thai airline that became

known for its trans-inclusive hiring practices. In case one had any doubts, the posters made clear that the clinic has molded the embodiment for kathoey in prominent labor roles.

In the waiting room, there was a large fish tank filled with yellow-hued water. I seated myself. I did not notice any interactions between staff and people in the waiting room. I did not see patients being admitted or discharged. Those in the waiting room were on their phones, bringing one another food from outside street stalls, and talking. The fish kept swimming.

Kitti, who had breast augmentation and testicle removal at Nuun Clinic, spoke to how the clinic did not use anesthesia. She said: “For this clinic, they don't use sleep anesthetic but use sleep [medication] and [topical numbness] anesthetic mixed together. Because if we use complete sleep anesthetic, we need to wait for an anesthetist. It wastes time. And there is no admission. We just have two hours of recovery.” Nuun Clinic’s lack of anesthesia use was also reported by international news reports, which stated that Dr. Bank “uses local anesthetic and sedatives [ketamine, propofol and morphine] to block the pain from the two-hour surgery he performs in a cramped room in his Bangkok clinic.” According to the report, his “no-frills approach” to gender surgeries includes one night’s stay in a recovery room, and a walk down three flights of concrete stairs the next day. The typical hospital stay after vaginoplasty is 21 days of bedrest. The services offered at Nuun Clinic demonstrate that although gender-affirming services is not regulated by the state: “[T]here is a shortage of highly qualified surgeons able to do some procedures such as vaginoplasty and phalloplasty, particularly outside of major urban centres”

(Mamoojee, Seal, and Quinton 2017:244). In contrast to the 66 internationally-accredited health care facilities in Thailand, a handful of kathoey with whom I spoke had mentioned their experiences with botched surgeries and “handbag doctors” – or those who practice in unregulated spaces.

Kathoey’s negative experiences are contrasted with those of Kali, a transwoman from New Zealand, who traveled to Thailand for genital reconstruction, breast augmentation, and five facial feminization surgeries, and said her experience was very “positive.” She recalled: “Thailand is so much better [than Australia, where she also had surgeries] when it comes to aftercare because they really take care of you during recovery... Once I left the hospital I had a nurse visit me daily to check up on me, change my dressings and to help me out with anything I needed.” Transgender medical tourists in Thailand are said to receive the “Rolls Royce treatment” in private clinics, as kathoey face difficulties accessing basic culturally-competent health care, sometimes seeking surgeries in “shop-houses,” or rooms rented in hospitals (Aizura 2011:143, 150). Nuun Clinic is just one example of a clinic with questionable (at best) safety practices and low-cost services. In comparison to other health care facilities, especially those which are internationally-accredited, it represents the gaps in kathoey’s access to basic levels of quality procedures – such as the use of anesthesia, time for bed rest, and appropriate follow-up care.

The issue of unregulated clinics affects cisgender and transgender people alike, both foreign and local. According to a 2013 article in *The Bangkok Post* (Thepbamrung and Ruffles 2013), around 20 to 25 unauthorized beauty treatment operators, or

“backroom clinics,” have been arrested annually over the past few years. For Jin, a beauty pageant winner, the growth of medical tourism and expansion of gender clinics in Thailand has had its pros and cons, as it results in varied tiers of quality care. Jin said:

The good thing is there are many options [for gender surgeries] to choose from. The bad thing is lots of time the surgeries have gone wrong. Since there are many clinics, they are very competitive and become less responsible because they care so much about making a profit.

As Jin remarked, the number of gender clinics has expanded with the growth of medical tourism to include some clinics which are “less responsible,” citing the negative factors of health care commodification. As health care becomes increasingly privatized and marketized, kathoey’s experiences with “less responsible” and “very competitive” clinics demonstrates that medical tourism does not just create a “brain drain” of medical personnel from the public health care sector to the private, but also creates various tiers of quality services within the private sector. Through medical tourism, there emerges not only quality divisions between public versus private health care, but also different quality tiers of private health services, as well.

Combined with the lesser quality of services and facilities, some said that the interactions between health care providers and patients is also compromised in settings such as Nuun Clinic. Nin, who went to Nuun Clinic for breast augmentation, said: “The customer relations is very bad... I think the nurses are too harsh... The words they use and attitude they show are too harsh. I just feel hurt while you speak to me badly... Hey, you should treat me better, shouldn’t you?” In an era of medical consumerism, doctor-patient relationships are transformed (McKinlay and Marceau 2008:229), as some have argued that there is an “erosion of Buddhist compassion” in Thai medical practices as

commodification has increased (Lindbeck 1984:24). Medical tourism and the increased growth of clinics, serving both Thais and foreigners, may augment health care interactions and services received.

Riki, an LGBT health advocate who studies public health, affirmed that as health care consumerism increases, personalized care will decrease – not just for kathoey and trans people, but for all Thais. Riki said: “If the doctor is seeing 100 patients an hour, they won’t care if you are a man or woman. They won’t even look at your face because they won’t have time for that.” With medical tourism increasing demands on doctors in the public sector as a result of doctor-poaching and brain drain, personalized care has the potential to diminish further in medical tourism destinations.

With these changes, Dr. Wirun, who works in the public sphere and as a health researcher, said that doctors in the public sphere may try to distinguish their work from commodities. He said: “We do not provide services. We provide medical care... ‘Health services’ creates a feeling of buy and sell and business sense of the word. It makes many physicians not happy with that.” Dr. Wirun draws out the linguistic differences between “health care” versus “health services,” signifying how public services such as health care “are seen merely as products to be sold which the private sector can deliver better” (McGregor 2001:6). Dr. Wirun added: “Once you commercialize health care, it changes people’s expectations. Once their expectations are changed, conflicts happen because instead of compassion and caring, it becomes buy and sell. When you buy, you want to have what you should get.” In this regard, through medical tourism “[c]itizens are consumers who should have the choice to buy the best health products they can afford”

(McGregor 2001:6). According to Patcharin, a founding Thai LGBT advocate, the “golden time of people-centered health care is already passing.” Patcharin referenced “more manipulation from the pharmaceutical industry” as taking precedent before LGBT rights in health care.

Dr. Kan, a CEO of a large private Thai hospital that is a forerunner in medical tourism, reflected on health care commodification, stating that the issue comes down to quality. He said: “We don’t provide a commodity, we provide high quality health care. Products, packages, pieces of individual technology: I don’t think that sells. Especially with Thais. They like to feel good... that’s hard to capture. It’s like a Volvo car.” When I asked him to clarify, he explained that a Volvo car does not stress a fancy exterior, but focuses more on interior reliability. On the one hand, health care is not a commodity, but at the same time it can be likened to a Volvo product.

Rather than simply a two-tier service between public and private sectors (Pocock and Phua 2011), kathoey’s experiences at Nuun Clinic and backroom clinics demonstrate the spectrum of health facilities and services available in Thailand, for cis and trans people, as medical tourism expands. Nuun Clinic reflects the proliferation of new tiers of private health care services, and the sharp contrast between them. Using the lens of transnational health, the case demonstrates how global shifts in health care delivery – through medical tourism, specifically – have impacted the availability and affordability of quality health care services (particularly specialized care) for local people. I now turn to how gendered public health inequalities persist for kathoey, as government and private resources are devoted to medical tourism.

Public Health Care Inequalities

I was seated at a high-top table at one of Bangkok's many Starbucks with Patcharin. We were meeting on an especially humid afternoon before an LGBT rights event for gay marriage, which would be held at the Embassy of the Netherlands.

“Would you like some *kanom*?” Patcharin asked, passing me some of the pastries and desserts she had ordered. Patcharin began to describe the health inequalities for LGBT people in Thailand, asserting that binary norms of sex and gender, and heterosexual assumptions, undergird health care interactions between doctors and patients. Health care in Thailand, she said, is:

similar to other institutions that do not recognize more diversity in the people – so they assume people to be men or women and to be heterosexual, and most people who don't fit those criteria are trying to find their ways to go about in the health care, and other institutions, as best they can. But sometimes they run into some humiliating experiences.

Among the humiliating experiences, Patcharin described doctors putting their hands in the pants of toms, grabbing their genitals to ask if they are a man or woman. “These things happen,” she confirmed. She continued: “There are stories of transgender women [in hospitals] who were refused to join female wards and refused to join in men's, and put in the corridor because there is no ward to go to.” I saw tears well up in Patcharin's eyes. She looked out the window to the motorcycles buzzing past on the street outside, and then looked back at me, stating: “When these things happen, they are out of sight by their communities and [happen] when you're most vulnerable – so people can't defend themselves or get services.” The binary structural setup of hospital wards and

interpersonal relations that take place between doctor and patient are key areas of inequality for people who are not cisgender. Patcharin also referenced “vulnerability” in the health care setting – a category that is rather ambiguous, and one to which I will return later in this chapter.

The sex and gender binary is concretized in public hospital infrastructure that divides male and female wards, which proves inadequate for Thai transgender people. Som spoke of her experience sleeping in a male hospital ward a decade ago. She said: “At that time, my hair was very long, so people just stared at me and my name tag because my title is ‘Mister,’ but I look like a girl. And people interrogated and laughed at me a lot...” Som experienced treatment as a male and recalls negative feedback from others in the health care setting.

Since Thai transgender people cannot change their legal identification cards to reflect their genders, several kathoey mentioned it was embarrassing that they were called “Mister” in hospital outpatient waiting rooms, even though they identify, and often present, as women. Fai, an LGBT advocate, also described her experiences as kathoey in outpatient departments of public hospitals:

I dress up as a woman, and I am a woman, but at the outpatient department they call the title of your name in front of 100 or 300 people. Have you ever been to a government hospital at 6am and 200 people are lined up very crowded? And if you are transgender and they call “Mr. Fai, Mr. Fai,” and you have to show up and you walk to the counter and the announcer keeps saying ‘Mister,’ and you have a very big disagreement... And nobody wants to face that kind of situation. So if you feel sick, you take self-medication and buy medicine over the counter in the drugstore and it doesn't fit to your symptoms.

Facing embarrassment and confusion with their legal identification cards, Fai stated that some kathoey might avoid public hospitals altogether and instead treat, and possibly mistreat, their symptoms on their own.

Health care professionals may also demonstrate implicit or explicit biases towards kathoey and transgender people more broadly. Dr. Wirat, a senior official at the Ministry of Public Health, expressed that Thai society does not completely accept transgender people because they are “different from nature.” He explained:

We are quite open in that we can accept transgender or perhaps MSM or homosexuals - now it's getting more and more publicly accepted in Thailand... It's not illegal. They are allowed to be... But I will say that for the perception of Thai people it's sometimes they feel it's not natural, I mean that its totally different from nature. I mean so it means that they still can't accept the transgender so this is one thing that I think this is the problem for the transgender.

Dr. Wirat captured in so many words the vast complexity and multiple layers of LGBT “acceptance” in Thailand. On the one hand, he said Thai people are “open” and “can accept” transgender people, but that they also think it is “totally different from nature” and that they “can't accept” them. These beliefs at the health policy level have the potential to trickle down to health services for kathoey and trans people.

Similarly, Dr. Wirun said that while private hospitals can be more “openminded” towards kathoey, the public healthcare system might not be as prepared to handle trans diversity due to beliefs about how kathoey behave. He explained: “People can be conservative on this. They don't want this group of trans people to come and then act weird – acting *kikikikiki* [makes loud noise] – in patient wards sometime.” Dr. Wirun emphasized his beliefs about how kathoey might (mis)behave in health care settings, which may then cause practitioners to be “conservative” about treating them. Taken

together, Drs. Wirun's and Wirat's comments elucidate how stereotypical beliefs of kathoey's personhood and conduct might become institutionalized in health care settings. I also return to the theme of kathoey's behavioral norms in the following chapter.

With health care practitioners and policymakers expressing negative beliefs about kathoey, kathoey themselves experienced distinct difficulties in the health care setting. Som said that she was refused care by nurses several years ago due to her gender, stating: "When I was 20, I had a severe car accident.... The nurses asked me to take a shower and wash my hair by myself. Despite my open forehead, they still insisted on denying my request for help." When female nurses wash female patients and male nurses wash male patients, they would not care for Som because she is kathoey. Refusal of care, as well as mistreatment, also occurred for others. Sunny, who was also hospitalized for a severe car accident, said that she was "not that satisfied" with the medical checkup procedure or medical treatment, as doctors were "treating me as a male patient rather than female."

Sunny added:

When I had to be washed up, for instance, they were slightly reluctant whether a male or female nurse needed to handle the task in order to look after me. Then they decided to ask my parents to be responsible for this task instead of themselves. Another example occurred when I got my upper abdomen x-rayed, the male nurse told me that I had to be strong and masculine, as my physical body still looked like a straight guy.

Similar to Som, Sunny encountered nurses who refused to bathe her, leaving the task to her parents instead. Sunny also interacted with health care providers who did not validate her gender identity, as she said she was also treated as a male when receiving her x-ray, with a male nurse stating her body still looked male. At best, her experience reflects a lack of clinical and cultural competency; at worst, it demonstrates discriminatory beliefs

and practices about sex and gender (e.g. that bodies born male be “strong and masculine”) that undergird health care treatment and interactions for Thai transgender people.

Fai spoke to how the sex and gender binary can dissuade kathoey from seeking care in public health facilities. Instead, Thai transgender people with the necessary financial resources may opt to pay more for a suitable experience in the private sector.

She said:

The binary opposition of gender categories affects medical doctors and medical services - separate male buildings and female building - and trans [people] face difficulties because they don't fit in those boxes. Trans [people] don't want to access medical services because they know from word of mouth what they have to face - they don't want to go to [a public] hospital. And that is a barrier because [at a public] hospital, maybe they pay less and they can also use health insurance, like 30 baht, but they don't want to go, and they have to pay more at a private clinic because they don't need to wait at outpatient department.

According to Fai, kathoey might avoid seeking care in public hospitals due to the negative experiences they experience or hear about through word of mouth. If they can afford it, they may even opt to pay more to go to a private health care setting where they will have access to their own room and won't have to face issues in the outpatient department.

Nan echoed that access to economic capital determines whether kathoey can afford trans-inclusive health care in private settings, saying:

It seems that if you don't have money, you will get less choices and another kind of treatment from hospital staff. I think it is because the system, that if you have more money, you get a special room, and you can have more privacy. But if I don't have money, I need to stay in a normal room with a bunch of patients, and face the binary gender system. So it is about how much money you have. If you don't have money, you need to wrestle with these kinds of problems, such as staying in a male ward or [facing] discrimination.

Nan emphasized that Thai transgender people must pay extra to receive basic clinically- and culturally-competent health care, encapsulating a core element of the inequalities that arise along with health care privatization, commodification, and medical tourism. Paying extra for trans-inclusive private health care demonstrates a core gap in the public health care system as far as transgender inclusion. Transgender or cisgender, foreign or Thai: those with greater financial resources can opt out of the public health care system if they have the means to do so.

Dr. Wirat acknowledged that the lack of clinic and hospital wards for transgender people is a distinct issue in the public health care setting. He stated:

I think the system is quite - it needs sometimes to change. For example, the inpatient wards, we have only male and female ward for our patients and if you are transgender sometimes it's difficult for the health care provider, for the nurse, for the doctor - which ward should we put patients in, either male ward or female ward.

While MOPH officials such as Dr. Wirat were aware of the fact that hospitals that do not have proper rooms for transgender people, policies have not yet been implemented to amend this.

The sociology of trans-national health assesses shifts in the delivery and availability of health care in a global context, paying particular attention to how this impacts people across the sex and gender spectrum. To paraphrase Foucault (2002), medical tourism leads to the birth of new clinics, and results in increased divisions in public and private sectors. Within the gendered technostate, national initiatives to expand technologies and medical tourism have transformed health care settings and practices, as local people with less financial resources lack access to the same level of specialized care

as foreign or wealthier counterparts. I now analyze the international bureaucratization, or “iron cage,” of transgender medicine in Thailand, an instance of how dominant global norms have manifested in local settings because of and alongside medical tourism.

The “Iron Cage” of Global Transgender Health

International guidelines on transgender health demonstrate the adoption and diffusion of dominant norms which categorize and classify sex, gender, and sexuality. With coding and classification necessary for trans and gender non-conforming people to access health care services and qualify for insurance reimbursements (Spade et al. 2010), the trend reflects “the diffusion of biomedical categories” in nonwestern countries (Conrad 2005). Medicalization is seen as an extension of Weberian rationality, wherein human experience is dissected and classified (Hillier 1987). Biomedical modernity is characterized by the increasing role of calculation and control in social life, demonstrating an “iron cage” (Weber 2009) of medical bureaucracy. The “global regulation of medical and health knowledge” (Broom and Adams 2016:2) manifests in input-output approaches such as coding and classification (Timmermans and Oh 2010). This section demonstrates how the global commodification of gender-affirming surgeries through medical tourism incorporates internationally-standardized health care practices in local settings. This creates an “iron cage” of global transgender health, which is built upon Western norms and dominant international guidelines.

In order for Thailand to become a trusted destination for gender-affirming surgeries, Thai doctors have utilized diagnostic and classificatory definitions from the

World Health Organization (WHO), World Professional Association of Transgender Health (WPATH), International Classification of Diseases (ICD), and American Psychiatric Association. While the new WHO guidelines have shifted the classification of “gender identity disorders” to “gender incongruence,” to be located in the chapter on sexual health rather than mental health (Knight 2018), international medical guidelines have delineated specific criteria for transgender people to access hormone therapy or undergo sex and/or gender reassignment surgeries, with diagnosis necessary for approval and insurance reimbursements throughout the world. Thai doctors employ psychiatric, endocrinological, and surgical knowledge emerging from these dominant institutions, and in 2009 the Thailand Medical Council began to regulate gender-affirming surgeries such as vaginoplasty with a policy that defined age requirements and necessitated psychiatric approval. The MOPH previously revised the ICD-10 to better code and classify Thai diseases, including transsexuality (Reed et al. 2019). Scholars and activists have argued that global medical institutions and discourses such as the DSM have constructed particular narratives for transgender people to uphold in order to be “treated” so they can assume the sex/gender with which they identify (Spade 2006). Through medical tourism, these norms are distributed to foreign patients across local settings, resulting in an international iron cage that impacts trans embodiment worldwide.

Scholarship has also pinpointed the role of medical “gatekeepers” in overseeing what they deem are necessary benchmarks for trans people to access services:

“Gatekeeping creates a structure that asks for trans clients, and providers, to slow down the process of initiating medical interventions” (Shuster 2016:328). Providers’ own

opinions of gender structure their decisions and clinical encounters regarding who is the right candidate for surgery, and broader “guidelines for trans healthcare cast light on providers’ assumptions surrounding gender” (Shuster 2016:322). Aspects of clinical gatekeeping were evident when Dr. Arun described what makes a good candidate for surgery. He explained:

I think we have to choose carefully the right one. Sex is something complicated... You have to find the right person who really wants to change from man to female. He most really wants to be a female. That’s a good candidate for surgery. [People] in between – I’m not so sure.

Dr. Arun said he prioritizes candidates who are not “in between” genders, demonstrating that surgeries are structured by beliefs that people embody binary ideals of sex and gender. He continued that his decision-making is often based on a “feeling,” as he said:

I have to have a good feeling they are a good candidate because I’m the one doing the surgery.... If I feel it’s not the right candidate, I tell you that you should spend more time and get real life experience as a woman. Dress like a woman, go out and see what you feel like. You have to show up as you are female. Go out and have real experience dressing as a woman showing up like a woman and come back to see me. There’s something else you can do. You can have breast augmentation. This is a reversible procedure to look like female and see if you are happy with that.

Dr. Arun demonstrates the importance of a person “showing up like a woman,” by wearing a particular kind of dress and having a “real experience” as a woman. Although WPATH modified its Standards of Care guidelines so that “real life experience” is no longer a requirement (Shuster 2016:327), providers such as Dr. Arun still utilize this framework as a means to assess a candidate’s readiness for surgery. He also delineated various steps to surgery, with breast augmentation preceding genital surgery, implying a necessary order and time-based protocol. His statement that he is the one doing the

surgery implied a sense of responsibility and accountability, perhaps reflecting how 74 percent of American medical providers sought to avoid lawsuits by their trans clients (Shuster 2019:194).

A testament to their medical authority, Dr. Preecha and other Thai surgeons penned research for an international journal about the importance of surgeries, arguing that “conventional psychiatric and endocrinological treatment [is used] to adjust the mind to the body” (Chonkrungvaranont and Tiewtranon 2004). Adopting “conventional” norms of psychiatry and endocrinology, only patients who “[f]ailed conservative treatment” may then undergo genital surgery (Chonkrungvaranont and Tiewtranon 2004). In this account, “sex reassignment surgery will be the only way to transform their biological sex to the image in their mind” (Tiewtranon et al. 2001:47). This also demonstrates the various steps – or protocols – through which trans people may access psychiatric, hormonal, and surgical interventions. “Conventional” treatment for local people and medical tourists is steeped in Western biomedical interventions on sex and gender, described in fuller depth in the Introduction.

The conventional norms emphasize a need for congruence between sexual anatomy and gender. According to Dr. Arun, trained by Dr. Preecha, genital surgery is necessary for broader acceptance for trans people in Asia. He said: “In the Asian way, the best way to be accepted as transgender is you have to cut the sexual part out... Then you will be accepted.” Adhering to binary norms that link certain sexual organs with a particular gender presentation, Dr. Arun shared that medical interventions allow for what he deems a congruent and binary alignment of sex and gender.

Thai surgeons have adapted “conventional” international protocols, classifications, and interventions that align with dominant institutions and “normal” science (Kuhn 1962:10), or those scientific achievements that have become paradigms of research traditions. Medical tourism necessitates the implementation of “normal” transgender medicine – an iron cage of transgender health – in locations throughout the world, demonstrating the bureaucratization of trans health on a global scale. As international norms structure transgender health care for local and foreign people amidst the rise of medical tourism, local specificities may be elided and rewritten if guidelines are not adapted to local contexts. International guidelines for trans healthcare revolve around a political economy of gender-affirming services, which are offered to international patients through medical tourism. As I discuss in the following chapter, abiding by international guidelines is integral for Thailand’s success as a medical hub and its rebranding efforts. I now discuss how kathoey navigate invisibilized uncertainty, in which global gaps in data collection result in uncertainty in medical settings. With people missing from global health metrics, I analyze how kathoey navigate the “grey zone” of health resources and information, as clinicians and providers lack evidence and research regarding trans medicine worldwide.

Invisibilized Uncertainty

To represent is to narrate, or to refuse to narrate. It is to perform, or to refuse to perform, a world of spatial assumptions populated by subjects and objects. To represent thus renders other possibilities impossible, unimaginable. It is, in other words, to perform a politics. A politics of ontology (Law and Benschop 1997: 158).

Scientific and medical knowledge represent and act upon people – or ignore and invisibilize. Scholars have interrogated the “political, economic, social, and institutional conditions under which we produce knowledge about health, disease, and populations” (Shim 2014:190). Scientific and medical knowledge is laden with social conditions, and from feminist STS, research has gleaned that “science is not a neutral category, but the consolidation of epistemic authority into a narrow set of approaches that constrain the querying of our worlds and how they work” (Hamilton et al. 2017:614). Humans are categorized and monitored through research in accordance with certain biases of social variables, with governmental processes regulating people’s health based on such scientific conceptions (Shim 2014:23-24). The creation and application of expert knowledge, and data, can be summarized as “epistemic imperialism,” or:

The application of ‘expert’ knowledge as interventions into global crises that include climate change, language endangerment, and extinctions and losses of genetic diversity. Often, that knowledge is presented as narratives of ‘risk’ for national and international security and sovereignty, as well as cultural and international heritage. Expert knowledge and their concomitant ‘risk’ narratives purport to overcome disciplinary ‘boundaries’ in order to establish partnerships that promote unifying research agendas that solve global insecurities (Perley 2011).

Epistemic imperialism defines who counts, while research has sought to deconstruct the processes through which knowledge and practices are shaped. The narrow approaches and constraints of knowledge production is rooted in “epistemic authority,” resulting in the visibility (and hypervisibility) of certain bodies and people, as well as those who are rendered missing and invisible; this is a “politics of invisibility” (Casper and Moore 2009).

Additionally, in the medical setting, scholars have asserted that uncertainty takes place in clinical encounters (Fox 1959), even though "...the doctor is regarded as an expert, a man professionally trained in matters pertaining to sickness and health and able by his medical competence to cure our ills and keep us well" (Fox 1979:20). Research has expanded taxonomies of medical uncertainty to relate to technical information, personal rapport, or conceptual application (Kim and Lee 2018). Economists and legal scholars have also developed the concept of "epistemic uncertainty" (Dougherty and Dunne 2012; Grandori 2010), referring to "the 'lack of knowledge' on cause-effect relations and therefore on what the relevant alternative moves and parameters for evaluating them might be all together" (Grandori 2010:481-82). Given that there is a "paucity of clinical trial data for the long-term risks of trans medical interventions" (Shuster 2019:192), transgender medicine, including surgical outcomes, hormone use, and general transgender health, reflects a new domain of medical uncertainty, in which medical providers navigate unknown clinical domains. I refer to this as *invisibilized uncertainty*, in which global biases and occlusions in data collection and knowledge production result in ambiguities in the clinical setting.

This section discusses kathoey's experiences with invisibilized uncertainty, particularly regarding surgical outcomes and hormones, amidst the broader gaps in clinical data and evidence. Invisibilized uncertainty pinpoints how global health metrics and data "enable certain kinds of medical practices while impeding others" (Adams 2016:225), manifesting in uncertain clinical encounters in which providers and patients lack standardized information and data to guide health outcomes.

Patcharin said that Thai public health care has not incorporated LGBT people in infrastructure, insurance coverage, or practices, leading transgender people to seek services without proper information or oversight. She said: “Most of these services are being offered in a grey zone – people have to find this information by searching hard, and they have to walk into the service institutions almost at their own risk and seek further advice. It’s limited choices.” The grey zone refers to gaps in transgender health that often arise as a result of unavailable or inaccessible clinical information. While surgeries and services are available in a wide range of settings, gender-affirming health services are offered with little education, standardization, or follow-up care for patients. Patcharin said:

I think the health institutions that are responsible for the overall health of people have not taken notice [of transgender people’s needs], and haven’t done their job in providing necessary information for people to care for themselves, to make a good choice on medical services - whether what kind of contraceptive pills they should take, what kind of hormone or how they should take it or what these surgeries mean and how to equip them in making their choices to get these services.

Patcharin spoke to overall gaps in transgender health services, regarding hormones, surgeries, and decision-making.

For instance, Goldie had breast augmentation at Nuun Clinic, and two rhinoplasties and lip injections at Yanhee Hopsital, a nationally- and internationally-accredited hospital in Bangkok. Yanhee Hospital is described on its website as “a center for health, and a destination for beauty.” As a price comparison, breast augmentation at the gender clinic amounted to half of the price at Yanhee. While there are no formal statistics of the number of international patients seen, Yanhee Hospital is well-known as a

medical tourist destination and features an extensive international section. In relating her experiences at both health facilities, Goldie said that practitioners at Yanhee “will give some information about the effects [of surgery], but [the other clinic] doesn't have this service - we just go and do the surgery.” Goldie emphasized the “grey zone” that kathoey face regarding lack of treatment information after surgeries.

Dr. Wanida, who oversees a transgender health clinic in Thailand, one of the few in the region, said that there is often not adequate short- or long-term care for the surgically-constructed neovagina as doctors do not know how to provide such care. With 20 percent of the clinic's kathoey patients undergoing surgeries, she said this is a significant issue. Riki, an LGBT health advocate, echoed that there is a gap in follow-up transgender health care. He said: “In terms of [gender surgeries], they prefer that you don't come back for long-term care. Doctors don't have any idea of how to do that.” Neovaginal care is a form of clinical competency in which there is a lack of information and data. Invisibilized uncertainty emerges with regards to post-operative care, since there is limited standardized research related to Thai trans health and post-surgical bodies.

While online and in-person networks can steer transgender women from all over the world to various options for surgeries, kathoey such as Bim face barriers in making informed choices about surgeries, particularly as the number of clinics offering such services has grown. Bim said that finding a good surgeon is a challenging issue for kathoey, stating: “I think the most serious problem... is surgery. Because sometimes we get inadequate information. Sometimes we go see doctors, and we don't know if this

doctor is good or not.” On the other hand, private medical tourism facilitators help foreigners book medical services and tours – including a trip to the kathoey cabaret –and the government has created several iPhone applications to link foreigners with medical treatments and providers.

One of the clearest examples of invisibilized uncertainty is in regards to hormones. Hormone access is offered in many countries only after transgender people prove their transition status to psychiatrists (Reisner et al. 2016; WPATH 2018), the Thai Food and Drug Administration (FDA) does not regulate hormones such as oral contraceptives, which are available over the counter without medical guidance or monitoring. Despite the medical institution’s role as gatekeeper for transgender people seeking gender-affirming technologies (Davis et al. 2016), the lack of hormone regulation in Thailand demonstrates how particular health issues emerge across country and institutional contexts. Although transgender identity has been pathologized through medical institutions, there is simultaneously a startling lack of population health data that includes transgender people, especially beyond Europe and North America (Reisner et al. 2016).

Of the 33 kathoey I interviewed, almost all had hormones recommended by friends, not doctors, and many expressed concerns about the health risks and damages the hormones might cause. Without prescriptions needed for Thai transgender people to access hormones, research has studied how unsupervised hormone use is a health risk (Humphries-Waa 2013; Gooren, Sungkaew and Giltay 2013). In a 2013 study of 60 Thai transgender women in Chiang Mai, 44 were taking hormones, with only two advised or prescribed by a doctor or pharmacist; the other 42 were advised by a friend. More than 50

percent of the transgender women taking hormones were overdosing on oral contraceptives (Gooren et al. 2013). This issue takes place beyond Thailand; for instance, at a transgender health consultation with representatives from a clinic in the Philippines, the clinic director told me that transgender women take hormones in the same way people eat M&Ms to enhance their femininity more rapidly. Reports have also circulated about transgender people's black market use of hormones in Vietnam (The Nation 2017).

Kathoey navigate risks sometimes with little support of health care providers, who are not trained to prescribe hormones. Evy, 44, said she had difficulty finding an endocrinologist who understood hormone treatment for transgender people. She said: "Most of the doctors in endocrinology don't know about hormone treatment - even endocrinology doctors don't know. Even famous hospitals don't have a doctor who knows about hormone treatment." Notably, Evy specified that there are "famous hospitals," implying the various tiers of health care services in the current phase of medical tourism. She also pointed out that while transgender people must have hormone treatment before they qualify for gender surgeries, "they don't have doctors to support us" in terms of choosing and maintaining a healthy hormone regimen. Without standardization related to hormone guidelines, Evy noted how kathoey lack supportive and knowledgeable doctors. She continued: "Maybe some doctor recommends you use hormones like this, like this, like this, but another doctor like - they don't have a standard for treatment... One doctor says something, another doctor has another way." Evy emphasized a lack of uniform standards and guidelines, which often differ depending on if a provider is affiliated with a professional organization (Shuster 2019:194; Shuster

2016). The trend also reflects findings from another study in which transgender participants stated they had “little confidence that the medical establishment truly had the necessary expertise on the matter of hormonal treatment...” and felt that they would receive “little sympathy for their needs” (Gooren et al. 2013:283).

Several kathoey stated they were worried about the long-term effects of hormones, with their family members also expressing concern. Evy said: “Maybe the doctors worry about risk for health, but some doctors don’t [show] concern... So transgender [people] know about the risk, the adverse effect - we know, but we still take [the] risk because we need [to be] feminine.” Evy stated that the risk is calculated due to the goal to become feminine. Additionally, Nin said: “I think we need to deeply consider our health and aftermath [of hormones]. When I was 20-something years old, I used a lot of hormones. But now that I am 30, I feel that my health condition is not too good. And I fear that it might even get worse in the future. Like, [I will] fall sick easily, or feel that [my] bones are increasingly weaker, because I feel muscle pain easily.” Nin and Evy spoke to themes related to decision-making and risk assessment in the midst of medical uncertainty.

The lack of medical guidelines regarding hormones and surgeries emerge within a context of biases and omissions in global health data. Scholarship has focused on how biomedical research is produced in a transnational setting through racial and nation-based hierarchies (Epstein 2008b). Other work focuses on how transnational governance, such as the United Nations Millennium Development Goals, surrounds demographic statistics such as Infant Mortality Rate (Casper and Simmons 2014). In national HIV/AIDS

prevention strategies worldwide, trans women are mostly categorized as “Men who have Sex with Men” (MSM), and only 39 percent of national HIV/AIDS strategies addressed transgender people as of 2014 (Baral et al. 2012; AVERT 2017). The conflation and occlusion of unique transgender identities often renders transgender people invisible in HIV/AIDS data collection, prevention marketing, and program implementation. In a study inclusive of transgender people from Peru, Ecuador, Thailand, Brazil, U.S., and South Africa, it was found that transgender women’s risk behaviors varied from cisgender gay men, with whom they are often categorized under the category of MSM. Aside from the fact that transgender men are not included in the “MSM” categorization, the invisibility of transgender women as a group demonstrates their missing personhood in clinical research. Similar to how “maternal/child health” practices “may not, in fact, foreground women’s needs and interests” (Casper and Simmons 2014:92), HIV prevention strategies that collapse transgender women under the MSM umbrella do not account for transgender women’s unique specificities in sexual behavior and identity (Winter 2012). At the same time, transgender people are overrepresented in HIV/AIDS research, with significantly less work focusing on their general health outcomes (Reisner et al. 2016). As Winter (2012:3) summarized:

...[T]hroughout much of the history of the global HIV response, trans* people have been invisibilised; in that they have seldom been properly recognised as a distinct population for purposes of confronting the HIV pandemic. Trans* women attracted to males have often been subsumed, researched and reported as MSM, or as a subpopulation within that behavioural group. The portrayal of these persons as MSM is often in direct conflict with their own identities as female or third gender. It undermines their frequently voiced claims to be treated as female. It often conflicts with the identities of their partners as heterosexual, or ‘real men’. Trans* men again have been completely left out of any kind of reporting; even

trans* men who have sex with men (TMSM), a group which (ironically, and unlike trans* women) are best thought of as a sub-group of MSM.

In addition to being grouped as men, international guidelines for trans medicine may fail to account for environmental, biological, and cultural specificities in gendered difference. Although sociologists acknowledge that the body is constructed within a social context, they also demonstrate that biological factors still matter in the social world (Almeling 2007). Mamoojee et al. (2017:245) has found that:

Good quality studies comparing the various available hormonal regimes used in transgender medicine across the world regimes are lacking, and international variation in hormonal regimes is multifactorial, principally arising from national licensing agreements, costs, product availability, and medication reimbursement practices, rather than high quality data.

For instance, “skin adherence of [estrogen] patch products is reduced in hot and humid tropical countries, such as Thailand” (Mamoojee et al. 2017:244), demonstrating how one’s geographic setting can structure health behaviors. According to Dr. Wanida, international guidelines about HIV/AIDS antiretroviral use, for example, might often be based on clinical trials in which participants are Caucasian. She said that since Thai people’s body mass is generally lower than that of Caucasian participants in large clinical trials regarding HIV/AIDS treatment dosages, their treatment regimens might be less. She said: “[N]ot only we can save money because we use less [medication], but it also decreases the chance of you getting unnecessary side effects from medications.” Yet there is currently not enough clinical research on transgender people, particularly in the Thai context.

Clinical research and guidelines related to transgender health reflect broader patterns in global health metrics. Scholars have shown that the production of data and

visibility of populations are produced in particular contexts, laden with various biases and occlusions (Adams 2016; Casper and Simmons 2014; Epstein 2008; Shim 2014). Trans medicine – particularly in countries outside of North America and Europe – is “characterized by a lack of scientific evidence” (Shuster 2016:329), demonstrating greater tensions in using clinical guidelines when data are less readily available. The case of trans health in Thailand demonstrates how health outcomes are structured by available data, which are often related to global health funding and programs related to HIV/AIDS.

Invisibilized uncertainty specifies the social and institutional processes through which certain people are missing in global health data and metrics, confirming that “the diagnosis of uncertainty in health care is a relational act” (Han et al. 2011:10), transcending the site of clinical encounters. The assumption of a sex and gender binary permeates global health research, rendering trans and intersex people invisible and missing, particularly outside of the U.S. and Europe (Reisner et al. 2016). With invisibilized uncertainty impacting medical encounters due to the exclusion of certain groups from clinical data and health research, I now discuss the relationship between clinical data, expert-approved guidelines, and Universal Health Coverage (UHC) for gender-affirming services.

HIV/AIDS, Hormones, and UHC

Gender-affirming health care services – which can include hormones, surgeries, and laser hair removal – are a social determinant of health (Asia Pacific Transgender Network 2017), yet such services are rarely covered by insurance programs. Although the

Thai state offers universal health coverage, research has shown how access is “uneven” for certain groups, such as migrant workers and stateless people (Harris 2013). According to Patcharin, universal health coverage “is noble but doesn’t address LGBT health care.” UHC, she said, is already under siege to reduce its capacity to take care of people rather than being refined to make it more capable of treating diverse people beyond “the mainstream.” Transgender people must pay out of pocket for hormones, sometimes working additional jobs (for instance, Chicky said she worked a part-time job at a resort near her house), and some studies have also shown that some transgender people may engage in sex work to afford surgeries and other gender-affirming health services (Winter et al. 2016). How are transgender health activists and practitioners mobilizing to incorporate gender-affirming services under UHC? What does this process demonstrate about knowledge hierarchies and health care activism and mobilization in a global era?

Dr. Wanida stated that adequate trans-insurance coverage would include the cost of hormones themselves, as well as the annual or semiannual monitoring of liver and kidney function, lipids, and blood sugar levels. Dr. Wanida and transgender health advocates stressed that hormones are not an auxiliary or cosmetic tool, but a foundation for transgender people to live better lives. Dr. Wanida said: “Please don’t think hormone is the toy. It’s not. People can choose to play or not play with the toys, [but] this is an essential part of transgender people’s lives.” Despite the medical necessity, gaps in research about transgender people’s hormone use makes it difficult to propose health coverage. Dr. Wanida said: “We need to have a large enough cohort to say something,” in order to adapt international guidelines for the specificities of Thai transgender people.

Jaya, a kathoey who is also an LGBT health advocate in an NGO, agreed that more “rigid” evidence is needed. She said: “We need to have rigid research that this [hormone] medicine can apply with us. Then we can have this medicine in a catalogue of necessary drugs in the social security system, so that we can have rights to be treated in a medical way specifically for transitioning.” Jaya said that it is difficult to propose health insurance for gender-affirming services such as hormones with such limited data.

Building research and creating guidelines are key for proposing changes to UHC. According to Dr. Wanida: “The steps for any health care services to get into the national coverage is that we need to have guidelines.” Credible guidelines, according to Dr. Wanida, must be based on empirical research - which is currently lacking on non-Caucasian transgender people. To modify WPATH in the Thai context, Dr. Wanida said: “We probably would like to do something very similar to WPATH, but just for Thai people so we can use it to propose a national guideline on transgender care. We can use the framework that WPATH has set but refine some details to suit our context.” Without enough of the right evidence, including transgender health services under UHC is at a standstill.

Since she does not believe quality of life is enough of a financial incentive for UHC policymakers, Dr. Wanida said her transgender health clinic is collecting data on the number of kathoey accessing the clinic and receiving hormone-related services, and tracking whether those who come in for hormones do more frequent HIV/AIDS testing or accept Pre- and Post- Exposure Prophylaxis (PREP and PEP, respectively). Globally, the risk of contracting HIV/AIDS is 49 times greater risk for transgender women than the

general population (AVERT 2017). They are also susceptible to other health vulnerabilities, such as social stigma (Reisner et al. 2016). With HIV prevention and treatment part of global development goals and global health funding schemes¹¹, Dr. Wanida said this can be a valuable selling point to state officials about including hormone access in UHC. She believed that when kathoey must pay out of pocket for hormones and hormone monitoring, they might not be able to afford more regular HIV/AIDS testing beyond the twice-yearly testing that is covered by UHC. In addition, Thai transgender people might not opt for HIV/AIDS testing and treatment unless they are already in a trusted care network. She said:

We started to see there is a trend that once you can make people come to you more often - although the first time they don't want to do HIV testing, the second and third time they will do so, and they will realize their risk to be [more of an] actual risk level than what they perceived. And they accept to be on PREP, or if they have any emergency exposure they can come in for emergency PEP. We already started to see that trend. This is the type of data we really have to make visible to the policy makers and funders.

By offering hormone access as part of comprehensive health insurance, Dr. Wanida said kathoey would be more likely to access HIV/AIDS-related services. Dr. Wanida stressed two points – first, that hormones are a necessary component of quality of life, reflecting global discourses that depathologize, or delink trans people from illness, and viewing hormones as a trans practice (Sullivan 2008) for some people to fulfill their transitions. Secondly, she speaks to the correspondence of hormones and HIV/AIDS

¹¹ For instance, the “90-90-90” campaign aims that 90 percent of people who are HIV-positive know their status; 90 percent of those are on treatment; and 90 percent have their viral loads suppressed.

prevention/treatment, signaling how trans health care receives “buy-in” from state officials when it is coupled with global health goals, such as the 90-90-90 campaign.

Despite the necessity of hormones to some trans people’s wellbeing, Dr. Wanida did not expect it would be an easy road to convince policymakers of the necessity in offering hormones. She said: “It’s really hard to say you have to provide hormone services to transgender [people]. Many people don’t think that’s worth an investment.” With the lack of inclusive scientific research on global transgender populations, Dr. Wanida emphasized the difficulty in guideline creation, which are necessary for UHC proposals. Transgender people’s rights to gender-affirming health care seem unlikely to stand on their own in Thailand, instead linked to global deliverables that state officials and NGO funders might see as more cost-effective. This speaks to how global health funding and organizational priorities construct sex, gender, and health based on “deliverables,” or targeted outcomes delineated by agencies with particular outcomes (Adams 2016:16).

Kathoey become visible in global health data and state health policies in relation to HIV/AIDS. The case of trans medicine and UHC demonstrates how evidence-based medicine, that which is based on clinical data, is an “imperialistic form of stratification,” (Broom and Adams 2016:13) as evidence-based guidelines are difficult to create without funding and resources for data collection. Evidence-based medicine, designed to assert objective validity of medical interventions, “may promote certain understandings of health and illness while silencing others” (Broom and Adams 2016:15). With the “politics of evidence” (Broom and Adams 2016:15) shrouded by global health funding

deliverables, and namely HIV/AIDS prevention strategies, “[e]vidence-based paradigms now fundamentally shape the way health service providers, health funding bodies, governments and policy makers view ‘effectiveness,’ and their willingness to fund and support interventions, practices, models of care and practitioner groups” (Broom and Adams 2016:153).

The gendered technostate is situated within global health hierarchies that elide particular people, as national health policies and programs are organized by dominant guidelines, global deliverables, and objectives. Without the right data or evidence related to trans medicine and policy across local and national settings, I now discuss how transgender people are categorized as vulnerable in global health funding programs and discourses, but not at the national level.

Constructing Vulnerability and UHC Benefits

Despite global guidelines and programming targeting transgender people as a “key population,” Thai state health officials do not consider them a vulnerable or countable group with specific health needs. What explains this fracture in global and state-level categorizations of trans vulnerability? Sociologists have sparsely unpacked the construction of “vulnerable populations” in health policy or federal funding. How do populations become vulnerable, and what does the status entail? Definitions of vulnerability vary, as Mechanic and Tanner (2007) took a “societal view” and saw vulnerability as “the susceptibility to harm.” In public health, Aday (1994:487) deemed vulnerable populations are those “at risk of poor physical, psychological, and/or social

health.” Legal scholar Fineman (2008:1) saw vulnerability as a necessary categorization to “replace the autonomous and independent subject asserted in the liberal tradition.” In the United States, research has described transgender youth’s vulnerability (Grossman and D’augelli 2006), as well as transgender and gender non-conforming people’s vulnerability to sexual violence (Stotzer 2009). However, we know less about how vulnerability related to gender is constructed in transnational settings, and how the category of “vulnerable” corresponds to health policy and health outcomes, particularly for gender-diverse people worldwide.

The MOPH had produced a study in 2014 about HIV/AIDS-related stigma and discrimination, which included kathoey, but has otherwise not focused on transgender people’s unique health needs. Dr. Wirat of the MOPH shared his ideas on the feasibility and implementation of hormone access via UHC, particularly as a gateway for Thai transgender people to access other essential services such as HIV/AIDS treatment and prevention.

Dr. Wirat had just returned that morning from a meeting in New Delhi. Seated together at a side table in his office, he began sipping espresso and we discussed issues related to medical tourism, brain drain, and the public health care sector. Dr. Wirat actively voiced his concerns about medical tourism shifting resources from Thais to foreigners, which led me to ask him how vulnerable populations, such as Thai transgender people, might be especially affected. Before I could finish my question, Dr. Wirat expressed confusion. He asked: “Why are you interested in just transgender, because vulnerable populations are not just...” As he suggested that there are other

vulnerable populations to consider, I responded that “not a lot of people focus on transgender people.” Dr. Wirat said that that is because it is a matter of finite health care resources, many of which are devoted to migrant laborers. He explained that there are over 2.3 million migrants from Myanmar living in Thailand, and only half of them are documented. Referring to them as the “low end of the foreigner patients,” he said they “go to the public sector without any perhaps documents, without health insurance.” For this reason, he said, “we have to allocate some resources – our limited resources – to the high-end foreigner patients, and also low-end foreigner patients without any insurance or perhaps any payment.” Dr. Wirat expressed necessary concern about migrant’s health, particularly as they face limited access to health resources and social services (Tangcharoensathien et al. 2017).

Dr. Wirat referenced the study conducted about Thai sex workers and health care stigma, and said he does not believe services or surgeries for transgender people can fit in the UHC benefits package, likening gender-affirming surgeries to cosmetic surgery or in-vitro fertilization, which are also excluded. He referenced how producing antiretrovirals and reducing the cost to one-tenth of the price under the benefits package would pay off long-term. He said determining which interventions are covered under UHC comes down to cost-effectiveness: “When we design which intervention should be included we use economic analysis. So for transgender, perhaps nobody proposed to have a cost effectiveness analysis – but I think perhaps it’s not from my perspective – it’s not cost effective [laughs].” Similar to Dr. Wanida’s concerns about demonstrating cost-efficacy

of providing hormones by documenting PREP and PEP access, Dr. Wirat distilled the issue to health economics.

Dr. Wirat added that providing transgender health services under UHC would be “too much” for societal approval. He said:

They should get rights in access to health services as a Thai citizen, but if we think they are a special group or they are vulnerable so perhaps they need more services, they need special attention, they need special treatment from government or from the public – perhaps I think this kind of request or requirement, perhaps, is too much. You know what I mean, it’s too much for the public to accept this proposal.

Denying transgender people’s “special” needs and status as vulnerable, Dr. Wirat did not think the idea would take hold. Trained to ask follow-up questions (Rubin and Rubin 2012: 153), I asked Dr. Wirat why he believed it would be too much for the public to accept. Dr. Wirat laughed and bristled back in his chair, and in this moment, I sensed that there had been some type of breach. Based on his visible discomfort and laughter, I may have broken a norm in Thai respectability politics – perhaps disrupting “Thai-Buddhist ideals of harmony” (Herzfeld 2009:140) – by asking a question that could have seemed confrontational, or potentially undermining the authority of a high-ranking person. While I asked the question with an even tone, I couldn’t help but feel as though I may have “lost face” by asserting the question, and I worried that I offended Dr. Wirat.

After several beats, Dr. Wirat responded that UHC policy is for those who are economically disadvantaged. He said: “I think perhaps we still classify transgender people as – we don’t classify transgender people as a vulnerable population.” Vulnerable populations, Dr. Wirat said, include disabled people, the elderly, migrants, poor people,

all of whom “cannot assist themselves.” To consider transgender people as vulnerable and in need of particular health benefits and services, he told me, “is quite controversial.”

Dr. Wirat also reflected on transgender people’s mobilization and political activism. He said that transgender people in Thailand are “voiceless” and “don’t have any complaints.” He said: “Perhaps they think what they get so far is good enough. I think sometimes the public thinks we already provide sufficient things for them – for example like their rights to... express themselves freely in public.” Although kathoey, toms, and Thai trans men are not always allowed free public expression, Dr. Wirat did not believe that kathoey were willing to ask for more in the way of health care benefits. He did not believe in categorizing Thai transgender people as a vulnerable population in need of additional services under UHC. This raises questions for future research about how people are categorized as vulnerable throughout the world, and what resources are allocated to them – or not – based on these groupings. While global funding and programs do categorize transgender people as vulnerable, why do some state officials not? In the midst of the grey zone and invisibilized uncertainty, I now discuss how Thai transgender people become their own experts, mobilized through in-person and virtual social networks to navigate a “grey zone” of health care services.

Resisting Invisibilized Uncertainty

Without standardized knowledge and clinical data regarding hormone use and trans medicine more broadly, kathoey access hormones at the peer and organizational level, as friends and grassroots organizations – and online spaces – serve as important

levers to assist kathoey in their hormone regimen. Kathoey's navigation of the grey zone speaks the "growing influence of lay expertise in the context of medical uncertainty" (Barker 2008:20), as patients become experts and are guided by anecdotal data and shared experiences, rather than empirical studies. From educating themselves about gender-affirming surgeries, finding a safe surgeon, and managing neovaginal follow-up care, kathoey navigate a "grey zone" of health services, relying not on medical experts or uniformly-regulated clinics, but rather through the advice of one another. Their shared experiences and personal networks – both physical and virtual – form new modes of knowledge and resistance to data occlusions and invisibilized uncertainty.

Research in medical sociology has addressed not only the cultural biases in health and medicine but also how "lay" individuals and groups resist medical authority and scientific hierarchies (Barker 2008; Bologh 1981; P. Brown 1992; Epstein 1995; Shim 2014). Despite showing the vast effects of medical authority, medical sociologists have argued that medical power is not one-sided and individuals and collectives have exhibited agency to decide and act for themselves (Epstein 1995; Harris 2015a, 2015b). For instance, Epstein's (1995) research on the case of LGBT health policies in the United States showed how activists responded to AIDS epidemic and reformed health policy on a state level.¹² This work illuminated how power emerges from not just state authorities but from "cracks and crevices of the social system" (Epstein 1995:412). Medical sociologists have argued that medical knowledge, which once only belonged to the

¹² While Epstein's (1995) work on LGBT activism focused mostly on gay and lesbian people, he left open the question about whether or not state-centered advocacy would promote transgender health issues in addition to sexual orientation.

physician class, has become more democratized over time (Bologh 1981; P. Brown 1992; Starr 1982). Research has also argued that health resources and medical information have become more egalitarian with the advent of online technologies such as Electronic Support Groups, or ESGs, signaling a shift from “elite” to “lay” access of scientific knowledge (Barker 2008; Conrad 2005). From online support groups about eating disorders to fibromyalgia, people have accessed and shared information in virtual collectives, creating opportunities for empowerment and a chance to reclaim their voices (Barker 2008). Indeed, the Internet represents one of the significant “shifting engines” of health and medicine (Conrad 2005:9).

While most kathoey participants did not have difficulty accessing hormones over the counter at Thai pharmacies, Kitti said that hormones were not easy for her to buy when she was growing up in her hometown, so she accessed them from the Internet. Without formal medical oversight, Kitti said that information from a Facebook page called “Miss Ladyboy” taught her how to take oral contraceptives and inject hormones. In addition to in-person support about hormone use offered by friends, online networks facilitate kathoey’s access to and use of hormone regimens. In an era of transnational health flows, this demonstrates the hybridity of physical and virtual worlds, as identities, embodiment, and health outcomes are augmented through online spaces and interactions.

For Naw, the onus was on transgender people like herself to learn more about medical knowledge, rather than medical providers as the source of information. She said: “We have no knowledge on hormones, like which hormone suits me. So, I think we have to learn more about medical knowledge that people like us have to face.” The personal

responsibility to become a medical expert, in the absence of broader trans-inclusive medicine, demonstrates Naw's beliefs that kathoey must learn for themselves how to take hormones. Naw's beliefs in learning medical knowledge herself may also be a function of internalized or self-stigma, a theme to which I will return in this chapter.

NGOs have attempted to fill in the gaps in invisibilized uncertainty regarding transgender health and endocrinology, creating regional "blueprints" for transgender health and medicine in Asia. Kathoey's access to hormones outside of the formal medical domain – and their knowledge-sharing with one another – demonstrates new trends in medicalization. With various drivers or "engines" of medicalization (Conrad 2005), kathoey themselves – as well as grassroots organizations (Lynne 2018) – serve as key nodes of knowledge production related to hormone use. With health care services and outreach for Thai transgender people are lacking, local and regional activist networks have mobilized to address these gaps.

Although kathoey's voices have perhaps not reached Dr. Wirat, I attended three meetings and consultations, held in Bangkok, related to transgender health and health care access. In these meetings, Thai transgender people were referred to as a "key population," a phrase notably distinct from "vulnerable." In mid-September 2017, the Asia Pacific Transgender Network and the Thai Red Cross AIDS Research Centre co-hosted a three-day dialogue in Bangkok called, "From Barriers to Bridges: Increasing access to HIV and other health services for trans people in Asia." One-hundred and fifty delegates from 20 countries in Asia gathered to discuss transgender health issues and strategies. The meeting was organized under partnerships with the United States Agency

for International Development (USAID), international nonprofit FHI 360, United Nations Development Programme (UNDP), and Joint United Nations Programme on HIV/AIDS (UNAIDS). According to the program, the objective was to “leverage their technical expertise and ongoing support to assist countries in the region in reaching the 90-90-90 targets.” The meeting culminated in a “preliminary regional mapping report” which delineated the specific issues of transgender people in 16 Asian countries. These included trans competent services, hormone use, surgeries, HIV/AIDS, and insurance. This meeting thus served as a site through which data and evidence are gathered and shared.

Several months later, in mid-November 2017, Asia Pacific Coalition on Male Sexual Health (APCOM) held a four-day meeting, also in Bangkok, entitled “Rights, Resources, & Resilience Asia Pacific: Strengthening the Regional Response to Community Health and Rights.” According to the program, the RRRAP Summit was held “[o]n the back of the UN’s Sustainable Development Goals and the UNAIDS 90-90-90 targets,” with a program featuring sessions about HIV treatment implementation and social rights orbiting around sexuality and gender identity. While trans people such as kathoey resist invisibilized uncertainty in these spaces, the organizations themselves are explicitly named as addressing “male sexual health,” demonstrating the ways in which populations appear or are collapsed together under global health organizational categories (e.g. MSM).

And in late November 2017, the Global Fund Advocates Network-Asia Pacific (GFAN-AP) collaborated with the Asia Pacific Council of AIDS Service Organizations (APCASO), a regional civil society network of community-based organizations (CBOs)

and NGOs, focusing on HIV, health, and social rights to host “Asia-Pacific Community and Civil Society Universal Health Coverage Forum.” Under the Strategic Framework of the Global Fund 2017-2022 and Sustainable Development Goals (SDGs), especially Target 3.8 on UHC, the caucus was held in order to allow stakeholders to address planning, gaps, messages, and activities related to UHC, particularly for key populations. The conference focused on UHC in relation to “key populations,” again distinguishing from using the term “vulnerable.” This event deliberately addressed data gaps in UHC, specifically how the “current inclusion metrics of UHC is tied to people in the informal sector, and the poorest populations, missing the middle.” At this event, people spoke that UHC more than just the “minimum” levels of coverage but rather “about equity and social inclusion.” Reflecting Dr. Wirat’s comments that Thai transgender people are “voiceless,” attendees discussed how the lack of political legitimacy for key populations such as trans people is a barrier to achieving more inclusive UHC. They stated that although key populations and communities are the most effective actors to acquire political legitimacy, they are “pushed into the area of non-participation” and cannot have input in conversations.

These events, statements, and dynamics raise questions about the ways in which regional organizations and local people create new forms of knowledge and participation. They may serve as what Harris (2015b) defines as autonomous political networks, or “loose groupings of people who share similar values and aims with respect to policy and politics and who operate in the intermediate space between dominant political actors.” The movement towards transgender-specific UHC necessitates various layers of clinical

guidelines and expert legitimacy, as well as public approval. At the same time, kathoey become “lay experts” (Epstein 2008a), demonstrating Shim’s (2014:206) notion to expand the concepts of “expertise” and “knowledge,” as kathoey form and share crucial experiential data in the absence of transgender-inclusive research, policies, and social support. In the gendered technostate, with increased flows of information and networks, there may arise new forms of medical-political networks, knowledge production, and health resistance amidst national policies and the privatized growth of medical tourism.

Self-Stigma and Categorizing Discrimination

While I and other Thai LGBT activists deem their experiences with invisibilized uncertainty and accessing poor quality care as unequal, kathoey themselves did not always classify their experiences as problematic or discriminatory. Sometimes they made light of the situation or accepted their treatment as a fact of the system. Bee, whose parents had to bathe her after her car accident since nurses refused, did not distinctly classify her experiences as problematic. Instead, she said it was “difficult to say whether I was treated equally or not.” Her difficulty categorizing this refusal of care as equal or not might be an instance of internalized stigma or self-stigma, wherein marginalized people have absorbed negative societal beliefs about their rights (Samakkeekarom and Taesombat 2013).

Gan laughed gently when she stated she stayed in a male patient room, saying it was “fine” and “not a problem.” She added that she did not want to stay in the female ward: “The [wards] are separated like this. Even kathoey who already transitioned will be

put in the male room.” Gan accepted this is the order of the binary divisions in hospitals as a fact, not feeling it is necessary to be treated with other women despite identifying as one. This contradicts LGBT activist discourse, published best practices for transgender health, as well as what other kathoey categorized as problems. Transgender health is multifaceted, punctured with various individual experiences and outlooks. Kitti said that when she was admitted to the hospital, “staff just felt awkward that my face didn't match with my male name and my short-haired identification card. But there's nothing bad about it. But when the doctor had to come, he couldn't find me, because of my male name.” For Kitti, she did not believe confusion or awkwardness about her gender are anything “bad” in the health care setting, seeming to accept these kinds of interactions instead as commonplace. Mirroring Dr. Wirat's observation, the services she received were “good enough.”

Others saw the positive aspects of not being assigned a proper ward. Nin said she appreciates the ways that staff have accommodated kathoey, even in a binary format. She said: “If we don't have money to pay for a special hospital room, we need to be sent to male ward because our title is ‘mister.’ But the hospital tries to help us, for example, [they] move male patients a bit further, or let us sleep outside the room in front of the elevator. But we can never stay in women's ward.” Nin viewed it as helpful that hospital staff allow kathoey to sleep outside of the wards in front of an elevator, a fact which made activists such as Patcharin visibly upset. Although moving men further away or allowing kathoey to sleep in the hallway does not address the underlying binary structure

of male and female hospital wards, Nin did not see these practices as discriminatory and rather views them as beneficial.

These differences in the categorization of problems and discrimination in the health care setting raise issues around how activists, practitioners, and researchers such as myself speak to the experiences of marginalized people. The variances in categorization symbolize that there is no clear or universal narrative of “rights” – that even within groups, there are major differences in how people experience their realities and social worlds. What strikes one person as inequality might be seen as a helpful strategy for another. While these questions reflect ongoing issues of power, positionality, and privilege embedded in human rights research, it is important that scholar-activists do not stop short of including all people, such as sex/gender minorities, in scholarship and activism. A primary step in understanding and addressing transgender people’s health disparities and experiences with discrimination is to identify and include transgender people in research and demographic surveys. The research on the experiences of gender minorities due to binary categorizations of sex and gender in legal documents and surveys from organizations, academia, and state/federal agencies is limited.

Due to the unique issues and needs of transgender people, research from the U.S. has suggested how population-based surveys can include questions to make visible transgender and gender minority people (The Williams Institute 2014). It is also important for research to measure levels of internalized stigma by creating and adapting scales to fit diverse cultural contexts. Surveys on transphobia provide a foundation to assess transgender people’s self-stigma and experiences with rights (Healy 2011).

Research on transgender people in the Philippines (Reyes et al. 2016) has adapted Wagner's Internalized Homophobia Scale (2014) and Mak and Cheung's Self-Stigma Scale (2010) to study how transgender people accepted negative societal beliefs and the impact on their concept of self. Rather than use a one-size-fits-all approach to measure self-stigma across diverse groups, existent models may be further crafted to reflect linguistic nuances and the lived realities of marginalized groups.

Using unique scales to account for self-stigma might allow human rights research and advocacy to better capture the context that undergirds how one frames their experiences with rights and/or oppression. Regardless of if and how we label as problematic the experiences of transgender people in the health care setting, it is clear that states can make healthcare more inclusive and accessible for transgender people by training medical professionals about transgender people's health needs, and expanding health insurance to include access to gender-affirming services. There are also regional roadmaps and global blueprints that consider cultural specificities and differences to address transgender people's unique needs (Wolf et al. 2016).

By understanding transgender people's experiences with and perceptions of health care, research and advocacy can illuminate interlocking issues related to stigma, discrimination, and rights. Qualitative interviews allow participants to expand on their experiences in the health care setting in ways that quantitative surveys might obscure, providing narrative accounts rather than just a yes or no answer. These findings also raise questions about the hierarchies of knowledge production and universalized human rights

discourses, issues which require a researcher's continued self-reflexivity and awareness of institutional power dynamics.

Conclusion

The gendered technostate is characterized by new trends in health care consumerism, technological flows, and knowledge production. This chapter has underscored the various health and health care inequalities that have persisted for kathoey alongside the growth of medical tourism. These issues include a crowding out effect and barriers in public health care settings, such as lacking a hospital ward of their own and refusal of health care. Dominant international norms construct an "iron cage" of global transgender health, delineating necessary steps and protocols for local people and tourists in medical tourism destinations. Kathoey navigate a "grey zone" of health services, lacking information about surgeries and hormones. Further, the global production of knowledge produces biases and occlusions about certain groups, resulting in invisibilized uncertainty, a form of medical uncertainty stemming from data hierarchies and epistemic imperialism. Invisibilized uncertainty not only pervades health care encounters, but also impacts health care policy, as missing evidence and guidelines make it difficult to propose changes to UHC. Kathoey actively resist invisibilized uncertainty by sharing their own health-seeking strategies and forming knowledge networks, both in-person and online, as well as organizing in NGO settings.

Kathoey's experiences in health care settings stand in stark contrast to the high-quality health care and LGBT-friendliness marketed to foreigners, raising questions over

whether Thai transgender health inequalities may be exacerbated as medical tourism expands. These findings demonstrate the multiple tiers of health services as private clinics and medical tourism have proliferated in recent decades. As scholars have suggested that the “movement of medical skill and resources towards catering to wealthier foreign clients” is an issue warranting “urgent investigation” (Jackson 2011:37), the Thai medical tourism industry signals new waves of globalized, commodified health care and medical technologies, with particular implications for transgender people, both local and foreign.

In the gendered technostate, state resources are devoted to the commodification and expansion of technologies, resulting in health inequalities for local people. While Thai transgender health inequalities existed since before the institutionalization of medical tourism, medical tourism has created a tiered health system, in which surgeons such as Dr. Somchai treat wealthier, mostly foreign patients who can afford services in urban, private settings. In the case of gender clinics, it is not just a matter of doctors moving from the public to the private sector, but also the creation of lower-quality private health care facilities, such as Nuun Clinic. International norms, Western-based clinical data, standards, and protocols govern Thai and foreign transgender people’s health encounters, in an era in which “conventional” and “normal” science become readily implemented in medical tourism destinations.

In the gendered technostate, not only are there ramifications on health care delivery and practices as medical technologies become globally-commodified, but also great impacts on medical knowledge, medicalization, knowledge production, and clinical

data. Thai transgender people access health care services – including hormones and surgeries – in a “grey zone,” often with a lack of clinical oversight, proficiency, standards, and safety. LGBT rights advocates, kathoey, and transgender health practitioners had all described the lack of uniform standards related to transgender health. This included standards related to pre- and post-surgical care and hormone treatment and monitoring. The Internet serves as an important space through which practices and information are shared related to health care services. Transgender people worldwide, including kathoey, are categorized as MSM under global health rubrics, demonstrating a confluence of global programs and discourses with unique local people. This raises future questions not only about how transgender people interact with global health programs but how these measures are linked to more inclusive health services.

Invisibilized uncertainty is a result of global health deliverables and the political economy of medical science. With the Thai government courting clinical trials through “lower requirements for first-in human studies than other Asian countries such as China and India” (Bangkok Post 2018), the priorities for clinical research may demonstrate economic interests rather than those related to transgender health, particularly as Thailand’s pharmaceutical industry is expected to grow to 10 billion dollars by 2020 (Bangkok Post 2018). Global health data and metrics regarding trans people speaks the need for new measurement technologies in both social scientific research, surveys, and broader data collection beyond binary sex and gender (Geist et al. 2015:8).

There are important implications for health care practice and policy, especially related to UHC. Despite hormones and surgeries providing a means for many transgender

people to fulfill aspects of their transitions, UHC does not cover these services, marking a gap that transgender health advocates and practitioners would like to see filled. In order to gain credibility and buy-in from policymakers, transgender health practitioners and advocates stressed that Thai transgender health care access must be coupled with HIV/AIDS global health programming deliverables.

This chapter has provided an example of how a sociology of trans-national health can analyze gendered health inequalities in the context of transnational health flows and medical tourism. The sociology of trans-national health can analyze macro political and economic shifts in health care services, meso-level elements of health care organization and interactions, and micro embodied experiences with health and medical technologies. An attention to virtual spaces is also key, as patients mobilize online – particularly in the absence of clinical support and knowledge. The framework expands sociological inquiries related to who is included and who is missing in health research (Adams 2016; Casper and Moore 2009; Casper and Simmons 2014; Epstein 2008b; Shim 2014), and how such gaps augment clinical practice, health policy, and obscure everyday realities and lived experiences of people worldwide. As the gendered technostate illuminates the connections between gendered labor and national policies related to technologies and medical tourism, this chapter underscores how gendered health outcomes are also constructed in such a context.

So far, the dissertation has elucidated kathoey's roles in advancing the medical hub through their display work, advertising both medical technologies and LGBT diversity on stage. With the growth of medical tourism, kathoey have also faced unique

health inequalities, described in this chapter. In the next chapter, I focus on how the gendered technostate redefines its brand and cultural wealth through both medical tourism and gendered labor, underscoring the roles of technologies, local people, and gender relations in the construction of the nation-state.

CHAPTER FOUR: The Cultural Wealth of Medical Tourism

The gendered technostate relies on new configurations of medical technologies and gendered labor to advance cultural wealth and redefine its brand on the global stage. The Thai nation-state's role as a global medical hub – and specifically a site for gender-affirming surgeries – remaps Thailand from a sex tourism destination to one with renowned medical skills. At the same time as medical tourism advances, the TAT (2019) has promoted Thailand's LGBT diversity, advertising kathoey entertainment as distinct from the “sleazy” sex industry. This chapter uses the lens of the gendered technostate to analyze how nation-branding and cultural wealth are intimately connected to technologies, medical tourism, and gendered labor. The chapter develops a gendered perspective on cultural wealth and nation-branding, demonstrating how gendered labor, gendered relations, and gendered embodiment help constitute these processes.

To understand the linkages between medical tourism, gendered labor, and the nation-state, the chapter orbits around the following questions: How are cultural wealth and nation-branding linked to medical tourism and gendered labor? How does the nation's shifting brand and cultural wealth manifest in local people's everyday experiences?

In the first part of the chapter, I focus on medical tourism as a process that redefines the Thai nation and its cultural wealth, outlining how a confluence, or hybridity, of local and global norms manifests through medical tourism. Scholars have shown how medical transformations and health policies are linked to the nation, in cases such as AIDS denialism in South Africa (Harris 2017b:172), anti-vaccination and anti-

colonialism in India (McMillen and Brimnes 2010), Indian “traditional” medicine (Alter 2015), and plastic surgeries in South Korea (Holliday et al. 2017). Based on the symbolic aspects of science and medicine as “modern” and “rational” (Epstein 2008a), medical tourism and the internationalization of gender-affirming surgeries signal how scientific and medical hierarchies are dynamically restructured, as expert knowledge and quality care shift to countries in the Global South. Simultaneously, Thai surgeons have become globally-known as “pioneers” and experts in gender-affirming surgeries, who then train other surgeons worldwide, demonstrating how knowledge hierarchies are relocated from the West (Harding 1993).

How is medical tourism – and its transgender niche – in Thailand legitimized on the global stage, and how does medical tourism then affect the Thai nation’s brand and cultural wealth? I first analyze the importance of international accreditations such as Joint Commission International (JCI) to Thailand’s rebranding and cultural wealth. I exemplify how Thai traditional medicine is both transformed by and changing the global health landscape, thus impacting Thailand’s brand and cultural wealth. This example serves as a foundation to then understand how Thailand’s transgender health expertise redefines the nation’s brand and cultural wealth, by both incorporating dominant global norms of biomedicine and rewriting global medical hierarchies.

In the second part of the chapter, I explain how kathoey’s work in the entertainment industry renders new levels of cultural wealth and rebrands the nation, by conveying not only dominant norms of gender, beauty, and LGBT diversity, but also representing professionalized labor that is distinct from sex work and HIV/AIDS. The

chapter asserts that the gendered technostate constructs its brand and amasses cultural wealth by promoting gendered labor roles that are detached from sex work and disease, such as HIV/AIDS. As discussed in Chapter 2, Thailand's role as an LGBT-friendly medical hub incorporates the display work of kathoey entertainers, who represent medical technologies and LGBT tolerance in the entertainment industry. In this chapter, I expand on how kathoey not only symbolize Thai medical technologies and LGBT inclusivity – thereby advancing medical tourism and Go Thai, Be Free – but also represent modern hygiene and public health, as they become distanced from HIV/AIDS. I argue that kathoey's professionalism in the entertainment industry is a form of “sanitary citizenship,” in which national belonging is linked to personal hygiene, public health, as well as self-reliance and individual responsibility (Briggs and Mantini-Briggs 2003:10; see also Ochoa 2014). This form of national belonging intersects with the notion of “healthicization,” or the pursuit of health as a “scientific imperative and key moral obligation for modern citizens” (Conrad 1992). Beyond individual sanitary citizens, kathoey's image and work have implications for the nation's brand, as “countries face the prospect of being thrust into the category of unsanitary states” (Briggs and Mantini-Briggs 2003:229). Kathoey's work redefines Thailand as a healthy, work-oriented nation-state.

After discussing how kathoey are framed in various discourses as professionalized workers and emblems of public health, I train our attention to kathoey's personal and embodied experiences maintaining face and social status. Kathoey's pressures to work, dress, and behave in accordance with dominant norms symbolize the nation-state's own

face and recovering reputation on the global stage. Linking micro aspects of embodiment to macro shifts in the nation-state, this chapter demonstrates how local people's gendered labor, embodiment, and behaviors are both augmenting and structured by the nation's rebranding efforts, while creating new levels of national prestige, themes elucidated in cases in Venezuela (Ochoa 2014), Vietnam (Hoang 2015), and India (Radhakrishnan 2009; Vijayakumar 2013).

While the previous chapters have highlighted inequalities, such as health care access and employment constraints in the era of Thailand 4.0, a similar theme reverberates in this chapter. Here, I underscore how medical tourism and labor norms construct new forms of national belonging and exclusion based on nation, class, HIV status, and public behavior. I demonstrate that the benefits of cultural wealth and rebranding are not evenly distributed – particularly for those who help generate these changes – elucidating how nation-branding can “maintain and reinforce historical inequalities and reify paternalist and neocolonial assumptions” (Aronczyk 2013:13). This also complicates previous research on cultural wealth, which has suggested that tourism activities may help “reduc[e] gender inequalities” for women as they are professionalized in market spaces (Regnault 2011:169).

With recent government campaigns emphasizing medical tourism, LGBT inclusion, and global citizenship, this chapter focuses on medical tourism and kathoey's labor to draw new conclusions about the intimate relationships between gendered labor, health and medicine, and the nation's cultural wealth and brand. The chapter demonstrates how the gendered technostate operationalizes cultural wealth and nation-

branding through medical tourism and gendered labor, highlighting how technologies and local gender relations redefine the nation-state. I now discuss the importance of international standards – namely Joint Commission International (JCI) – to the nation’s cultural wealth and brand.

International Accreditations

Wattana, a publisher of a Thai medical tourism magazine, handed me a hard-cover blue book with 187 glossy full-color pages. Seated across from me at his office desk, he waited for me to thumb through the publication, which featured images and text of every health care institution in Thailand accredited by Joint Commission International, (JCI). JCI, an international accreditation body founded in 1994 and based in Minnesota, offers a gold star of approval to signal world-class care, legitimizing health care sites in hundreds of countries. Thailand is home to the first JCI-accredited hospital, Bumrungrad International in Bangkok, which was awarded the gold star in 2002. The country now has 66 total health care sites bearing the JCI seal (JCI 2019), and leads the trail in comparison to other Asian medical tourism destinations, such as South Korea (27 accreditations), Singapore (22), Malaysia (13), and India (38).¹³ The process of JCI accreditation intersects with other research on the construction of global standards (Kowalski 2011; Quark 2012). Much like the designation of UNESCO “world heritage” sites, which involves actors who make decisions to identify, construct, and market “heritage” (Kowalski 2011), JCI is a “symbolic resource” (Bandelj and Wherry 2011:13) with

¹³ China’s number of JCI accreditations surpasses all of these countries, totaling 110 (JCI 2019).

cultural and economic effects, as it garners both trust and foreign currency by promoting medical tourism.

With medical tourism once seen as an “anxious demand” that involves convincing First World patients to travel to Third World countries for medical care (Wilson 2010:121), research has shown that “JCI accreditation is an important quality signal to attract medical tourists” (Pocock and Phua 2011:9). In an MOPH (2017) brochure entitled, “Thailand World Class of Medical and Wellness Tourism,” the agency emphasized JCI accreditation as a main factor that motivates foreigners to access treatment in Thailand. Yet research has not yet asserted how JCI – and the adherence to international quality standards – impacts the brand and cultural wealth of nations by legitimizing their roles as medical hubs.

“Have you heard of JCI?” Wattana asked me, the pads of his fingers pressed together.

I nodded, and he seemed to smile approvingly. He continued: “We understand that the international patient - they trusted this logo very much. This [JCI logo] is very American. So, to promote medical tourism you need to have *this*. To attract the customer.” He was still smiling, and from my perspective, Wattana seemed almost charmed by American bureaucracy. Before our interview officially began, he looked up at me while signing my Institutional Review Board (IRB) consent forms, with what I thought would be an exasperated comment about the lengthy packet. Instead, he smiled

and remarked that the documentation and request for signatures was a very American process.¹⁴

Wattana's medical tourism publishing company, he said, was first financed by the Prime Minister and Ministry of Foreign Affairs in 2009, with the purpose of selling advertisements to Thai hospitals to promote medical tourism abroad. According to Newswire (2009), the publisher produces a monthly magazine distributed to 60 countries worldwide to advertise "Thailand's best doctors and physicians." The blue book I was holding, he told me, went to various embassies and consulates to boast the country's internationally-accredited health facilities to potential medical tourists.

Achieving JCI accreditation was a "headache," for Dr. Met, a director of a public hospital, but important because the international standard "goes beyond the Thai hospital accreditation." He explained: "[The Thai] Health Accreditation is not as high of a standard. JCI is the gold star." His comments demonstrate the hierarchy of international versus national accreditations. Although there exists a national health accreditation and the Institute of Hospital Quality Improvement and Accreditation to certify Thai hospitals (Arunanondchai and Fink 2007), discourses from government agencies and private hospitals stress the importance of international accreditations such as JCI, signaling the ways in which the Thai nation gains global legitimacy as a medical hub by adhering to international norms. According to Dr. Met, JCI standards help raise the level of care for local and foreign patients. He said: "(By abiding by) international standards, our patients

¹⁴ Also an American process, Wattana said, was when JCI sued his company for using their logo in publications without permission.

get a higher standard of care... [It] means we are good enough for international patients. We become a model.” Dr. Met’s distinction between health care that is “good enough for international patients” demonstrates that medical tourism increases a bifurcation between nationally- and internationally-accredited care, a theme discussed in the previous chapter. Nonetheless, JCI-approved Thai health care sites become “models” of quality care.

As a symbolic and material resource, JCI contributes to the cultural wealth of Thailand by rendering its medical care credible on the global stage. Similar to how U.S. standards became global indicators for cotton quality classification (Quark 2012), JCI demonstrates how Global North-based rubrics have become “international.” The international legitimization of health care sites, as part of the medical hub strategy, rebrands the nation and affords it new levels of cultural wealth by incorporating global norms of health care quality and credibility, such as JCI. The JCI accreditation process speaks to how global norms are diffused and adopted in local settings, with JCI catalyzing a nation’s cultural wealth by serving as one of the “international prizes earned by its citizens” (Bandelj and Wherry 2011:7). I now analyze how Thai traditional medicine in the international domain provides a gateway to assess the implications of Thai gender-affirming surgeries for the brand and cultural wealth of the nation.

Regulating and Internationalizing Thai Traditional Medicine

At the MOPH in Nonthaburi, Thailand – just outside of Bangkok – pillars and walls were painted with images depicting Thai traditional healing. I was meeting with Dr. Pavin, an MOPH official, on a Friday afternoon. As we sat at a large conference table, he

smiled serenely and shared that he had just come from a Thai massage, which incorporates yogic stretching and pressure points as one of the subsets of Thai traditional medicine, or in his words, the “Thai style of wellness services.” The current medical hub policies regulate and sell Thai traditional medicine for international consumption, exported to foreigners as one of the four main categories of the medical hub policy instantiated in 2003 by the MOPH. Thai traditional medicine is a source not just of “national pride,” according to Dr. Pavin, but also an element that makes Thailand more unique for foreigners seeking health care. What are the implications for the nation’s brand and cultural wealth as Thai traditional health services are revived and regulated under Thailand 4.0 and medical tourism? And what does this example suggest about how other forms of medicine – namely gender-affirming surgeries – become internationalized through medical tourism?

Thai-specific standards assert credibility for traditional Thai medicine, both in Thailand and abroad, rendering new levels of legitimacy for Thai medical practices. Since 2016, the wellness hub policy enforces the Health Service Establishment Act, which has certified 1,701 health spas, health massage, and beauty massage establishments (MOPH 2017). The National Institute of Thai Traditional Medicine, a branch of the MOPH, started to promote traditional Thai healers and develop licensure and regulation.¹⁵ Thai medicine becomes “modernized” through university education practices and licensing by the state, while the creation of expertise through licensing

¹⁵ While there was once a binary between *maw duu*, a spirit healer, and *maw gradat*, or “paper” doctors, research has also shown how regulation has led to the disenfranchisement of folk healers in Northeast Thailand (Cassaniti 2017), who are not directly persecuted but asked not to practice.

speaks to trends in “selective legitimation” (Lambert 2012), in which guidelines and registration for indigenous healing have emerged to distinguish “magical knowledge” from scientific rationality.¹⁶ The case in Thailand demonstrates how traditional medical practices themselves have become hybridized as international standardization transforms how, by, and for whom they are practiced. The medical hub policy impacts local knowledge and healing communities through standards of expertise and legitimacy, demonstrating how global norms of rationality and scientific legitimacy merge with local medicine.

The Thai standards are also used to certify overseas establishments in Germany and Australia, demonstrating the ways in which Thai standards of health care permeate health establishments beyond Thai borders. In addition, the Thai American Chamber of Commerce of California also inspects health establishments in the U.S, asserting a Thai model of health practice and care beyond the container of the nation. Thai medicine is replicated and practiced beyond Thai borders, while also complying with Thai-specific standards. This facet of the medical hub challenges aspects of world-polity theory that assert Western norms are uniformly adopted (Meyer et al. 1997). Instead, Thai traditional medicine is hybridized with transnational health norms, as traditional health care practices are both localized in Thailand and diffused globally.

As the current plans for the Thai medical hub now regulate and sell Thai traditional medicine for international consumption, and the MOPH seeks to become a

¹⁶ In South Africa, too, parallel convergences, or hybridity, of biomedical and indigenous healing practices exist through people’s “hybrid health behavior” to treat HIV/AIDS (Decoteau 2013).

“product hub,” one can walk into any 7-11 in Thailand and find shelves of manufactured herbs — from turmeric capsules for overall “detoxification” to a host of “cosmeceuticals,” a portmanteau of cosmetics and pharmaceuticals. The term cosmeceutical demonstrates the increasing hybridity of traditional medicine, aesthetic, and medical technologies commodified through transnational health practices. The current medical hub plans reflect the historical collision of European technologies with Thais – encounters that did not always take hold in “smooth-as-silk” ways (Winichakul 1994:61). Although the Thai government has strongly supported the development of biomedicine in Thailand, which presently “dominates health-care delivery” (Techatraisak and Glesler 1989), it is not a uniform institution.

The internationalization and regulation of Thai traditional medicine through medical hub policies demonstrates the hybridity of local and global norms that arises through medical tourism, both reifying and complicating aspects of Western medical dominance. The legitimization and alteration of Thai traditional medicine through standardization, commodification, and regulation speaks to how the Thai nation-state gains cultural wealth by incorporating dominant regulatory norms with its traditional healing practices. Thailand’s brand and reputation on the global stage is reconfigured, as the country has become an esteemed destination for alternative and complementary medicine, including spiritual, health, and wellness practices that incorporate local forms of knowledge. Thai policy makers both create and comply with international health standards, which are coupled with locally-specific practices, laws, and norms, assuring a distinction between sexualized services and medical tourism.

With hybrid health practices and accreditations, local specificities converge with global norms – sometimes accidentally, but often strategically. I now discuss how Thai surgeons who specialize in gender-affirming surgeries incorporate international standards *and* remake global hierarchies of knowledge, demonstrating how this niche of medical tourism advances the nation’s rebranding efforts and cultural wealth.

Thai “Pioneers” and Global Health Hierarchies

In 2014, Bangkok hosted the World Professional Association of Transgender Health (WPATH) Biannual Conference, themed “Transgender Health in a Global Perspective.” WPATH is a nonprofit developed in 1979 that advances professional and educational aspects of transgender health worldwide, and is considered the “gold standard” of health care by several Thai health practitioners. In the promotional video for the 2014 WPATH conference, we see images of temples, beaches, traditional Thai dance, and Dr. Preecha, the first gender surgeon in Thailand. Seated behind an office desk, Dr. Preecha invites participants to Bangkok, stating: “This is our opportunity to bring together worldwide professionals who are dedicated to developing the best practice[s], supportive policies, research, education, and rights for gender variance in all cultural settings.” That Bangkok hosted the international professional organization centered on best practices symbolizes the country’s growing role in the domain of global transgender health. How do Thailand’s brand and cultural wealth shift with its global expertise in gender-affirming surgeries? While Chapter 3 analyzed the “iron cage” of global transgender health and the dominance of international norms of sex, gender, and

biomedicine, this chapter nuances the implications for the nation's brand and cultural wealth.

Thai expertise in gender-affirming surgeries is a form of hybrid knowledge, that incorporates “normal” and “conventional” science, but also local expertise. Although many Thai doctors operate within an iron cage of global transgender health, they also trained themselves in the surgical techniques. There was no reliance on external authorities or outside medical knowledge, as the first genital reconstruction surgery in Thailand took place in 1975 by Dr. Preecha at the public hospital of Chulalongkorn. Dr Preecha then went on to train other Thai surgeons, and has since opened a branch of his clinic in Vietnam (Asia News Monitor 2009). Dr Preecha is referred to as one of the “pioneers” of gender surgeries, according to FacialTeam, a WPATH-incorporated company formed in Spain with an international presence in the U.S., Italy, Switzerland, Sweden, and Brazil. The global reputation of Thai surgeons as “pioneers” demonstrates their impact on the field of transgender health, which was not only developed through Western biomedicine or standards, but by doctors in Thailand. Medical expertise is hybridized through medical tourism and transnational health flows.

Thai surgeons such as Dr. Preecha also contribute to the global formation of medical knowledge, providing professional trainings to doctors worldwide, and symbolizing how actors in the Global South can become key players in a global health field. While the Introduction described how U.S. missionary Dan Beach Bradley performed surgical practices for smallpox in front of live audiences in 1835 (Puaksom 2007:314), Thai surgeons have more recently performed gender-affirming surgeries live.

The operation videos have streamed virtually, with European surgeons invited to watch a broadcast (China Daily 2004). Dr. Preecha was quoted in a news report as saying: “We want to show the world that our standards of treatment are comparable to the international level. That is why we have invited world renowned surgeons from Europe” (China Daily 2004). The broadcasting of Thai surgical techniques speaks to Thailand’s role as a node of global transgender health knowledge formation, redefining the global landscape of health and medicine by becoming a leader in transgender health professional networks. According to Dr. Arun, a gender surgeon in a public hospital who also performs surgeries in the private setting, virtual networks have helped develop surgeons’ skills, both in Thailand and globally. He said: “In the past, you don’t have YouTube, you don’t have the videos to show you how to do that [surgery.] You have to talk to them, go out. Now it’s much more easier.” Medical reputations, national brands, and cultural wealth are built not only from material practices or symbolic resources such as JCI, but also through virtual communities such as YouTube.

The growing role of Thai health professionals in the global transgender health arena exemplifies a growing Thai professional movement, encapsulated by “knowledge, networks, and resources” (Harris 2017a:254), which may shape health care policy and practices globally by asserting particular values of transgender health. The virtual practices of knowledge-sharing regarding transgender health suggest how health hierarchies and professional expertise are redefined through “digital assemblages” (Sassen 2006:377) and online networks.

Indicative of Thai doctors' prominent role in the global transgender health field, surgeons from the United States have also identified Thai doctors as a source of comparison and even competition, indicating shifting hierarchies of knowledge and medicine. For example, the website of Dr. Marci Bowers, a leading gender surgeon based in California, situates her expertise distinctly in relation to Thai surgeons. In the Frequently Asked Question section of her website, one question states: "What makes Dr. Bowers' vaginoplasty procedure different from surgeons in Thailand?" The answer distinguishes her techniques from "a dinosaur technique that the world is slowly abandoning." In another question, she specifies the use of a two-stage procedure, using parts of the anatomy that she asserts Thai surgeons do not use. Dr. Bowers' inclusion of these questions about Thai doctors, and her positioning of Thai expertise as archaic or "dinosaur," elicits colonialist discourses that frame Global South countries as "behind" or "traditional" (Decoteau 2013:265). While the website characterizes Thailand as tragically behind, it also demonstrates that potential patients frequently compare U.S. and Thai surgeons, elucidating Thai competition and expertise in the global transgender health domain.

Yet adhering to international standards is also important for Thailand's gender surgery expertise. For example, Dr. Arun spoke to how JCI is a ubiquitous need for health care institutions. He said: "Everybody wants JCI now, to be accredited. They want more standards, they want more credentials. Doctors have to pass all the highest [boards]." The emphasis on international standards helps construct Thailand's success as

a medical hub. Dr. Arun asserted that abiding by dominant standards such as JCI,

Thailand earns its place as a medical tourism destination. He said:

Quality and safety standards is the most important aspects of offering gender-affirming surgeries through medical tourism... We all feel that concerning more medical tourism, nothing else is more important than safety regulations... Many hospitals adopt safety regulations from the U.S., U.K., and from all over world to make sure you really improve not just the technique of transgender surgical techniques, but the anesthesiologists, the post op care...

JCI accreditations distinguish gender surgery venues for medical tourists, implying the divisions in “[q]uality and safety standards” for local versus foreign people, as discussed earlier in Chapter 3.

Additionally, Thai doctors with education from abroad legitimize health care practices and medical tourism in Thailand. For Dr. Wirun, since there are “certified board physicians from [institutions in] the U.S., [it] makes the Thai system credible.” Akin to the creation of professional boundaries in the United States (Friedson 1988), many Thai surgeons have been board certified beyond Thailand, receiving standardized education from countries such as the U.S., Britain, and Australia. This foreign training has helped Thai surgeons become internationally-renowned.

Thai expertise in gender-affirming surgeries redefines global hierarchies of medicine and knowledge, complicating aspects of world polity theory that posit a monolithic diffusion of Western culture (Meyer et al. 1997). While some scholars have expressed concern that Thailand is weak in the areas of science and technology (Reynolds 2002), Thailand’s unique knowledge formation regarding transgender health has afforded the nation-state new levels of cultural wealth, as Thai surgeons redefine global health practices. Thailand has become a destination that hosts and develops

professional transgender health networks and practices— with Thai doctors training foreign doctors, and representing potential competition in the field of surgical expertise. With transgender health and human rights at the forefront of the WPATH conference held in Bangkok, Thai surgeons help boost Thailand’s role as a global center for gender-affirming surgeries. This reputation is constructed not just by local knowledge and medical professionals, but also through adherence to international norms and globally-bureaucratized treatment guidelines, as discussed in Chapter 3. There exists a hybridity of local medical knowledge and international norms, as the medical hub and nation are bolstered by local specificities (e.g. traditional medicine or pioneering surgeons), as well as adhering to international standards and global transgender health guidelines. Thai transgender health expertise represents the hybridity of local knowledges and international standards of care that takes shape through medical tourism, with great potential to redefine cultural wealth and the nation’s brand.

Redefining the Nation through Medical Tourism

As biomedicine is deemed a marker of economic and symbolic capital (Decoteau 2013; Epstein 2008; Ong 2010), medical tourism extends our understanding of how nations define their brands and accrue new levels of cultural wealth by becoming medical hubs for foreigners. For developing countries such as Thailand to advance science and technology, Reynolds (2002:325) argued, it is “the difference between economic sovereignty and economic dependency.” Yet beyond economic gains, I argue that

medical tourism reconfigures the Thai nation's brand and cultural wealth, by positioning the nation as a site for professionalized skills and a reputable work culture.

For several interviewees, medical tourism has an intangible impact on Thailand's image. Dr. Wirun mentioned that the nation maintains a positive image through medical tourism. He said: "In the medical field we have a very positive image internationally: we have good doctors, our people are friendly, those patients come here and they are all happy with our hospitality. [Medical tourism] is indeed a very positive image, [and has] a good impact for the country." Despite its crowding out effect and the increased privatization of health services, several kathoey mentioned they were proud that Thailand has become a medical hub. For Sunny, medical tourism represents the skills of Thai doctors and enhances the nation's "soft power."

Some also believed the nation has become more professionalized through medical tourism, which they believe may augment local work culture. Dr. Met, for example, said he believes that Thai people's relationship to "work and play" shifts as a result of globalization and the medical hub. He explained: "The downside of Thai culture is *mai pen rai* ("don't worry"). You feel the laidback attitude. When the world is open, interconnected, and other people work systematically and show up on time and know when to work and play... the medical hub helps because it opens up Thai health care system to world." Dr. Met implied a cultural shift resulting from medical tourism. The distinction between "other people work[ing] systematically and show[ing] up on time" – and adhering to a division between work and play – demonstrates how the *mai pen rai* culture, or "laidback attitude," is reformulated in accordance with global norms and

practices of working more “systematically.” Thai people’s work ethic and cultural attitudes are believed to be augmented as medical tourism advances, symbolizing a different version of the nation in relation to the global economy.

Dr. Wirun also speculated that medical tourism creates cultural shifts, as Thailand becomes more open to other customs and people. Just like medical tourism can foster new diseases as people travel across borders, he said: “[T]here are new foreigners, new people, new social interactions taking place.” His voice became quieter, as he wondered aloud if globalization and medical tourism could influence Thailand’s identity. He said: “Openness can be good or bad – it depends on how we look at it and manage it. Can we bring about good things out of openness, or let it threaten our own identity?” His question was phrased rhetorically, but led me to follow up:

“What identity?”

“Well,” he began, “each country has its own identity. Some people may come to Thailand because they want to experience Thai identity. But if globalization takes over this unique identity of Thailand, people may not want to come here anymore because, ok, we are like the Netherlands... Too much openness may not be good.” Dr. Wirun seemed weary that Thailand’s cultural uniqueness could merge, and eventually disappear, with other cultures in the era of globalization and medical tourism. Although I sensed his tone drop, I asked:

“What is Thailand’s unique identity? What is Thainess?”

Dr. Wirun paused to think, responding: “Most obviously language. Our way of living. The smile. Cultural practices – the way we *wai* (bow). If the western culture

comes here too strong, we may forget how to *wai*. What will happen if Thai people no longer perform the *wai* anymore?" Dr. Wirun expressed discomfort at the thought of Thai culture becoming "forgotten" as globalization and medical tourism advance. He seemed fearful of losing unique aspects such as the *wai*, expressing how foreign influence could overwrite aspects of local culture.

While medical tourism might augment elements of national culture, it also incorporates particular cultural tropes. Some interviewees spoke of a "natural" quality of Thai people, who they said are open to people from a variety of backgrounds. For instance, Dr. Wirun told me that Thai people innately do not discriminate against others, which enhances medical tourism. He said:

The culture of the people of this country welcomes foreigners. Thai people by nature are not the people who discriminate or build barriers to foreigners regardless of their nationality or religious belief. You don't have to wear a certain pattern of clothes, you can find any kind of food – [we are] friendly to all restrictions around the world.

This conception of Thai people characterizes them as innately open to a variety of nationalities and religions. Attributing non-discrimination as a cultural trait is also attached to ideas of Buddhism, implying a unique comparative advantage for the Thai nation. For instance, Dr. Wirun said: "In general Buddhist people are more open-minded, we welcome culture from other countries, we don't discriminate." Medical tourism both redefines and incorporates elements of Thai culture, such as open-mindedness and Buddhist values.

For expatriates such as Ali, medical tourism positively helps redefine the nation's image, as it diverts resources from the sex industry to the medical field. Ali said:

Rather than a place for ping pong shows, prostitutes, and drugs, now [Thailand] is [known for] medical treatment, ecotourism – things that are still flawed industries because it's still using a culture to make money [and] changing the price of things to [attract] more tourists. If at the end of the day people are coming for healthcare, nature, spirituality, or food it's so much better than coming for prostitution, sex, and drugs. I like what [medical tourism] does for the country because I want this to be my home, and when I say [I live in] Bangkok, I don't want people to laugh. Anything we can do to shift money away from the sex industry.

Ali asserted that medical tourism can help rebrand the nation as one with medical treatments rather than sexualized services. This shift – from a sex tourism destination to a medical hub – is indicative of Thailand's cultural wealth and rebranding efforts through medical tourism.

There is a notable intersection between the regulation of health/medical spas and sexualized entertainment services. Dr. Pavin explained that there was previously no law to regulate health spas, massage parlors, and “grey services,” such as colonics, but a law emerged through the Ministry of Interior to regulate “entertainment premises,” such as discoteques or bars. Dr. Pavin was clear to distinguish these sites from sexualized services. He said that the entertainment venues certified by the Ministry of Interior are “not the brothels, but the kind that have some service, like, uh, ladies. But it's not for sex, *na*. It's illegal for sex. But for entertainment – karaoke, something like that – it's [regulated] under the Ministry of Interior.” Dr. Pavin's explicit desexualization of entertainment venues, such as massage parlors and karaoke bars, demonstrates how government actors de-emphasize the sex industry, turning attention toward regulating and certifying health and medical venues.

Medical tourism in Thailand both reifies and transforms global medical hierarchies, as international accreditations and U.S. medical trainings earn the trust of

foreign consumers, positioning the nation-state as compliant of Western medical practices. The relocation of internationally-accredited health services – whether Thai traditional medicine or gender-affirming surgeries – to countries in the Global South speaks to a shift in global medical hierarchies. The growth of medical tourism in Thailand demonstrates that non-Western states have the potential to both adopt and redefine aspects of world culture, representing the “lumpiness” of global networks – including those which are virtual (Sassen 2006:350). Rather than the smooth, isomorphic uniformity of monolithic Western medical science, local Thai traditional health practices – and Thai doctors’ internally-developed skills regarding transgender health – demonstrate that international medical norms and practices are not blanketed across locations. They are instead consistently renegotiated and blended with various non-Western actors, particularly those from the Global South. In the sections that follow, I analyze how kathoey also advance Thailand’s rebranding efforts and cultural wealth – not only by advertising technologically-enhanced femininity and LGBT diversity, as discussed in Chapter 2 – but also through their projections of professionalism, public health, and upholding of proper behavior, or “face.”

Professionalizing Kathoey, Sanitizing the Nation

Kathoey’s shifts in professionalized labor and public demeanor reflect and recraft the Thai nation-state’s changing role as an internationally-legitimate medical hub, signifying the nation’s own changing face on the global stage. Research on cultural wealth and nation-branding has not often focused on how gendered relations are part of

these processes. This section underscores how kathoey's gendered labor is realigned from sex work, augmenting the nation's shifting wealth and branding efforts.

I build on work that has analyzed how Western hygienic practices have been linked to women's (and particularly sex workers') sexual health, and the modernity of the nation (Yen 2014:782). For instance, under instruction from the U.S. and WHO, the Taiwanese government established Venereal Disease control clinics for bar girls to protect foreign soldiers from infection during the Vietnam War (Yen 2014:783). Women's health and the nation were linked, as "women's contaminated bodies seem paralleling to the unhygienic and backward state of Taiwan, where their prostitutes and people were assumed not as clean and fit as those of a healthier and stronger nation" (Yen 2014:784). By managing the sexual health of sex workers, Yen (2014:784) argued that the Taiwanese national reputation was rebuilt through the implementation of modern hygiene. Related to biocitizenship, discussed in the Introduction, a form of "sanitary citizenship" extends beyond the individual's clean or unclean body, but also constructs the cleanliness of the national body (Briggs and Mantini-Briggs 2003). Using the case of cholera in Venezuela, sanitary citizens "possessed a full set of normative economic, cultural, familial, legal, educational, sexual, and medical characteristics" (Briggs and Mantini-Briggs 2003:41). Similarly, I argue that kathoey's labor roles in the entertainment industry are distinguished from sex work and HIV/AIDS, rendering kathoey symbols of a sanitized Thai nation.

Kathoey cabarets are featured on a number of TAT (2019) websites, which market the "world-class performers" and "world-class extravagant productions and

stunning exclusively-created costumes.” The emphasis on “world-class” venues parallels medical tourism discourses on the world-class standards of Thai doctors and hospitals, emphasizing the nation’s belonging on the global stage with shows that are compared to Broadway and Moulin Rouge. In addition, the TAT’s Go Thai, Be Free marketing materials acknowledge that the “sleazy” reputations of certain Thai destinations are rewritten with kathoey cabarets. For instance, on the TAT webpage about Pattaya, which is home to one of the country’s most well-known red-light districts, the text reads:

The region has suffered from a somewhat sleazy reputation in the past, but things are changing – though you’re still guaranteed a good dose of gay-ol’ fun here! For instance, why not check out a humorous cabaret drag show at Castro Bar that will have you and your BFF crying with laughter?

Kathoey alleviate Thailand’s “suffering” from a negative reputation, as they become symbolic brands of how “things are changing,” through the nation’s hard work and increased professionalism. Under military leader Prayuth Chan-ocha’s, the government also attempted to rebrand Pattaya from a sex tourism district by naming it “Happy Zone,” in order to “promote Thailand’s quality tourism” and “stamp out prostitution in the area,” according to the chief of Pattaya city police who was quoted in the Reuters (2017) report. Further, the private company’s website for the Aphrodite Cabaret Show stated the performance “is suitable to open-minded audiences of all ages and nationalities,” which implies not only the liberal attitude of audience members, but a shift from sexualized entertainment to shows for “all ages.” Kathoey entertainers stand in for and construct Thailand’s professionalized brand and cultural wealth, as their labor roles are distinguished from sex work through both government initiatives, websites, and private discourses.

Many kathoey I interviewed believed it was their individual and collective responsibility to gain respect through successful employment and a strong work ethic. May elaborated: “If we are hard-working and do a good job, who is going to blame us? Good work performance is the proof of everything.” Working hard, for May, would alleviate societal discrimination or mistreatment in the workplace. Earning an income was also important for kathoey’s familial acceptance. Wan, who worked at an LGBT NGO, said: “My father did not want to accept me as his daughter. Then I finished school, found work and sent money home. My dad now proudly tells others that I'm his daughter.” Wan’s ability to fulfill familial obligation by sending remittances to her parents enabled her acceptance, not unlike what others have found in research on homosexual women in Thailand (Sinnott 2004:11-12).

For many interviewees, the entertainment industry has promoted a positive image of kathoey, particularly because it highlights their skills as workers. Ahn said: “When we become Miss Tiffany, everyone will be more accepting. Everyone is going to praise us and that is what we really want. We also want people to acknowledge our skill and capabilities. That can also change the mindsets of people who dislike us.” Ahn specified how publicizing their skills and capabilities help redefine kathoey’s reputation, allowing for greater social acceptance and praise. Overall, the Thai nation-state is comprised of a new class of professionalized workers, in both the kathoey entertainment industry and medical field.

Specifically, kathoey’s hard work was seen as more valuable since it took place outside of the sex industry. Oom said that social acceptance and rights have been granted

to those who can prove they are not “dirty kathoey.” The emphasis on “dirty” versus kathoey who are clean reflects the concept of sanitary citizenship, or “the ways that states read bodies and bodily practices and assess the biomedical knowledge of individuals and populations” (Briggs and Hallin 2007:43). With hygienic threats linked to different groups across lines of race and nation (White 2018), kathoey entertainers have become more discursively detached from the public health concern of HIV/AIDS. Kathoey’s professionalism in the entertainment industry is not only related to their prized skills as workers, but also to their breakage from HIV/AIDS campaigns and programs. To emphasize kathoey’s changing reputation, Jin described what she would like others to know about kathoey, stating:

So don't stereotype us as working as dancers, prostitutes, or having a foreign husband. I think society is still not open about this. And I think society still thinks that we die from HIV/AIDS. I want them to know that [we] love and take care of ourselves. We use condoms.

Jin’s desire to distinguish kathoey from sex workers and the HIV/AIDS epidemic speaks to the need to counter dominant beliefs that position trans people in relation to HIV/AIDS, an association which dominates global health funding and trans medicine, detailed in the previous chapter. Kathoey’s professionalized labor in the entertainment industry affords them a new reputation distinct from HIV/AIDS and sex work, and symbolizes how professional outcomes intersect with public health surveillance. Kathoey themselves overcome the reputation of sex tourism and an unsanitary nation, complying with public health norms by becoming sanitized through their jobs outside of the sex industry.

That kathoey gain acceptance through non-sexualized work and cabaret professionalism – and becoming sanitary citizens – reverberated in informal conversations and other interviews with medical professionals, often unprompted. For example, Dr. Arun, a Bangkok surgeon who has been performing surgeries on kathoey for several decades, said that kathoey are more accepted now because they are more educated and get better jobs. He said:

The real thing about the transgender in Thailand is 30 years ago, because society thinks they are weird, they were not well educated so they don't get a good job and most jobs working in sex services so prostitutes... So I think it's much better for them. Yes, many still work in the sex fields but I think it's their choice. You cannot say that some transgender can't find a job. It's your choice.

Dr. Arun characterized Thai society as more egalitarian than in the past, framing sex workers as choosing their work despite other “good” options. His juxtaposition of trans sex workers versus those who find good jobs emphasizes the existence of a still underlying disapproval of sex workers, who choose their work outcomes outside of what is good or acceptable.

While Chapter 2 discussed how kathoey have helped launch Thailand's reputation as a global destination for gender surgeries, Dr. Arun cited how medical tourism – particularly its cultural flows – has also changed the social status of kathoey. He said:

Because Thai society at that time [did] not recognize these [transgender] people are so good... until we recognize [Thailand as] the capital of sex change – then people know more about transgender and they start to know that the transgender is not just only the low-class people they saw. More and more transgender [people were] coming up and stand[ing] with [their] community and say[ing], “I am transgender but I have a good career, I have a good social status, I'm a celebrity, I'm the actress, I'm the normal business [person] like you...” So this fact more and more [is] known among the [society]. This is the progression: positive progression, more acceptance.

Dr. Arun saw the medical tourism industry as making visible transgender people with “good career[s],” thereby improving the reputation of kathoey and trans people more broadly. Kathoey’s visible and lauded work in the tourism industry has led to a “positive progression” of great societal acceptance, as kathoey have become more well-known as celebrities, actresses, or “normal business [people],” rather than “low-class.” Associating kathoey actresses and celebrities with “good career[s],” “good social status,” and “normal business,” Dr. Arun implies their distancing from sex work, a field that is outside the range of good and normal.

In the gendered technostate, economic and social pressures to participate in the formal economy (while also exhibiting gendered norms of technologically-enhanced embodiment) represent the “technologies of citizenship,” which ascribe that individuals manage themselves as autonomous subjects (Inda 2008:19). The stigma of sex work and HIV/AIDS has permeated public opinion of kathoey, which they are responsible for recovering by proving their hard work and skills on stage. Not only do kathoey entertainers embody the skills of Thai surgeons, but they also represent a distinctly professionalized sphere of labor outside of the sex industry, as they become iterations of “sanitary citizens” (Briggs and Mantini-Briggs 2003:10), who are delinked from sex work and HIV/AIDS. As the Ministry of Commerce (2016) endorsed the notion that Thais “improv[e] themselves” and become “self-reliant” so that Thailand becomes a “high-income” country, these neoliberal discourses of choice, hard work, respectability, and individual responsibility justify the labor relations that naturalize kathoey’s pressures to access technologies, described in Chapter 2. Their professionalization then augments

the trajectory of Thailand's brand and cultural wealth by projecting these qualities of skilled, desexualized, sanitized labor on a global stage. I now discuss how kathoey control their behavior and manner to maintain "face," or public appearance, illustrating a microcosm of how the nation procures its own face on the global stage.

The Gendered Politics of Cultural Wealth

Being a mere woman,
 I can only ask you, a woman-to-be
 to softly sense and tenderly touch
 life's multi-textured realities
 and
 with a woman's heart,
 try to feel and understand...
 Forever try to understand.
 --- Chamnongsri L. Rutnin, 1998

While Thai poets have sketched the emotional contours of Thai cisgender women's roles as "soft" and "tender," kathoey's concern over face, or public respectability and status (Ukosakul 2005), demonstrates how norms of behavior are incorporated in daily practices alongside as the nation brands itself and accumulates cultural wealth. Norms of dress and conduct are not unique to kathoey in the era of Thailand 4.0, and are instead connected to previous mandates regarding fashion and civility (Käng 2014), such as gendered codes of dress which emerged in a royal decree in 1941, discussed in the Introduction. Scholars have shown how "[c]itizenship...requires the performance and contestation of the behavior, ideas, and images of the proper citizen" (Manalansan 2003:14). Gay men in the Philippines, for instance, reflect and reimagine Western "modern elements" of consumerism and language (Manalansan 2003:17-18).

Additionally, Radhakrishnan's (2009:198) work on Indian professional women in the Information Technology (IT) industry showed how their respectable femininity – in which they prioritize home over career, uphold materialism, and fear promiscuity – represents and impacts the changing national culture. Kathoey's bodily comportment and behavior also parallel how the Thai nation recasts its own behavior on the global stage, by adhering to, and at times rewriting, dominant norms of conduct. The case thus elucidates how gendered interactions and behaviors on an individual level are linked to the changing cultural wealth and brand of the broader nation.

Many kathoey stated that it was important to control their manner, conduct, and behavior in order to gain social rights and acceptance. Kathoey spoke to the rigid codification of behavioral norms, reflecting monarchical values that Thais appear *siwilai* (civilized) (Winichakul 2000). Oom added: "We dress well, and speak well. So, society accepted us more." Adhering to norms of dress and speech also affords kathoey greater societal acceptance. For Fai, becoming a woman is a "tough experience," which entailed both bodily transformation as well as manner: She said: "It's not [just] about having to transform your body to fit with the feminine standard. You also need to shape your manner to fit the standard as well: the way you dress, the way you sit, the way you talk, the way you eat right, the way you speak, the way you release your voice – everything." Fai demonstrates the underlying gendered bodily politics of maintaining social status in Thailand.

In these ways, kathoey spoke to aspects of bodily composure (Berlant 2011:5), or "gestural economies that register norms of self-management that differ according to what

kinds of confidence people have enjoyed about the entitlements of their social locations.” They represent broader norms in which a “Thai lady of good breeding... shall not externalize her inner most sentiments in explicit form” (Rutin 1988). For instance, Jin said that beauty involves a “soft character” of a lady, involving bodily constraint and demeanor. In addition, Song said: “[Ending discrimination] has to start with us: we have to be more polite and control ourselves not to act wild in public places.” Song pinpoints kathoey’s “polite” and controlled behavior as a catalyst for greater social acceptance. In addition, the focus on politeness and not acting “wild” or “weird” in the health care setting was also emphasized by other interviewees, such as Dr. Wirun, discussed in Chapter 3.

Gendered behavioral norms also encapsulate aspects of transnormativity, or abiding by the norms of dominant institutions (Vipond 2015). In order for kathoey to gain mainstream acceptance, they must typically display proper norms of conduct that delimit their expressions of diversity. According to the ILO (2014:42), in official settings such as government offices and public-private institutions, Thai LGBT people “are expected to suppress or tone down their “divergent” sexuality and behave within social norms. As a result, transgender persons tend to avoid, or opt out of formal society.” Although Go Thai, Be Free emphasizes LGBT diversity, norms of conduct constrain Thai trans people to “tone down” their differences. This demonstrates how gender hierarchies are constructed in the workplace (Schilt and Connell 2007).

Social media also circulates gendered norms of conduct for kathoey. For example, Pinky spoke to how internet celebrities have become spokesmodels for public conduct,

stating: “There are some *sao praphet sorng* who are internet celebrities that speak in the media about how *sao praphet sorng* should behave in the public... Sometimes they Facebook Live to talk about how to behave, how to live as a *sao praphet sorng*.” Pinky emphasized how sites such as Facebook Live allow people to stream norms of conduct, underscoring the role of online groups and social media in advancing particular ways of being and behaving.

The gendered technostate rebrands itself and achieves new levels of cultural wealth as people are rendered acceptable subjects by adhering to dominant norms of gendered embodiment, behavior, and professionalism. Kathoey entertainers enact a form of “Thainess” (Phongpaichit and Baker 1998), or Thai identity that is skilled, proper, and delinked from sex work. While this chapter has focused on kathoey’s physicality as it is augmented by technologies of embodiment, I now discuss how beauty and social belonging are also constructed within and beyond the body itself, tied to Buddhist values of merit and having a good heart.

Beauty as Social Merit

Aside from physical embodiment and conduct, public displays of merit¹⁷ can also boost kathoey’s social acceptance, as the entertainment industry promotes kathoey’s acts of charity. For instance, San said: “Many transgender people contribute for society a lot. Some of them make merit and some of them do many charity projects. So, society

¹⁷ In Buddhist tradition, making merit involves generous acts or deeds that can earn a person benefits in this life or a future one (Falk 2007:140).

becomes more accepting of *sao praphet sorng*.” Egg also spoke to how kathoey have become more accepted as “social contributors.” The entertainment industry not only circulates physical and occupational ideals, but also promotes kathoey’s merit-making, contributing to their greater social acceptance. Dao, for instance, said:

In accordance to the transgender beauty pageant, they usually highlight the career and educational background of each contestant to portray that we are born equally and the social contribution... can contribute to the future of the Kingdom of Thailand as well other Thai people. They have [shown that] transgender people can do countless things to benefit the society.

Nana’s beauty pageant, too, raised money for a temple to be built in San Francisco, an element she said is unlike others since it is based on charity. Since Nana’s beauty pageant contest collects money through ticket sales to donate to the temple in the United States, she said the aspect of charity can help raise kathoey’s social acceptance:

We want to improve the image of not only *sao praphet sorng*, but also *toms* (masculine homosexual women), *dees* (feminine homosexual women), and kathoey. We want to prove that we can do anything and any job. Because Thai tradition made us into a strange thing. Religion can help shape ours mind and hearts. It can change us into a better person, sometimes even better than man and woman. But the media never shows this, they only show when we did a bad thing.

Beauty contests and entertainment venues can put forth public acts of charity, raising the status of kathoey in society.

Jin, a pageant winner, said her work as a beauty consultant result in making merit. She said: “In my point of view, it’s like doing good deeds. It’s like making merit helping other people to obtain their beauty, helping them grow with beauty and confidence so that they don’t get stuck in their past.” Beauty, and work associated with beauty, are linked to merit-making, contributing to more positive opinions of kathoey and their social contributions. Addressing the role of virtual communities, Naw stated that online

networks have improved kathoey's reputations as a way to showcase their social contributions. She said: "From social media, [society] learned that transgender women joined so many charity projects, so they start to know that there are some good sides of people like us in society." Kathoey spoke to how beauty contests, and high-scale cabarets, can serve as "a form of cultural activism" (Jackson 2011:36), through which kathoey may "challenge the demeaning stereotypes that still dominate other fields of Thai popular culture... and reflect a claim for recognition and status in a beauty obsessed society (Van Esterik 2000, as cited by Jackson 2011:36).

Norms of Buddhism and ideas of merit-making are assembled throughout most aspects of Thai society and life, and thus, kathoey's social contributions through beauty and the entertainment industry impact their broader acceptance. These more positive public images then have the potential to advance the brand and cultural wealth of the nation-state, as kathoey's image is enhanced on a global stage and continually detached from sex work and thievery. I now discuss how the gains of cultural wealth through medical tourism and kathoey's labor are unequally distributed based on class, nation, gender, and HIV status.

On Borders and Belonging

Medical tourism encapsulates the exclusionary politics of cultural wealth and nation-branding, as Thailand's provision of health care is most available to people from particular nations and class backgrounds. Health care in Thailand is compartmentalized not only for local people, as discussed in the previous chapter, but also for foreigners.

Historically, medical tourism expanded in Thailand and India because of the 9/11 attacks in the U.S., when people from Middle Eastern countries faced constraints and suspicion from Western countries and could not receive medical care in the West (Interview data; Bochaton and Lefebvre 2008:99). Within medical tourism, global politics of exclusion have become institutionalized.

Such practices take place through visa policies that allow some and not others across borders. For instance, the Thai Ministry of Foreign Affairs has updated visa requirements for medical tourists, making it easier for people from particular locations to travel for these services. According to a 2013 statement by the government Public Relations Department, the Thai state would initially grant visa extensions from 30 days to 90 days for citizens from six Middle Eastern countries, and in 2017 the state approved 90-day visas patients and medical visitors from Cambodia, Lao PDR., Myanmar, and Vietnam (CLMV) as well as China. Long-stay 10-year visas are also offered for senior nationals of 14 countries, which include: Japan, Australia, Denmark, Finland, France, Germany, Italy, Netherlands, Norway, Sweden, Switzerland, the United Kingdom, Canada and the United States. The selection of high-earning countries whose older citizens may stay in Thailand long-term represents the classed and nation-based divisions of medical tourism.

Ali, a medical tourism facilitator, shared that she tried to bring a patient from Eritrea to Thailand for an eye surgery, but Thai embassy representatives claimed that an Eritrean person has never been to Thailand and there is no Thai embassy for Eritreans. She sounded exasperated when telling the story, adding: “I talked to Eritrean embassies

and couldn't get them over." While medical tourism policies and visa extensions welcome some patients from particular countries, there are also hierarchies of class and nation that disallow people from other nations. Government officials at the MOPH also spoke of "high end" and "low end" foreigner patients from neighboring countries such as Laos, Myanmar, Bangladesh, or Cambodia, indicating a hierarchy of foreigners who enter the country for medical services.

In addition to nationality and class background, medical tourism creates borders that exclude or target people living with HIV/AIDS. Several gender-affirming surgeons in Thailand mandate a 30 percent tax for HIV-positive patients, or refuse treating them at all, according to their websites (some surgeons state on their websites that people who are HIV-positive are a risk to health care workers). That gender-affirming surgeries are inaccessible or more expensive for people with HIV/AIDS demonstrates another nuance to a country whose medical professionals advocated for access to antiretrovirals and health care access for people with HIV/AIDS (Harris 2017b). Thailand's LGBT-friendly medical hub in Thailand is most available for those who are not living with HIV, demonstrating another area of health care discrimination for foreign and local people who are HIV-positive.

The gendered technostate incorporates exclusionary practices to define its brand and cultural wealth, demonstrating how "the practical and institutional norms promoted by these professionals [well-intentioned experts and knowledge producers] still have strong and systematic negative effects of global cultural equality" (Bandelj and Wherry

2011:14). Medical tourism and gendered labor impact the nation and cultural wealth through a politics of belonging and exclusion, within and beyond the Thai nation.

Conclusion

This chapter has demonstrated the gendered and technologized elements of cultural wealth and nation-branding in Thailand, which are achieved through both medical tourism and the professionalized, sanitized labor of kathoey. Building off of research on how technologies (such as surnames, maps, and surveys) were used as instruments to map national boundaries and instill Thai sovereignty (Winichakul 1994), this chapter highlights two additional mediators – medical tourism and kathoey’s labor – as some of the “social institutions and practices which perpetuate the operation and reproduction of the imagined community in actual human relations” (Winichakul 1994:15). Through medical tourism and sanitized gendered labor, middle-income countries such as Thailand stand to gain global authority and prestige, earning a reputation for professionalized (non-sexualized) services, local medical skills, and internationally-accredited health care sites. As government policies and private industries expand medical tourism and technologies, the gendered technostate furthers our understandings of how gendered labor relations and technologies are embedded in a nation’s rebranding and cultural wealth.

By becoming a global medical hub, the nation simultaneously excels at and redefines global norms centered on medical science, as medical tourism evokes shifts in the cultural wealth and brand of the Thai nation. Thai expertise in traditional medicine

and gender-affirming surgeries has spurred shifts in global knowledge production and rewritten global hierarchies of medicine, representing how medical tourism is an “internationalized state project” (Glassman 2004:156) that redefines both the borders and brand of Thailand. Local elements of Thai-specific medical practices are packaged for international consumers, and Thailand’s reputation on the global stage is reconfigured through the standardized practices and techniques it now offers. Thai doctors’ expertise in gender-affirming surgeries, and the nation’s broader capabilities as a medical hub, are both highly localized and connected to dominant global health norms, and historical imperialist relations through which Western medicine was first introduced. Professional norms in the nation-state have the potential to change, as Dr. Met shared that medical tourism causes people to work more “systematically,” possibly lessening the influence of the *mai pen rai*, carefree attitude. With increased cultural wealth and international prestige attained through medical tourism, local people’s relationship to work is augmented.

The study of medical tourism and the nation-state challenges world polity theory by demonstrating the hybrid forms of medical care that emerge in the Global South, complicating the idea that Western scripts are uniformly adopted (Meyer et al. 1997). While scholarship on cultural wealth attests that there exists a “global culture” which “renders certain strategies and narratives more legitimate than others” (Bandjel and Wherry 2011:9), this chapter has shown that there are mixed and hybrid medical practices through which the Thai nation-state gains cultural wealth, drawing on both international accreditation and local forms of knowledge in the medical tourism industry.

Hybridized norms of quality standards also exist, such as those that revitalize Thai traditional medicine, and standards that regulate gender-affirming surgeries. In both cases, the convergence of local Thai knowledge with international and Western medical standards demonstrates increased hybridity in local and global medical practices. Rather than a monolithic umbrella of Western medicine cast over health practices worldwide, we see more nuanced and hybridized forms of knowledge, such as traditional medicine and trans health expertise, emerging from middle-income countries such as Thailand. This health care hybridity can impact the nation's brand and accrual of cultural wealth. Medical tourism is not only a defined instance of how nation-states assert their reputation and prestige on a global stage, but also shows how knowledge and power in the global health arena are not unidirectional, nor do they emerge from a single origin.

At the same time, a skilled, sanitized gendered workforce signals the nation's move away from sex work toward a new class of workers who are hailed as professional and distinct from people living with HIV/AIDS. Kathoey serve not only as icons of medical modernity and LGBT diversity, but also represent Thai professionalism, public health, and sanitized labor. Kathoey's prized work ethic and gendered embodiment in the entertainment industry demonstrates how technologically-enhanced gendered labor, such as in beauty pageants or cabarets, is both altered by and constructing new iterations of national identity (Balogun 2012; Hoang 2014, 2015; Ochoa 2014). Similar to the incorporation and heroization of transfeminine people in Filipino call centers (David 2016), katoey's technologically-enhanced labor outside of the sex industry grants new forms of acceptance and legibility to these workers. Kathoey become sanitary citizens

who adapt to dominant ideals of citizenship and behavior, as the face of the Thai nation changes amidst medical tourism and diversity campaigns. Kathoey modify not only their embodiment and occupations – as discussed in Chapter 2 – but also their manner and bodily comportment to align with Thailand’s changing face on the global stage. Kathoey entertainers mirror the professionalized, internationally-regarded skills that comprise the Thai medical tourism industry, demonstrating how medical tourism *and* katoey labor redefine the nation’s brand and cultural wealth by adhering to global norms of professionalism and public health. As Thailand becomes a professionalized and LGBT-friendly medical hub, katoey in turn modify their embodiment and constrain their behaviors to align with dominant norms of class, gender, health, and bodily comportment.

In the gendered technostate, technologies, gendered labor, and gendered relations are integral to a nation’s cultural wealth and branding efforts. The gendered technostate advances cultural wealth through the exclusion of others – based on boundaries of gender, profession, class, nation, and HIV/AIDS status. With these inequalities, medical tourism and katoey’s labor concurrently redefine the Thai nation-state and its cultural wealth.

CONCLUSION

In the gendered technostate, states, technologies, and gendered labor are inextricably linked and mapped on to individual bodies. Kathoey's current norms of sex, gender, and beauty – often hinged on technologies of embodiment – are made possible by the growth of medical tourism, Asian biotech (Ong 2010), and new hospitals and clinics. The entertainment industry circulates technologically-enhanced norms of embodiment, with its formal sponsorships by clinics, while helping symbolize Thailand's role as an LGBT-friendly medical hub. Through this dissertation, I have unveiled the gendered cultural economy of medical tourism, demonstrating how kathoey's labor is bundled into the assemblage of medical tourism and the nation-state.

In Chapter 2, the dissertation showed how sexed and gendered embodiment and identities are constructed in the organizational setting of the workplace (C. Connell 2010, 2014; Mears 2014; Mears and Connell 2016), as entertainers use technologies and contribute to state economic and political gains. The global brand of Thai medicine and medical tourism is constructed not only through international accreditations or Harvard-trained Thai doctors; it is also made by kathoey, who convey medical technologies and represent narratives of Thailand's LGBT diversity. This demonstrates the co-construction of states, technologies, and gendered labor. Thailand's reputation for gender-affirming surgeries intersects with recent tourism campaigns centered on LGBT diversity, signifying how the gendered technostate is constructed simultaneously by medical technologies, gender relations, and the gendered labor of kathoey.

Unlike cisgender people, kathoey chose to access technologies in a societal context that does not legally recognize their gender identities, nor fully institutionally support sex/gender diversity. While many kathoey lack access to mainstream employment (see also Thongnoi 2015; Asia Pacific Transgender Network 2017), those who work in the entertainment industry also provide unpaid labor, as their physical work on stage circulates in a digital “afterlife” (Peterson 2011), in medical tourism marketing and Go Thai, Be Free campaigns. Their work in the entertainment industry is contingent upon the technologies and medical tourist clinics that they themselves helped make into a multi-billion dollar industry.

Since the state does not formally recognize their gender identities on legal identification cards, nor is the 2015 Thailand Gender Equality Act fully enforced (UNDP, MSDHS 2018), there are incentives for kathoey to access surgeries that bring them into alignment with social expectations of femininity. Kathoey have been barred from various professions and workplaces (Fuhrmann 2016), and those who have not undergone surgeries are still required to enroll in military conscription (Pravattiyagul 2018:32). Social acceptance and occupational outcomes are stratified for kathoey who can access sex/gender normativity and beauty through surgical means. Due to their legal sex not matching their gender identity or presentation, many respondents stated that they have faced discrimination in employment settings and/or experienced difficulties finding jobs. Several were told by employers to cut their hair and dress like a man, with some stating that certain workplaces - such offices, factories, and restaurants - do not hire transgender

people because of stereotypes that transgender people are loud, not capable, or will fight with others.

Kathoey's unequal experiences in the workplace and broader society speak to a broader lack of public inclusion and protection for people who do not conform to dominant norms of beauty, sex, and gender. Like many of the kathoey with whom I spoke, Jib believed the government should allow Thai transgender people to change their legal identifications. She said: "I do not think that it is right, and Thai authorities should declare more constructive things to solve these issues." The issue of legal gender recognition permeates many aspects of Thai transgender rights beyond health care, such as immigration and employment. While kathoey performed work with the TAT across national borders, legal identification cards served as a means through which sex and gender are regulated in institutional spaces such as airports, or public settings such as bars and clubs.

In Chapter 3, I put forth a *sociology of trans-national health*, which addresses the intersections between the global political economy, sex, and gender, to better understand health and health care for people throughout the world, including those who are transgender. Medical sociologists and anthropologists have analyzed how cultural, political, and economic conditions have constructed health and inequalities in a global context (Bakhtiari, Olafsdottir, and Beckfield 2018; Casper and Simmons 2014; Conrad and Gallagher 1993; Conrad 2005; Harris 2013, 2017; Heimer 2007; Noy 2019; Olafsdottir 2007). By tending to transnational flows of people, resources, objects, and ideas, the sociology of trans-national health demonstrates how health is shaped by

structural and cultural conditions for people across the sex and gender spectrum, adding to work on sex, gender, and health (Casper and Clarke 1998; Conrad 2005; Mamo and Fosket 2014; Pitts-Taylor 2009; Turner 1996). Studying how the state-led process of medical tourism impacts the health of local people – especially sex and gender minorities – in unequal ways, the case also adds to scholarship on health and global development (Harris 2017b; Noy 2019). It dovetails with the “political economy of global health,” which accounts for health in the context of global economic and political conditions (Birn, Pillay, and Holtz 2017). The dissertation demonstrates how global transgender health (Reisner et al. 2016) is constructed within a political and economic context, and how health care resources are divided and accessed in unequal ways across categories of sex, gender, and nation. While much research in medical sociology has focused on cisgender people, the sociology of trans-national health can highlight some of the overlapping, unique and unequal ways in which transgender people interact with medical institutions and health care throughout the world.

There are particular health inequalities that emerge in the gendered technostate, as technologies become increasingly linked to embodied health outcomes, state and private economic growth, and people’s labor roles. Medical tourism has been shown to increase local health disparities by prompting a “brain drain” and “resource drain” of medical expertise and resources from the public to private health care sector (Morgan 2010). The chapter analyzed the various tiers of services in public and private settings, and kathoey’s experiences crowded out of health care services. The chapter also elucidated the concept of *invisibilized uncertainty*, in which medical uncertainty emerges due gaps and biases in

global health data, clinical trials, and evidence-based medicine. Invisibilized uncertainty identifies who is included in “population health,” what issues are studied and funded, and the processes through which people appear or disappear in global health statistics, adding to our understandings of global health metrics and the politics of (in)visibility (Adams 2016; Casper and Simmons 2014). The lack of reliable data in trans medicine manifests in clinical encounters through invisibilized uncertainty, as kathoey and other trans people encounter practitioners with little to no knowledge of hormone doses or trans-specific care. A lack of formal medical guidance and health monitoring regarding hormone use leaves kathoey vulnerable to health risks such as overmedicating, and many expressed concerns about their health on hormones. Invisibilized uncertainty enhances our understandings of medical uncertainty by accounting for the broader constellation of global health funding and resources that construct or ignore certain groups of people. The case allows us to glean new insights about patient resistance and activism (Barker 2008), as kathoey often cope with invisibilized uncertainty by relying on personal networks, both online and in-person.

Chapter 4 considered implications of medical tourism and gendered labor on the nation, particularly its cultural wealth and rebranding efforts. In the gendered technostate, technologies (e.g. medical science or medical tourism) and gendered labor are integral to cultural wealth and rebranding efforts, as gendered relations and intimate lives are connected to the nation. Medical tourism, a gendered economy, signals how nation-states in the Global South have advanced both economically and politically by offering health care to foreigners, gaining clout and status as providers of internationally-accredited

medical services, including traditional medicine or gender-affirming surgeries. International accreditations merge with local medical practices and expertise, demonstrating how Thailand has become a hub for transgender health services and other forms of medical care. The medical hub, hybridized through international and local practices, offers the Thai nation new alternatives for cultural wealth and nation-branding, with medicine and science key markers of rational modernity (Epstein 2008a).

The chapter also showed how Thailand's cultural wealth and rebranding campaigns are not gender-neutral processes, and are instead comprised of gendered relations and kathoey's labor. With interviewees emphasizing kathoey's professionalized status outside of the sex industry, narratives related to public health and kathoey's HIV/AIDS status seemed to linger like ghosts. Kathoey contribute to Thailand's cultural wealth and rebranding efforts by becoming part of a skilled workforce in "family-friendly" entertainment attractions. I argue that kathoey signify the Thai nation's move from sex work to more "legitimate" forms of work outside of the sex industry. Kathoey represent a form of "sanitary citizenship" (Briggs and Mantini-Briggs 2003; Ochoa 2014), through which their labor roles become an emblem of the health of the nation, as entertainers become publicly detached from sex work and HIV/AIDS. Although population health data and global health interventions often grossly categorize trans people as "vectors of disease" (Humphries-Waa 2013:20), kathoey workers take on professionalized roles in the all-ages entertainment industry, which becomes a solution to the public health problem of HIV/AIDS. Through kathoey's labor in the entertainment

industry, the nation gains cultural wealth and rebrands itself by becoming increasingly sanitized.

Discourses of respectability – in terms of sex/gender conformity and adherence to norms of professionalism – demonstrate kathoey’s “incorporation into the market and state” (David 2015:401-2), while continuing to marginalize those who cannot or will not do the embodied reconstructions and behavioral adaptations that the state depends on. Several kathoey were only accepted by family members when they began earning an income. Participants emphasized kathoey’s choice and responsibility to become educated and work hard, reflecting the entrepreneurial neoliberal values of capitalism, and the ways in which queer and gender non-normative subjects are involved in the politics of homonationalism, which upholds values and institutions related to heteronormativity, domesticity, and consumption (Duggan 2003). Simultaneously, nation-branding and cultural wealth manifest in the conduct and bodily comportment of local people, as kathoey must embody a particular “face,” or public persona, doing their best to behave in accordance with norms of acceptable citizenship. This mirrors trends in Indian ciswomen’s changing classed and gender dynamics amidst globalization, neoliberalism, and the knowledge economy (Radhakrishnan 2009; Vijayakumar 2013). Chapter 4 also elucidated the politics of belonging and exclusion in the gendered technostate, as divisions emerge based on national origin, class status, labor role, HIV/AIDS status, and gendered embodiment. In addition to sanitized norms of professionalism and conduct, kathoey spoke to how beauty is connected to social contributions and merit-making. This

demonstrates the increasing hybridity of local particularities, such as religiosity, with national and global imperatives to behave well and work in the formal economy.

Combined with the missing global health data and metrics resulting in invisibilized uncertainty, themes also emerged related to the deliberate obfuscation of medical tourism data. Scholars have called attention to the “acute lack of reliable empirical data concerning medical tourist flows” (Pocock and Phua 2011:10), as there is “no systematic analysis of the balance between how much revenue medical tourism generates” (Kanchanachitra et al. 2012:83). According to medical tourism magazine publisher Wattana, medical tourism revenue and investment data are purposely obscured by government officials and private hospital executives. Wattana shared:

In this country this [data] is the secret: they don't want to tell you. You can never find out... They even lie to you about the number of American patients... They don't want you to know. I tried to find out... You don't know how they count. So if you're getting sick today, you're holding American passport, you go into Bumrungrad [Hospital] in the morning, they have recorded one American. But in the afternoon, you are not feeling better, you go in there in afternoon, they have second. This is the figure: it depends. You can never find out accurately. We have our figure and I don't believe my figure is accurate. They are hiding it.

Wattana identified what scholars note is the lack of “a universal definition of who counts as a medical tourist (e.g. per procedure or per inpatient),” with suggestions that the definition of a medical tourist be decided at the international or regional level (such as through WHO or tourism ministries) (Pocock and Phua 2011:10). Across countries such as Thailand, Singapore, and Malaysia, there is ample variation in these descriptives and numerics, and the processes through which medical tourism data are collected (e.g. exit interviews in Singapore versus varied forms of hospital data in Thailand (Pocock and

Phua 2011). Without such standardized evidence, it is difficult to make concrete suggestions or assessments regarding the scope and impact of medical tourism.

There are also distinct policy implications related to medical tourism on the level of health care access. Research has warned against the “danger that governments may focus on the potential benefits of medical tourism at the expense of the domestic health systems,” while “claims that medical tourism benefits the public health sector have yet to be proven” (Kanchanachitra et al. 2012:75). For Dr. Wirun, corporate social responsibility would be an important aspect of medical tourism. He said: “I just want to see corporate societal responsibility among private hospital chains regarding this kind of thing... like provide free care with this kind of advancement of technologies from time to time with certain number of cases that ordinary poor Thai people can access.” He said he can “only wish” this is a policy recommendation, continuing that there could be an emergency system that Thai people can access in both public and private settings in the case of a life-threatening event. However, Dr. Wirun added:

There’s a lot of cry-out from private hospitals that they are losing money. I think that’s not good... They should accept the risk [of people with life-threatening conditions] as their social responsibility as a healthcare provider... If they choose to do business in healthcare, they have [to have] some responsibility in humanity - not just their own investment.

While Dr. Wirun asserted that it is the responsibility of private health care executives to channel profits to the public sector, according to Dr. Nat, a CEO of a large private Thai hospital, the hospital already provides charity cases. He said that merging with the government to provide more services to the public is “too complicated.” He said:

They want to centralize, they want the public-private to have equal share. It’s a free market. They can’t artificially control it. They want us to bring in all these

dollars for medical tourism but last year they tried to do price control. They keep trying. They did a few good things: medical visas which helped Myanmar nationals coming. We really have to fight for everything. They think we are greedy.

Based on these comments, it is unclear if “private hospitals will provide some health services to local people for free or reduced rates,” as scholars, and interviewees, have suggested (Kanchanachitra et al. 2012:77).

Other themes emerged related to the possible benefits of medical tourism, such as how the industry can allow hospitals to better serve local patients. In this regard, “government policies around developing medical tourism can work in synergy with policies to achieve universal health care coverage,” while “revenues from medical tourism can be used to address inequities in health care” (Kanchanachitra et al. 2012:83). Dr. Met suggested taxing medical tourists and creating a close-looped system to support public health. Additionally, Dr. Wirun said that medical tourism can result in the import of new technologies and medical services. He states:

Partly because of medical tourism, the crying out for more advanced technology may help benefit the people of this country. If we didn't have medical hub or medical tourism we might not import certain kind of technologies so Thai people may not have exposure to the advancement in medicine in certain areas. That may be another benefit of the policy. But it depends whether the public recognize this and utilize this opportunity for the general good not let this development limited only to private sector.

Medical tourism thus has the potential to increase the flow of technologies and impact the availability of tools and services. Dr. Arun, who works in both public and private health care settings, also noted how public health care practices shift for the better as a result of medical tourism and developments in the private sector. For instance, the public hospital in which he works adapted their lunchtime hours to see patients, creating less barriers to

care. Perhaps these extended hours are evident of Dr. Met's belief that work culture has changed through medical tourism, with less of a "*mai pen rai*" and carefree attitude. With the advent of internationalized health care practices, this complicates the idea that medical tourism only "drains," public settings, but instead has the potential to augment local practices and settings. Yet as this dissertation and other research has so far shown, such "trickle down" effects have yet to be realized for local people in health care settings (J. Connell 2011).

Medical tourism also represents a domain through which participatory policymaking has emerged (Pitakdumrongkit 2017), and suggests a future area of focus for research on health policy and activism. For instance, in 2010, the Thai National Health Assembly, a three-day national forum that engages citizens in health agendas (Harris 2017b:44), resolved to "monitor and address health work resource issues arising from medical tourism and established a public-private partnership to train health workers, especially in fields with shortages" (Kanchanachitra et al. 2012:79). According to Pitakdumrongkit (2017:14), Resolution 8 at the Third NHA Annual Conference, in 2010 sought:

to implement the medical hub policies or strategies that are not affecting the health service system provided to the Thai people and must [sic] develop a mechanism for collaboration between the people, private sector and related agencies to develop such medical hub policies, both the national plan and action plan, in order to lessen negative impacts on the development of the health service system to the Thai people.

This resolution directly addresses the issue that local people shoulder the burden of brain drain, resource drain, and crowding out effects. Accordingly, the MOPH was tasked to incorporate these points into the 2014-2018 Second Strategic Plan's Strategy 4, to target

the “spillover effects” of medical tourism onto health services, including equity to health care access by quantifying the percentage of the Thai population with access to higher-cost healthcare services. In this case, the NHA conventions “served as channels linking together stakeholders in the public, private and civil society segments” (Pitakdumrongkit 2017:16). It remains unclear how NHA might be a domain for transgender health activists.

The dissertation expands our understandings of the implications of medical tourism on local people’s health outcomes, particularly those whose sex and gender do not conform to binary norms. The phenomenon of medical tourism in Thailand contributes to research on how health care and medicine are reorganized by national policies and private industries, against the ever-changing kaleidoscope of transnational flows of people, capital, resources, and discourses. More in-depth research is needed to understand how gender, technologies, and labor shift alongside national economic plans such as medical tourism.

The dissertation has implications for how we understand sex, gender, and sexuality in the era of globalization and technological transformations. Medical tourism, and the gains of the nation-state, are constructed through gendered labor that is enhanced by technologies. The dissertation underscores the global workplace as a site through which hierarchical norms of sex and gender are deployed, augmenting not only people’s lived and embodied experiences, but also their contributions to national agendas to advance medical tourism. It also elucidates the cultural relations embedded in transnational health flows and the technologized nation-state, as medical tourism

incorporates gendered relations and labor in intimate ways. The gendered technostate addresses the ways national policies and private businesses impact people's labor and health outcomes – it explains how and why certain “seams and sutures” appear on some people's bodies, and how state and private actors may profit off of one's inevitable scars (Stryker 1994:238).

APPENDIX

Sample Interview Guides

Interview guide for kathoey

Screening Questions

- Are you over the age of 18?
- How do you identify your gender?
- Are you a Thai citizen?

Basic Information

- How old are you?
- What is the highest level of education you have completed?
- Where were you born and raised?
- Where do you live now?
- What is your religion?
- Are you married?
- Do you have any children?
- What is your current job? What is your average monthly income?
- How long have you worked there?
- What made you decide to work there?
- Describe a typical day in your life.
- What sorts of clothing/dress do you prefer?

Experiences with Health Care

- Do you see a doctor regularly?
- Where do you seek medical care?
- Why do you go there?
- What has your experience been like going to the doctor?

Have you ever used hormones?

If yes, when did you begin using them? What prompted you?

How do you obtain hormones? How much do they cost?

Why do you use them?

Have you had any gender or sexual reassignment surgeries?

If so, where did you have them done? If not, how come?

What motivated you to seek them?

Do you plan on having any procedures done? If so, which? Why?

Are there any other comments you would like to add?

Interview guide for Academics, MOPH, TAT, and civil society members

Medical Tourism

What is medical tourism?

When did medical tourism develop? How and through what policies?

Who were the key decision-makers? What were the main institutions or agencies involved?

Why has Thailand become such a large destination for medical tourists?

How much revenue does medical tourism generate?

What is the “medical hub” policy?

What does the future of medical tourism look like in Thailand?

State Policies and Discourses

What agencies are involved in developing and overseeing medical tourism?

What specific policies exist to develop medical tourism?

 Why were these policies put in place?

 Who advocated for them?

What is the role of the Tourism Authority of Thailand in developing medical tourism?

What is the Medical Tourism Portal? Who is it geared toward?

Can you tell me about the Medical Tourism Iphone app? When did it develop and what purpose does it serve?

What other sorts of resources or publications are available related to medical tourism?

JCI Certification and Training

Do you know how many hospitals in Thailand are JCI certified? How many of these are public and how many private?

What is the purpose of JCI?

Is JCI important to the medical tourism industry? Why or why not?

What are the training and background for doctors who specialize in treatment for medical tourists?

Are there other credentials for hospitals or doctors that would be useful for medical tourists to know about?

Statistics: Profits and Visitors

Is medical tourism important for the Thai economy?

Is there a way to know how much the Thai state earns from medical tourism?

Is there a way to know how many people travel to Thailand for medical tourism?

Regional Coordination

Does Thailand compete or “cooperate” with other countries in the region to advance medical tourism?

ASEAN has promoted a medical hub policy. What does this involve? Why is it important for ASEAN to be involved?

Does medical tourism coincide with the ASEAN Economic Community 2015 goals? Why or why not?

What role do regional organizations such as ASEAN play in medical tourism?

What impact does medical tourism in Thailand have on the region? The world?

Global Agreements

What sorts of global trade agreements or policies can help advance medical tourism?

Public Health Care System

Does medical tourism impact the public health care system? How?

“Trickle Down”

What do you think are the impacts of medical tourism on the local economy? Does it create more jobs in other industries? Which ones?

Gender Surgeries and Transgender Rights

According to a brochure published by the Tourism Authority of Thailand, the country is the “global center for Sex change operations.” How and why did this come to be?

Do you know who performs S/GRS surgeries in public and private facilities?

What rights do transgender people have in accessing health care? In accessing surgeries?

How much do these surgeries cost? How do most people pay for these surgeries? Out of pocket/public/or private?

What forms of investment, policies or protocols does the state have in transgender health?

What do you think are the main health issues impacting transgender people in Thailand?

What are possible solutions or interventions?

Funding Flows

As Thailand’s government investment in health has risen since 2002 (Pocock and Phua 2011), what are the origins of foreign investment in Thai health care? What are the trends in state/private investments in the health care sector and medical tourism industry?

Do specific countries have a stake in medical tourism - China, Japan, India?

Impacts

Does medical tourism impact health care services for local people? Does it impact the public health care system? If so, why and how?

What does Thailand stand to gain by becoming internationally accredited for health care services?

Do rates of medical tourists decline more than other kinds of visitors during political outbreaks? Why or why not?

Other Questions

How do foreign patients usually pay for medical services?

Who benefits most from the medical tourism industry?

Do you think medical tourism impacts the country's reputation or image? How?

What sorts of changes do you see taking place in the medical tourism industry in the next five, ten, or fifteen (narrow this question down) years? How come?

Do you have any other comments you would like to add?

Interview guide for Medical Tourists

What procedures are you undergoing? Why?

Why did you decide to come to Thailand for these medical services?

What has your experience been like so far?

What about [name of health care site] made you feel comfortable to seek these services?

How did you book your travel? What was the process like for you?

How long will you stay in Thailand? What will you do?

How much did everything cost - flight, accommodations, procedure?

Are you familiar with Thailand's local LGBT population? If so, what do you know about them?

Is Thailand an LGBT-friendly place to you? Why or why not? Did this impact your decision to travel here for services?

Is there anything about your experience that has surprised you? Is there anything you would do differently?

Interview guide for Medical Tourism Private Companies/Facilitators

Can you tell me a little bit about your company? What services do you offer and at what cost? When was it established and by whom?

Who are the primary people you serve? Do you have demographic information about those who access your services?

What is the revenue earned from your company?

Do you have any partnerships with businesses or organizations in Thailand or globally?

Has your company been impacted by recent political instability?

Do you know how many of your clients are transgender?

What do you think the future of medical tourism looks like in Thailand?

Interview guide for Health Care Workers/Clinic/Hospital Personnel

Background Info about Site

Who does your hospital/clinic serve? Do you have patient demographics?

Is [name of hospital/clinic] certified by JCI?

How do patients usually pay for services? How much do services cost?

Medical Tourism

What is medical tourism?

Can you think of why Thailand has become a leader in medical tourism?

Have you noticed changes in health care in recent years? If so, what? What do you attribute these changes to?

How does the increase in foreign tourists accessing services impact the country as a whole as well as its citizens?

Gender Surgeries and Transgender Rights

According to a brochure published by the Tourism Authority of Thailand, the country is the “global center for Sex change operations.” How and why did this come to be?

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What rights do transgender people have in accessing health care? In accessing surgeries?

How much do these surgeries cost? How do most people pay for these surgeries? Out of pocket/public/or private?

What do you think are the main health issues impacting transgender people in Thailand?

What are possible solutions or interventions?

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