

THE COST OF STIGMA:

*Understanding and
Addressing Health
Implications of Transphobia
and Discrimination
on Transgender and
Gender Diverse People*

Evidence from Community-led Research
in Nepal, Indonesia, Thailand and Vietnam



aptn

THE COST OF STIGMA

The background features an abstract graphic design with overlapping shapes. A large white shape is at the top right, partially overlapping a light gray shape. Below these, a dark gray shape rises from the bottom left towards the center. The overall composition is minimalist and modern.

Understanding *and* Addressing
Health Implications of
Transphobia *and* Discrimination
on Transgender *and*
Gender Diverse People

CONTENTS

07

Acknowledgements

08

Acronyms

11

Summary *and* Findings

18

Research Methods

23

Stressors *and*
Resilience Factors

28

Mental Health
and Healthcare Use

46

Sexual Health *and*
Healthcare Use

63

Seeking General
Healthcare

75

Seeking Advice *about*
Gender-affirming Hormones

87

Conclusions

92

Recommendations

99

Bibliography



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FOREWORD

The Cost of Stigma: Understanding and Addressing Health Implications of Transphobia and Discrimination on Transgender and Gender Diverse People showcases the many ways in which APTN supports the work at country and regional level to advance social justice and address health inequities for trans people in Asia, working closely with public health experts, researchers, local community-based organisations (CBOs) and a wide range of partners to realise rights and build resilience.

We embarked on the creation of this trans-led research with the intention to center the experiences, knowledge and power within the community to lead a study themselves about their lives based on a multidisciplinary approach and collaborative exchange of expertise. This was the first time that we have undertaken a research project of this scale and we have learnt many valuable lessons in this research journey. It is not news to many of us from the community that experiences of trans men are often overlooked and under researched. When we started this project, we were firm and adamant that this research must include the diversity within the trans communities, including gender diverse people and trans men.

The Key Populations Research and Advocacy (KPR) project in collaboration with four country partners: GWL INA from Indonesia, the Blue Diamond Society (BDS) from Nepal, the Sisters Foundation from Thailand, and the Vietnam Transgender Network (VNTG) supported by the Centre for Supporting Community Development Initiatives (SCDI) in Vietnam, funded by the Global Fund through Save the Children Nepal is a community-based participatory research (CBPR), a model rooted physically and conceptually in community. In the KPR project, public health experts and researchers worked in close collaboration with community partners involved in all phases of the research, from the inception of the research questions and study design, to the collection of the data, monitoring of ethical concerns, and interpretation of the study results. Importantly, the research findings are communicated to the broader community—including to the government, policymakers and healthcare providers—so they may be utilised to affect needed changes in access to healthcare services and health policy to improve existing conditions.

Building upon existing strengths and resources, KPR seeks to build capacity and resources in communities and ensure that government agencies, HIV programmers and funders are better able to understand and incorporate community concerns into their national healthcare agendas and budgets.

The study has some understandable limitations outlined in the methods section. Noting these limitations, the KPR study addresses and fills crucial empirical research gaps in transgender health, while expanding on theoretical knowledge about the mental, physical, and sexual health of transgender people interacting with discriminatory health systems in the region. The community-led and community-inclusive participatory research methodology was an effective approach for building the skills of transgender CBOs and empowering them to start using the results to design advocacy campaigns. As the regional network, APTN has invested time in building the capacity and processes of CBOs to implement the study. One of the lessons learned from this KPR project is that strengthening capacity continues to be an ongoing process. More investment in research will be needed to better understand the vulnerabilities among transgender people and identify interventions that will best meet community needs. The findings from this multi-faceted KPR project are a first step and provide essential building blocks for further multi-stakeholder, collaborative research and programming.

I am grateful to the technical advisors who have lent their support since the preparation of the research proposal, namely, Manuel Da Quinta, Tony Lisle, Sam Winter, Jack Byrne and Sarah Zaidi. This report is a five year long of behind the scenes hardwork and shows a shift emphasizing on “community ownership” and collaboration between interdisciplinary HIV/AIDS programmers, funders, and multi-sector stakeholders (healthcare, policymakers and government). This diverse group of opinions, technical expertise including those of our trans leaders and community groups, reinforce and remind us that trans communities must continue to advocate for inclusion and integration into public health decision-making. The findings of the research surfaces the ways in which a system that continues to ignore, exclude and stigmatise against trans people comes at a high price and often at the expense of trans people. We must strengthen and expand partnerships and put forth a strong emphasis on boosting government commitments to strengthen health systems across the region, building the political will to address priority challenges and developing national budgets to make services available and affordable to trans people. Our health can wait no more.

JOE WONG
Executive Director
Asia Pacific Transgender Network (APTN)

FOREWORD

While we all must be proud of successes and the potential of our shared future— breakthroughs in each and every aspect of HIV response, holding promise for a generation of people who will be able to take control of their ability to stop HIV, we should be clear that we have another major task, and its to make all key services available for those who are deprived, marginalized and discriminated against. To do so, we must promote and ensure wider participation of key populations(KPs) community in each aspect of HIV response, and ensure that programs that target KPs are designed, and implemented with the participation of community.

We are proud to present this study report as one of the examples of continuing efforts of the Asia Pacific Transgender Network and Save the Children International to widely engage KP in building evidence for an effective HIV response in the region. The underlying objective of the study was to understand the gaps in availability, accessibility, and acceptability of healthcare services provided to Trans people in Nepal, Indonesia, Thailand, and Vietnam.

The results of the study show that across all four countries trans people report fear of discrimination at healthcare centers as the biggest barrier to healthcare accessibility. This barrier is the highest compared to cost of treatment, distance from the healthcare center, and access to health insurance. Findings suggest that fear of discrimination causes trans people to avoid treatment or delay it past the optimal time, resulting in the worsening of their health conditions.

Overall, the results expose severe gaps in availability, accessibility, and especially acceptability of healthcare provision for trans people in all the four countries investigated. In essence, service providers don't have the relevant training and guidance that allows for trans people to have a positive and comfortable experience free of discrimination at healthcare settings, nor do they have the specific technical and clinical competency necessary. Given the current scenario, this study provides a set of recommendations for the highlighted critical gaps in healthcare provision, to help both health practitioners and trans people seeking healthcare.

Recommendations derived from the study are also helpful to understand the ways in which we all can support work at country and regional level to produce sustainable results while realizing trans rights and building resilience.

We at Save the Children are grateful for the partnerships we built within the framework of KPRA and consider those vital in achieving policy results and scaling up provision of comprehensive services to the communities in the region.

DR. ZAKIR KADIROV

Chief of Party,

Key Populations Research and Advocacy Program

Save the Children International

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ACRONYMS

APTN

Asia Pacific Transgender Network

ARROW

The Asian Pacific Resource and Research Centre for Women

ART

Antiretroviral Therapy

ARV

Antiretroviral

BDS

Blue Diamond Society

CBO

Community-based Organisation

CFS

Community field supervisor

CTRL

Community Team Research Lead

FGD

Focus Group Discussions

GBV

Gender-based violence

GMSR

Gender Minority Stress and Resilience

GWL-INA

Jaringan Gaya Warna Lentera

HCP

Health care provider

KII

Key Informant Interview

KPRA

Key Populations Research and Advocacy

LGB

Lesbian, Gay and Bisexual

LGBTI

Lesbian, Gay, Bisexual, Transgender, Intersex

MoH

Ministry of Health

MSM

Men who have Sex with Men

NGO

Non-governmental organisation

NSP

National Strategy on HIV/AIDs

PLHIV

People Living with HIV

PrEP

Pre-exposure Prophylaxis

SCDI

Centre for Supporting Community Development Initiatives

SOGIE

Sexual Orientation and Gender Identity and Expression

SRHR

Sexual and Reproductive Health and Rights

STI

Sexually Transmitted Infections

UNAIDS

The Joint United Nations Programme on HIV/AIDS

VNTG

Vietnam Network of Transgender People

VUSTA

Vietnam Union of Science and Technology Associations

WHO

World Health Organization

ABOUT: *Asia Pacific Transgender Network*

The Asia Pacific Transgender Network (APTN) is a regional trans-led network that is working towards the advancement of trans rights in the Asia Pacific region through research and evidence generation, legal, policy and programmatic advocacy, and public campaigning. The network serves as a platform for transgender people to advocate for access to health, legal gender recognition, legislative reform, social justice and human rights, and to exchange information and strategies with each other.

ABOUT: *Key Populations Research and Advocacy Project*

Save the Children Nepal was the principal recipient for the 3-year (2018-2020) regional Key Populations Research and Advocacy (KPRA) project in South and Southeast Asia. The aim was to gather evidence for community led HIV prevention, testing and other health services amongst populations of People living with HIV (sub-recipient APN+), People who use drugs (ANPUD), Sex workers (APNSW) and Transgender people (APTN).

APTN was the sub-recipient of this project leading a community-led and community-inclusive research in Indonesia, Nepal, Thailand and Vietnam funded by the Global Fund grant through Save the Children, Nepal. The aim of the research is to provide information on HIV and other healthcare for trans people in national settings, the barriers in accessing services, and the ways in which barriers can be removed through community empowerment. APTN implemented the Key Populations Research and Advocacy (KPRA) project in collaboration with four country partners: Jaringan Gaya Warna Lentera (GWL INA) from Indonesia, the Blue Diamond Society (BDS) from Nepal, the Sisters Foundation from Thailand, and the Vietnam Transgender Network (VNTG) supported by the Centre for Supporting Community Development

Initiatives (SCDI) in Vietnam. The KPRA project started in July 2018, and national reports were finalised in September 2020. This regional report is based on the findings from the national community-based surveys (CBS).

The community-led research was based on a multi-functional methodology that included focus group discussions (FGDs) with transgender participantsⁱ, key informant interviews (KII)ⁱⁱ with HIV and health care service providers and policy makers, and a community-based survey. One of the driving factors of the research was to build transgender peoples' capacity on evidence-based advocacy, and to empower them as researchers. This is also the first primary research that has collected data on trans men, reducing their invisibility within the community of trans people. The KPRA project has been designed to have a real-world impact on trans people in each country. The findings from the research are intended to serve as a springboard for advocacy; directed to influencing and informing national policy formulation, financing, and the reform of health care services to address the comprehensive health needs of trans people in the Asia region.

TERMINOLOGY

Transgender and Trans

is the umbrella term being used in this report to encompass trans men, trans women, culturally specific terms for gender diversity such as waria/transpuan in Indonesia and meti in Nepal, and gender non-conforming, non-binary and other gender diverse people.

Assigned female at birth (AFAB)

refers to a person who was thought to be female when born and initially raised as a girl.

Assigned male at birth (AMAB)

refers to a person who was thought to be male when born and initially raised as a boy.

Cis or cisgender

person refers to someone whose gender identity aligns with their sex assigned at birth.

Trans man

refers to someone whose gender identity does not exclusively align with the female sex they were assigned at birth.

Trans woman

refers to someone whose gender identity does not exclusively align with the male sex they were assigned at birth.

Gender-affirming healthcare

is used in this report to refer to any form of healthcare that trans and non-binary people receive to align their body with their gender. It can include non-medical care (such as hair removal, counselling support, mental health assessments, and voice therapy), medical care such as gender-affirming hormone therapy, and a wide range of surgeries.

Trans-competent care

refers to care that demonstrates both trans cultural competency and technical, clinical competency.ⁱⁱⁱ

Trans-clinical competency

refers to demonstrated competency across the specific gender-affirming healthcare needs of trans people and also about the application of prevention and screening tools for general healthcare to trans people.

Trans-cultural competency

refers to the ability to understand, communicate with, and effectively interact with trans people in a respectful, non-judgemental, compassionate manner in settings free of stigma and discrimination.

Gender diverse person

refers to someone who does not conform to their society or culture's expectations for males and females. Being transgender can be one way of being gender diverse. Not all gender diverse people identify as being transgender.

SUMMARY *and* FINDINGS

Everyone has the right to enjoy the highest attainable standard of physical and mental health.^{iv} Despite this, relatively little primary research data exists about factors impacting transgender people's access to healthcare services. Where research does exist, it tends to isolate analysis to one healthcare setting, such as HIV services, or takes the form of UN agency and NGO reports which rely heavily on meetings with activists, and case reports. The Key Populations and Research Advocacy (KPR) project led by the regional transgender network, the Asia Pacific Transgender Network (APT), involved qualitative and quantitative primary data collection in four countries: Nepal, Indonesia, Thailand, and Vietnam. This report presents key findings of the KPR study, documenting barriers to health services access and use for transgender people, and the ways in which those barriers can be mitigated or removed.

The Gender Minority Stress and Resilience model

The Gender Minority Stress and Resilience (GMSR) model (Testa et al, 2015) has been used in different contexts to understand negative health outcomes for transgender and gender diverse people. The GMSR model proposes these negative health outcomes are the result of stress specifically experienced by gender minorities, which can lead to negative outcomes directly (e.g., poor mental health), as well as indirectly, through decreased utilisation of healthcare services (which also negatively impacts health outcomes). In this report, GMSR has been used as a framework to understand the circumstances that can impact transgender people's access and use of healthcare. We propose stress specifically associated with being transgender is an important driver of negative health outcomes for transgender people, along with decreased utilisation of healthcare services due to mistrust in health systems. We also consider potential stressors not relating to gender identity, such as cost of treatment or distance from health facilities, as important potential reasons why trans people may or may not access particular healthcare services. The framework also includes resilience factors that can be a positive influence on health and healthcare utilisation, such as identity pride in being transgender, or being a member of a community-based organisation. This report includes analysis of each of these factors in turn, to provide a unique and comprehensive overview of psychosocial and practical barriers to accessing healthcare for trans people in each country.

Methods

The KPR project used a variety of interview methods—focus group discussions, key informant interviews, and a community-based survey—to capture the lived experience of transgender people who were 18-years and above, citizens of the country, and identify with a gender that is different from their sex assigned at birth. The research was based in urban centres of Indonesia (Jakarta and surrounding suburbs), Nepal (Kathmandu and Nepalgunj), Thailand (Pattaya), and Vietnam (Hanoi). It was implemented by APT's national partner organisations, GWL-INA in Indonesia, Blue Diamond Society (BDS) in Nepal, Sisters Foundation in Thailand, and the Vietnam Transgender Network (VNTG) with support from the Centre for Supporting Community Development Initiatives (SCDI). In each county the research was approved by national ethical review boards and the data was collected between November 2018 and July 2019. The KPR project is the first of its kind, community-led and community inclusive, to collect information from trans men, trans women, warias, metis and other people identifying with a culturally specific gender identity, and other gender diverse people, as well as from policy makers and service providers. The community-based cross-sectional survey on which this report is primarily focused was based on convenience sampling of 250 respondents in each country. The questionnaire collected socio-demographic information and documented transgender people's gender transitioning experience and priorities, access to HIV and STI services and general health care services, and health status. A total of 996 transgender respondents participated in the study.

1. Mental Health and Healthcare Use

- High rates of recent and severe symptoms of depression and anxiety, contrasted with low rates of testing and diagnosis of depression and anxiety in all four countries. Trans men experienced more anxiety and depression in Indonesia and Nepal – though mental healthcare utilisation varied.
- There was a high prevalence of suicidal ideation and attempts, and little professional help after such suicidal thoughts or attempts.
- Rates of accessing professional counselling and mental health services (lifetime prevalence) were very low, and only varied slightly between countries.
- The most significant gender minority stressors affecting mental health varied by country. In Nepal, experiencing discrimination in HIV services was linked to symptoms of depression. In Indonesia, delaying necessary treatment due to past experience of invasive questions was linked to higher rates of depression, anxiety, and suicide attempts. In Thailand, having ever been seriously assaulted was linked to higher rates of depression and anxiety. In Vietnam, having been previously refused treatment was linked to worse symptoms of anxiety, depression, suicidal ideation, and suicide attempts.
- Gender minority stressors affecting mental healthcare use also varied by country. For example, in Indonesia and Thailand: discrimination in HIV treatment was linked to lower rates of testing for anxiety and depression. In Vietnam: having been refused treatment in the past due to your transgender identity was linked to lower rates of accessing counselling or professional mental health services.
- Practical stressors not related to belonging to a gender minority were associated with higher anxiety. Delaying treatment due to cost was linked to higher anxiety in all four countries.
- Proposed resilience factors show some promising signs of positive impacts on mental health. For example, in Nepal and Indonesia, transgender people who were CBO members had lower rates of anxiety and depression. In Indonesia and Thailand, transgender people high in pride had better mental health. In Thailand, higher pride was also linked to seeking more help.

2. Sexual Health and Healthcare Use

- Most transgender people across all countries were aware of STIs and HIV, and most had been tested for STIs and HIV at some point. The proportion of respondents who had ever been tested for an STI ranged from 56% in Nepal to approximately 76% in Indonesia and Thailand (and 63% in Vietnam). The majority in all countries had received an HIV test, with the highest in Indonesia (81%) and lowest in Vietnam (74%). There were small numbers of HIV-positive participants in each country, but nearly all were on ART. Low self-perceived risk of exposure was the most common reason for not being tested for an STI – other than in Vietnam. Approximately 80% of transgender people in Nepal and Vietnam who had not been tested for an STI said it was because it was unlikely that they had been exposed. In Thailand, fear of stigma was the most common reason for not seeking STI testing.
- CBOs were common sources of treatment for STIs. CBOs were the most common source of treatment in Nepal, Indonesia and Vietnam; while in Thailand most went to the government health centre, clinic or hospital.
- Trans women were tested for STIs and HIV at higher rates, and with higher frequency, than trans men – other than in Vietnam, the only country where more trans men than trans women had been tested for STIs.
- Sex workers were more likely to be tested for STIs, tested more frequently, and sought treatment immediately. This finding was replicated across Nepal, Indonesia, and Thailand. There were too few sex workers in Vietnam for reliable analysis.
- Use of preventive and prophylactic treatments like PEP and PrEP was low across the four countries.
- For STI and HIV healthcare, gender minority stressors were mostly linked to higher rates of awareness and treatment – with some notable exceptions. We suggest this means that respondents who were regularly seeking sexual health services are more likely to experience gender minority stressors while accessing their testing or treatment.
- HIV status itself may influence whether transgender patients are refused treatment. HIV-positive respondents in Nepal and Indonesia were more likely to say they had experienced gender minority stress—a potential exacerbation of discriminatory treatment related to being both transgender and HIV-positive.
- Transgender people associated with CBOs had more awareness of STIs and HIV, were more likely to be tested, tested more frequently, and to access combination-prevention services – other than in Vietnam.

3. Use of General Healthcare

- General healthcare check-ups can be the front line for preventing serious or longer-term health issues, and rates of general healthcare usage varied by country.

In Nepal, 70% of transgender people had never had a check-up, and this was also the case for almost a third of participants from Indonesia (mostly trans women).

- Gender was less prominent in explaining differences in behaviours around general healthcare than in mental and sexual health settings.

The one country where gender was linked to greater use of general healthcare was Indonesia. Trans women were more likely to have never had a check-up or to have had check-ups less frequently.

- Delaying general healthcare treatment due to fear of discrimination was a common outcome in the general healthcare setting

In Vietnam, more than half of survey participants had delayed treatment because of anticipated discrimination. In Nepal and Thailand more than a third of participants gave this reason for delaying treatment, particularly sex workers (in both countries), as well as trans women and older people in Nepal.

- Delaying treatment due to invasive questions was a significant stressor reducing healthcare seeking behaviour across the four countries

- Experiencing discrimination in HIV services led to delays in accessing general healthcare in Nepal and Indonesia, but not Thailand or Vietnam.

- Experiencing the stressor of previous assault did not impact general healthcare use (unlike in mental healthcare settings). The only exception to this finding was Thailand, where people who had been assaulted were also more likely to have delayed needed treatment due to fear of discrimination.

- People who delayed general healthcare for one reason were more likely to delay it for other reasons as well

4. Use of Gender-affirming Hormones

- Hormones use was highest in Thailand and Indonesia, and more people had taken hormones in the past than currently used them

- First use of hormones was the most medically unregulated

Across the four countries, first hormone use tended to be informal sources, though more transgender people sought medical advice before currently taking hormones. While this increased medical consultation is promising, where it is helpful and inclusive, the first use of hormones is where the largest risk lies.

- The important variable of interest - seeking medical advice prior to taking hormones - was not linked to experiencing gender minority stress or resilience factors across the four countries.

The limited data in this section did not show that gender minority stress was linked to decreased use of medical advice around taking hormones. Nor did the proposed resilience factors encourage use of medical advice around hormone use. Further research is recommended in this area.

Critical Healthcare Gaps

This KPRA project has provided new and additional knowledge on barriers to HIV and other health services for transgender people in Indonesia, Nepal, Thailand, and Vietnam. It has identified some critical gaps in the availability, acceptability and accessibility of healthcare for trans communities in all four countries. The concluding section of the report discusses some of these pressing areas of concern:

- Trans people's right to health is compromised across the region due to gaps in the availability of services, particularly gender-affirming care; discrimination and cost barriers that undermine accessibility; and acceptability issues due to lack of guidance about providing services in ways that are culturally competent for trans people.
- Stigma and discrimination limit trans people's access to general healthcare services. The absence of knowledgeable service providers and their lack of training in providing trans-competent care is a formidable barrier that needs to be addressed.
- Trans people desperately need mental health support services, there were simply not enough services available in any of the four countries.
- There are gaps in sexual health services for trans women and no services targeted at trans men.
- Gender-affirming healthcare is very limited and unregulated, so trans people are typically navigating access to hormones and other forms of gender-affirming healthcare with very limited information and few, if any, formal health pathways.

Recommendations

The recommendations in this report focus on the steps that health ministries; academics and policymakers, health providers, CBOs and others need to take to:

- Address discrimination and improve the responsiveness of healthcare services to trans people
- Address significant information gaps about trans people's health
- Ensure trans people's equal access to mental health services
- Ensure trans people's equal access to HIV and sexual health services and
- Improve trans people's access to gender-affirming care.

The detailed actions in each area, collated at the end of the report, have the potential to reduce discrimination and other compounding stressor experiences that transgender people face because of their gender identity, remove practical barriers, and bolster the resilience of trans people and trans communities.

The study has some understandable limitations outlined in the methods section. Noting these limitations, the KPRA study addresses and fills crucial empirical research gaps in transgender health, while expanding on theoretical knowledge about the mental, physical, and sexual health of transgender people interacting with discriminatory health systems in the region. The community-led and community-inclusive participatory research methodology was an effective approach for building the skills of transgender CBOs and empowering them to start using the results to design advocacy campaigns. As the regional network, APTN has invested time in building a capacity and processes of CBOs to implement the study. One of the lessons learned from this KPRA project is that strengthening capacity continues to be an ongoing process. More investment in research will be needed to better understand the vulnerabilities among transgender people and identify interventions that will best meet community needs. The findings from this multi-faceted KPRA project are a first step and provide essential building blocks for further multi-stakeholder, collaborative research and programming.

INTRODUCTION

There are a range of negative experiences transgender people encounter trying to access healthcare in a cis-normative society. These negative experiences, both systemic and interpersonal, produce unique stress for transgender people that can lead directly to negative health outcomes, including poor physical or mental health. Stressors can also be a barrier to utilising healthcare for transgender people, such as when a previous experience with discrimination in a healthcare setting leads to future avoidance of medical care. It is vital to understand the impact of stressors on how transgender people use healthcare services, so that stressors can be mitigated, and healthcare access and utilisation improved.

Gender Minority Stress and Resilience Model

The Gender Minority Stress and Resilience (GMSR) model (Testa et al, 2015) is often used to understand health outcomes for transgender individuals. Gender Minority Stress and Resilience frames negative health outcomes for transgender and gender diverse people as the direct and indirect result of stress specifically associated with belonging to a gender minority.

Stressors can include previous experience with discrimination, such as receiving inadequate healthcare because of one's gender; victimisation, such as having experienced violence because of belonging to a gender minority, and non-affirmation of gender identity, such as administrative forms at a doctor's office not allowing for self-identified gender. Stressors associated with being a gender minority have been shown to negatively impact health outcomes for trans and gender diverse individuals, particularly mental health.

More recently, the gender minority stress model has incorporated resilience as a key factor that can reduce the impact of gender minority stress on health outcomes. Resilience factors can include internal identity processes such as taking pride in being transgender, along with social and community connectedness, and evidence suggests these factors can act as a buffer against the negative impacts of gender minority stress.

Most studies of stress and resilience factors focus on mental and physical health outcomes, such as whether stress increases mental illness or stress-related illnesses

Other factors can provide a buffer against these stressors and encourage healthcare utilisation for transgender people. These resilience factors may include feelings of pride in being transgender, or feelings of community connectedness fostered through membership in a community-based organisation (CBO). Barriers related to material factors, such as cost of healthcare, distance from services, and whether or not a transgender person has health insurance, could also impact (and in some cases compound) inequalities in health system use.

such as high blood pressure. However, focusing only on health status can be problematic for two reasons: First, it is harder to measure the impacts of additional stress when someone already has long-term or chronic disability or illness. Second, it implies that an inclusive healthcare system is only as important as the health outcomes it produces, rather than an end in itself. In the absence of inclusive practices for trans patients, too many people exit the health system, and turn to unregulated healthcare.

Most researchers have looked how stress and resilience factors linked to being transgender have impacted mental health outcomes. Specifically, researchers have focused on negative mental health, such as experiencing depression and anxiety; and reduced mental healthcare service use, such as accessing counselling or other psychosocial services. But healthcare services should not be treated as silos, and it is important to simultaneously consider healthcare settings such as sexual healthcare, including HIV services; general healthcare, including regular check-ups; and gender-affirming healthcare, including use of hormones and associated medical advice.

Although healthcare-seeking behaviour is not usually used as an outcome variable in Gender Minority Stress and Resilience studies, the model is grounded in the concept that trans and gender diverse individuals are "less healthy than the general population in part because of their avoidance and underutilisation of healthcare" due to gender minority-related stress.^v

In 2019, the Asia Pacific Transgender Network (APTN) and partner organisations in four countries – Nepal, Indonesia, Thailand, and Vietnam – conducted a mixed-methods research project aiming to uncover barriers and gaps to accessing health services for transgender people across a range of healthcare settings. This report provides in-depth analysis of the findings, using a framework for understanding barriers and enablers that encompasses stress, resilience, and practical considerations (such as cost and distance). We also explore healthcare utilisation patterns for people of different genders, age groups, and type of work, i.e., sex work. The research population includes trans men, trans women, culturally specific terms for gender diversity such as *meti*, those who identify as gender non-conforming or non-binary, and other gender diverse people.

The APTN KPRA research provides the first data in this region helping to explain transgender people’s healthcare utilisation across a range of healthcare settings. Understanding the systemic and structural barriers that prevent transgender people from seeking healthcare will help to inform policies and advocacy designed to give transgender people access to comprehensive healthcare. Peer-led community research such as this is the most reliable means of uncovering what barriers people face, including stressors and practical barriers, and what helps them to overcome those barriers, including resilience factors like identity pride, and community connectedness through CBO membership.

Research question and variables measured

Alongside presenting overall findings at the country and comparative level, this report seeks to address one core research question: What are the stressors and resilience factors impacting the health, mental health, and healthcare utilisation of transgender people in different healthcare settings?

Gender Minority Stress and Resilience is used as a broad framework in order to understand how trans people in Nepal, Indonesia, Thailand, and Vietnam interact with health systems, and the stressors and resilience factors that can discourage or encourage healthcare utilisation. We explore these stressors in four different healthcare settings: a) mental health and healthcare, b) sexual health and healthcare, c) general healthcare, and d) gender-affirming healthcare.

The key measures presented in this report include:

- Overall physical, mental, sexual/reproductive, and gender-affirming healthcare seeking behaviours;
- Group factors, such as gender identity, age, and sex work status, associated with different healthcare seeking behaviours;
- Potential stressors relating to being a gender minority, including: having been previously refused treatment due to one’s gender identity; having been assaulted in the past; having experienced discrimination while accessing HIV services; delaying treatment due to past experience of invasive questions; and delaying treatment due to past experience with lack of guidance for transgender patients;
- Potential stressors not specifically related to being a gender minority, such as cost, distance, and health insurance, and;
- Potential resilience factors that may encourage healthcare seeking behaviour, such as identity pride, or CBO membership.

COUNTRY CONTEXTS

The KPRA research data was collected between November 2018 and June 2019. This report focuses primarily on the quantitative survey data, informed by findings from the qualitative FGDs and key informant interviews. In September 2017 APTN hosted the ***From Barriers to Bridges conference*** on increasing access to HIV and other health services for trans people in Asia. Background qualitative data were collected by country and regional partners in preparation for that conference and subsequently published as the ***Regional Mapping Report on Trans Health, Rights and Development in Asia***.^{vi}

South Asia: Nepal

Information collated in late 2017 for APTN's regional mapping report noted that trans women had access to sexual and reproductive health services, and to trans-specific HIV services including within CBOs. The National Guideline also prioritised access to PrEP for trans women, and there was both trans-specific HIV data and health research. However, there were no reported counselling services available for trans people or youth mental health services. The regional mapping report did not identify any training available for healthcare professionals that was designed to improve their competency when providing healthcare to trans people.

Southeast Asia: Indonesia

Again, APTN's 2017 regional mapping identified that trans women in Indonesia had access to sexual and reproductive health services, and to trans-specific HIV services including within CBOs. Trans women were counted in HIV data and included in the national HIV Strategy and in broader trans health research. However, there was no access to PrEP in Indonesia. On the other hand, Indonesia was the other country where the 2017 regional mapping noted that counselling and youth mental health services were available for trans people. It was also the sole country where some training was available for health professionals about providing competent, trans-inclusive care.

That baseline data, largely covering trans people's access to HIV services, and to mental health and counselling services, is summarised below. Further background context about access to gender-affirming healthcare services in each of these four countries is covered separately in section four of this report.

The individual country briefs written for this KPRA project detail the legal, policy and regulatory framework for the delivery of health services in Nepal (South Asia), and Indonesia, Thailand and Vietnam (Southeast Asia). These briefs are available from the national country partners and from APTN.

Southeast Asia: Thailand

Similarly, information collated in late 2017 for APTN's regional mapping report noted that trans women in Thailand had access to sexual and reproductive health services, and to trans-specific HIV services including within CBOs, and had access to PrEP. Trans women were identified as a key population, counted in HIV data and included in the national HIV Strategy. There was also a wider level of trans health research being done in Thailand. Of the four countries covered by this KPRA report, Thailand was one of only two where the 2017 regional mapping noted that counselling services and youth mental health services were available for trans people. However, at that time, there was no trans-competency training available for healthcare professionals.

Southeast Asia: Vietnam

APTN's regional mapping report again showed that trans women had some access to sexual and reproductive health services, and to trans-specific HIV services including within CBOs. PrEP was available for trans women through a small-scale PrEP pilot project. Some HIV data and other health research was available about trans women, and trans women were included in a HIV harm reduction and PrEP pilot project designed to address stigma, discrimination and violence, pilot PrEP, and reduce harm.^{vii} In 2018, UNAIDS estimated that the rate of HIV infection among trans women in Ho Chi Minh City was 18%.^{viii} The regional mapping report found no identified trans-competency training for healthcare professionals.

RESEARCH METHODS

Data Collection

Data collection was carried out between August 2018 and June 2019 in urban areas of four countries—Indonesia, Nepal, Thailand and Vietnam by APTN partner organisations, and included both focus group discussions (FGDs) and a community-based survey (CBS). The aim of the community-based survey was to collect information from a total of 1000 trans people, 250 transgender people per country, with a minimum of 25% trans men. The questionnaire was developed through a consultative process that included inputs from national partners on priority themes. Research teams included a mix of trans women and trans men. Data was analysed by country, and by healthcare setting, using the same potential stressors, resilience factors, and practical barriers to guide that analysis.

Partner Organisations

The following table presents country partners. These trans-led partner organisations have been long-term advocates of trans inclusion in the HIV response and have been engaged in advancing the legal and human rights of sexual and gender minorities. The exception is the Vietnam Transgender Network (VNTG), which has

recently emerged as a separate group from the network of men who have sex with men (MSM) and it was supported by the Centre for Supporting Community Development Initiatives (SCDI) in managing this KPRA project.

Questionnaire Development

The initial set of questions were developed in English and based on issues identified in the Blueprint for the Provision of Comprehensive Care for Trans People and Trans Communities in Asia and the Pacific. On subsequent revisions, questions from *Counting Ourselves: the Aotearoa New Zealand Trans and Non-binary Health Survey*^x and *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*^x were also reviewed, and some of the more relevant questions were included. APTN first reviewed the revised questionnaire, and then each question was thoroughly vetted by country teams at the August 2018 regional meeting.^{xi} Once agreement was reached on the questions, the country teams then translated them into their national language and further adapted vocabulary to reflect local norms on gender identity and sexuality. Although the questionnaire retained its basic structure, questions were adjusted based on local knowledge during the three-day national training.

	WHEN	WHO	WHERE
INDONESIA	13-15 th Nov	GWL - INA	Jakarta and surrounding suburbs including Bekasi, Bogo, Depok, and Tangerang
NEPAL	6-8 th October	Blue Diamond Society (BDS)	Kathmandu & Nepalgunj
THAILAND	2-4 th December	SISTERS Foundation	Pattaya
VIETNAM	24-26 th October	VNTG (supported by SCDI)	Hanoi

The final questionnaire, in addition to the introduction, eligibility criteria and informed consent process, included five sections (Table 1). Section B collected socio-demographic information such as sex at birth, current gender, age, schooling, employment status, housing, ethnicity, and religious grouping. Section C asked questions about transitioning and types of health services needed to support transition. Section D included questions on general health and healthcare-seeking behaviour, including mental health. The questions in Section E focused on access to HIV and STI prevention, and treatment services and reasons for any delays in seeking these services. The last section, Section F, asked about alcohol, smoking, and other drug use.

Survey Implementation

Ethical approval was received from relevant national authorities.^{xii} The data for CBS was collected between November 2018 and June 2019. Each country developed its own implementation timeline based on the schedule of approval from the ethical review board, taking into account national and religious holidays. Research teams included a mix of trans women and trans men. Some had previous experience in carrying out research. In some cases, the research team included current staff of the CBO. The field enumerators and community field supervisors (CFS) were responsible for the data collection, reading out each interview question to respondents and filling in responses based on their answers. The CFS was responsible for checking the questionnaire for completion. Discrepancies, if any, were worked out soon

after the interview took place. The community team research lead performed spot checks to ensure that the data being obtained was complete and of quality. The completed questionnaires were placed in secure storage until data entry.

Recruitment

Recruitment of participants took place through word of mouth by community outreach workers from country partners, online through social media channels, bars, nightclubs, and drop-in centres. In Vietnam, the research team used online platforms such as Facebook, fan pages, online networks of sexual and gender minorities groups, and email groups inviting participants to provide their contact information through links to a Google form. In Thailand, the research team posted information at entertainment venues. The Nepal research team recruited respondents through its own network. All research teams noted the difficulty in recruiting trans men for the survey.

Interviews took place in private locations where the respondents felt most comfortable, such as respondents' homes, CBO offices, hotel rooms, cafes, restaurants, and parks. On an average, the time to complete the questionnaire varied between 40 minutes to one hour. All eligible participants were requested to provide written informed consent before participating in the study. Respondents were given a nominal compensation for travel and refreshments, between USD 5 to USD 10, which was viewed as beneficial in terms of recruiting participants.

TABLE 1: Description of sections in the APTN-KPRA community-based survey questionnaire

Introduction	Guide to the questionnaire; location and time of interview; eligibility and informed consent; and verification by Community Field Supervisors
Section B	Socio-demographic questions– age, sex at birth, self-identified gender, education, employment, occupation (including sex work), relationship status, member of CBO and benefit, religious affiliation, ethnicity
Section C	Transition-related questions– stages of gender identity, hormone use (current and future), hormone procurement, medical advice, transition-related surgery, transitioning priorities
Section D	General health and healthcare-seeking behaviour– overall health (physical health, mental health, and gender-affirming health) service provider, delaying treatment (practical reasons: distance, lack of transport, clinic timings; gender identity reasons: discrimination, intrusive questions, lack of guidance and standards, safety and security), suicide-related questions (ideation and attempts)
Section E	HIV and STI risk perception and access to services: sexual partners, STI testing, HIV testing, access to treatment, HIV status, access to prevention services
Section F	Alcohol use, drug use (including injectable drugs), and smoking

Ethical Considerations and Consent

Participation in the study was voluntary. Each participant provided written consent after an explanation of the study objectives. Participants were informed at the beginning of each section that they could stop responding to questions, and discontinue participation at any time. No personal identifiers were taken on the survey response form so that individuals could not be identified. Mobile telephone numbers were collected separately to allow verification of a random sample of 10% of records completed.

Data Management and Analysis

The Research Electronic Data Capture (REDCap),^{xiii} a web-based application developed by Vanderbilt University to capture data for clinical and field research, was used to submit the national data through an online secure server based at the Indus Hospital in Karachi, Pakistan. The data entry interface for each country was developed in local languages. Since there was no double entry of questionnaires, the national research teams were asked to re-enter 10% of the questionnaires (n=25) for verification with the original data entry. An error rate of less than 5% (n=10) questions (excluding spellings) was considered acceptable. Indonesia, Thailand, and Vietnam research teams were requested to re-enter the questionnaires a second time. The data entry was verified again before any analysis commenced.

The REDCap data for each country was exported to the Statistical Package for Social Sciences (SPSS) Version 17 for analysis. National level descriptive information including percentages, means and standard deviation (SD) were generated for all variables. Gender identity (trans women and trans men), age group (18-25 years old, and above 25 years old), and sex work (those had ever done sex work and those who had never done sex work) were identified as variables of interest.

Selection of Variables

Gender minority stressors were identified through a review of the literature, and in consultation with APTN and subject matter experts. Stressors were experiences of stigma and prejudices someone had encountered previously in their life due to being transgender, specifically:

- Having been assaulted to the point of requiring medical treatment;
- During previous general health care encounters, having been refused treatment due to their gender identity;
- Having delayed medical treatment due to past experience of invasive questions;

- Having delayed medical treatment due to knowing there were no standards or guidance for transgender patients, and one stressor related specifically to experiencing discrimination while accessing HIV services and was included across the healthcare settings to see if discrimination in one healthcare setting changed behaviour in another.

Other **practical stressors** were measured by asking:

- Whether participants had delayed healthcare in the last six months due to cost, and;
- Whether they delayed healthcare in the last six months due to distance.

Potential **resilience factors** were identified as:

- Being a member of a trans or MSM community-based organisation and feelings of pride in one's gender identity, measured by combining six survey items.^{xiv}

As the survey is cross-sectional, we can only point to associations between variables, and speculate on the direction of the relationship. In some cases, this will produce results showing that increased contact with a healthcare system also sadly increases the likelihood of a negative experience for transgender individuals seeking healthcare.

Challenges and Added Value of this Research

The APTN KPRA project was one of the first of its kind in the region, with trans communities taking the lead in design and implementation of the research. It directly engaged the community, and grew community knowledge on evidence-based strategic actions. There was a steep learning curve of research methods by partner organisations who managed the ethical approval, staffing and training of research team members, recruitment of respondents, interviews, and data input. However, the community-inclusive nature led to greater understanding of research methodologies, community needs, and limitations. At the July 2019 meeting, the research team participants expressed that they had learned immensely, and felt confident as community-based researchers. They also noted that they would have benefited from having a national consultant who was part of the entire project from beginning to end, compared to the KPRA set up of product-based, limited days of consultant engagement. In general, the KPRA project would have benefited from full-time research staff supporting national teams and data analysis rather than the consultants engaged for a smaller number of days.

Historically, the HIV response has largely focused on trans women. However the inclusion of trans men in the KPRA project was an important time in developing trust and understanding between the communities, and gaining awareness and knowledge in understanding barriers to HIV and other health services faced by trans men. Having trans men as part of the research team is also helpful in recruitment of trans men as participants. Building an understanding of the diversity within the trans communities and the connections amongst the trans communities was an important outcome for the KPRA project.

Using existing networks for recruitment, and snowballing data collection through these connections for additional participants, was methodologically easier. However, it could also result in sampling and response bias. As a sample of convenience drawn from urban centres through transgender CBOs, there may not be as much heterogeneity among participants. For example, the research team in Thailand had difficulty in recruiting trans men (n=15). The research team in Vietnam recruited a larger percentage of young transgender people (70% between 18-25 years old). Because of the peer-based nature of the research, participants could choose whether to reveal personal information or conceal details that they were uncomfortable sharing. This may explain, for example, why participants from Thailand and Vietnam reported very low levels of ever having worked on the street or engaged in sex work. There was also a potential for response bias in the HIV and STI section since trans women have been more involved in programming, and could be more aware of their rights and more prone to feeling discrimination as compared with trans men who have not been part of the HIV response.

Limitations

The study has some understandable limitations. The methodology of convenience sampling through CBO networks necessarily limits the findings to only those transgender individuals who were able to be contacted through such networks. The sample skews towards urban populations. There are fewer trans men than trans women in the sample (especially in Thailand). This means that trans men are under-represented. Again, generalisations are limited to only the study sample, rather than the entire population of trans men in Thailand.

Ideally, a theoretical model like GMSR would be analysed using complex multilevel statistics – but for the purposes of exploring the model in a community report, we have deliberately contained the statistical analysis to comparisons of percentages and proportions between groups, using individual tests of significance for each association. This means that we only measure how one variable is associated with another, and cannot comment on whether, for example, the affordability of treatment is more of a stressor than previous refusal of healthcare, only that both are associated with avoiding medical care. This is especially important to consider when comparing stressors and resilience factors. For example, we do not know if being associated with a CBO is actually a buffer against the impacts of gender minority stress, such as being assaulted. What we do know, for example, is that CBO members are more likely to go to counselling while people who have been previously assaulted are less likely to go to counselling.

Who participated in our study?

This section provides an overview of the gender and age of survey participants, the types of work they did (including sex work), and whether they were members of a community-based organisation (CBO).

Gender Identity

The majority of respondents were trans women. In Indonesia, 72.9% self-identified as trans women; Nepal 72.4%; Thailand 85.7% and Vietnam 63.4%. The relatively low numbers of trans men in the sample, particularly in Thailand, do limit some conclusions around gender. For example, there may be a difference in a particular behaviour between trans men and women in Thailand across the whole trans population but that does not show up as a statistically significant result in this report because there were only 15 trans men in the Thailand sample. For visibility around these issues, we still provide this analysis while noting the limitations.

Age

The mean age in Indonesia, Nepal, and Thailand ranged between 29 and 32 years, with a younger mean age in Vietnam of 24. The age distribution across the four countries also varied, with Vietnam having nearly 70% of respondents between ages 18-25 years old, Nepal and Thailand 30%, and Indonesia only 21%. All the respondents had completed at least secondary and high school. In Nepal nearly 36%, and in Vietnam, 40% had completed university level education. Across the four countries, respondents' self-report low levels of drug and alcohol use, potentially due to the peer-based nature of interviews.

Employment status

Since the majority of respondents were trans women, particularly in Thailand, this heavily skewed the types of occupations and industries where transgender people worked. Most respondents in Thailand, 73%, reported working full-time in the entertainment industry, clerical/secretarial work, or as beauticians/hairdressers. In Indonesia, no one reported having full-time work. 39% reported being self-employed, 38% working part-time, and 20% were unemployed. In Nepal, 40% had full-time work, 10% part-time work, 9% were self-employed, and 42% were unemployed despite the high level of education. In Vietnam, 82% of respondents had some forms of employment and 18% were unemployed. Most respondents worked in a limited number of occupations open to trans women, such as entertainment, administrative/secretarial work, or personal care services such as those offered by beauticians/hairdressers. Sex work was reported as the number one occupation for Indonesia, with 58% of respondents having ever worked as a sex worker, and 45% of respondents in Nepal having ever worked as a sex worker.

CBO Membership

Many of the respondents were affiliated with local CBOs but there was considerable difference between countries ranging from almost two thirds (65%) in Nepal to only just over one third in Indonesia (37%) and Thailand (36%), and only 21% in Vietnam. Overall, trans women were more likely to belong to a CBO than trans men. However, in Vietnam, there were no differences by gender identity.

Reported services associated with CBOs were access to both health information and services that were trans-specific; the chance to build advocacy and community outreach skills; a sense of solidarity belonging; networking with other trans people in Nepal; and employment opportunities.

Stressors and Resilience Factors in Each Country

In this section, we provide an initial exploration of the frequency of the proposed stressors and resilience factors within each country, along with gender differences in experiences of these stressors and resilience factors. In the following tables, we present survey data we have proposed using to measure stressors related to being a gender minority. These gender minority stressors are: being refused treatment, physically assaulted, experiencing discrimination in HIV services, delaying treatment due to past experience of invasive questions, and delaying treatment due to poor guidance or standards for transgender patients.

Being refused treatment or turned away by a doctor or healthcare provider because of transgender identity was highest in Nepal, with 8.4% of all participants having experienced this (21 individuals), followed by Vietnam (6.5% or 16 individuals), Indonesia (2.0% or five individuals) and Thailand (1.6% or four individuals). There were no significant gender differences in any of the countries for this gender minority stressor.

Experiencing discrimination when accessing HIV services was experienced most frequently in Thailand, by 9.6% (24 individuals), followed by Nepal (6.8% or 17 individuals), Indonesia (6.0% or 15 individuals), and Vietnam (4.1% or 10 individuals). In Thailand, trans women were most likely to have experienced discrimination while accessing HIV services (noting that this stressor implies having attempted to access HIV services).

The most common gender minority stressors experienced across all countries were our two measures related to delaying necessary treatment in the previous six months, and both were most commonly experienced in Vietnam.

Having been seriously physically assaulted in the past varied by country. It was experienced most frequently in Nepal (19.2% or 48 individuals), followed by Thailand (10.0% or 25 individuals), Vietnam (1.2% or three individuals), and Indonesia, where no one reported having been assaulted. In Nepal, trans men were less likely to have been assaulted than trans women, or people who identified as third gender.

Delaying treatment due to past experience of invasive or unnecessary questions was reported by 47.2% of survey participants in Vietnam (116 individuals). This stressor was also experienced in Nepal by 30.8% (73 individuals), Thailand (31.5% or 79 individuals), and Indonesia (25% or 186 individuals). In Indonesia, trans women were more likely to report this gender minority stressor than trans men.

Delaying treatment due to poor guidance or standards for transgender patients was most common in Vietnam, with 45.5% (112 individuals) experiencing this, followed by Indonesia (34.8% or 87 individuals), Nepal (30.5% or 71 individuals), and Thailand (23.5% or 59 individuals). There were gender differences in three countries: Nepal, where participants who identified as third gender were most likely to report this stressor; Indonesia, where trans women were more likely to report this stressor, and Thailand, where trans women were less likely to report this stressor than trans women or those who identified as third gender.

Frequency table for each potential gender minority stressor, by country

STRESSOR-GENDER MINORITY	NEPAL	INDONESIA	THAILAND	VIETNAM
Have you ever been refused treatment or turned away by a doctor or healthcare service provider because of your transgender identity?	<p>8.4%</p> <p>TG 8.3% TM 7.7% TW 9.1%</p>	<p>2%</p> <p>TM 3.6% TW 1.5%</p>	<p>1.6%</p> <p>TW 1.9%</p>	<p>6.5%</p> <p>TM 4.5% TW 7.7%</p>
Have you ever been physically assaulted such that you require medical treatment?	<p>19.2%</p> <p>TG 20.5% TM 7.7% TW 24.8%</p>	<p>10%</p> <p>TM 5% TM 26.7% TW 9.4%</p>	<p>1.2%</p> <p>TM 2.3% TW 0.7%</p>	
Have you experienced discrimination , or discriminatory behaviour from healthcare service providers, when accessing HIV services?	<p>6.8%</p> <p>TG 8.3% TM 3.8% TW 7.2%</p>	<p>6%</p> <p>TM 3.6% TW 6.7%</p>	<p>9.6%</p> <p>TW 11.2%</p>	<p>4.1%</p> <p>TM 4.6% TW 3.9%</p>

*Nepal: Trans men (TM) less likely to have been assaulted than other genders

**Nepal: People who identify as third gender (TG) more likely to have delayed treatment due to poor standards

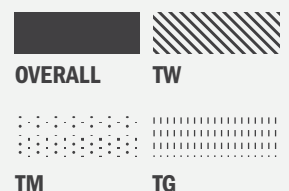
***Indonesia: Trans women (TW) more likely to have delayed treatment due to invasive questions

****Indonesia: Trans women (TW) more likely to have delayed treatment due to poor clinic standards

*Thailand: Trans men (TM) more likely to have been assaulted than trans women

**Thailand: Trans women (TW) most likely to have experienced discrimination in HIV services

***Thailand: Trans women (TW) least likely to have delayed treatment due to poor clinic standards



**STRESSOR-
GENDER MINORITY**

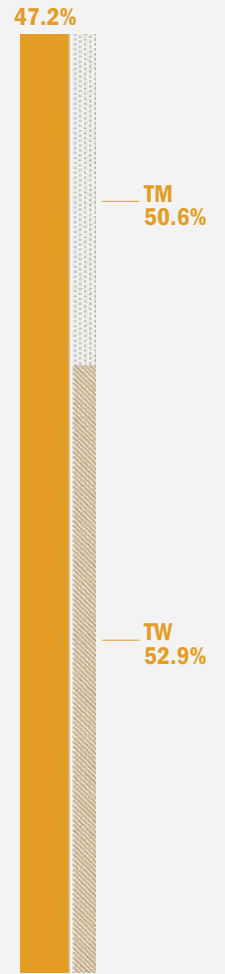
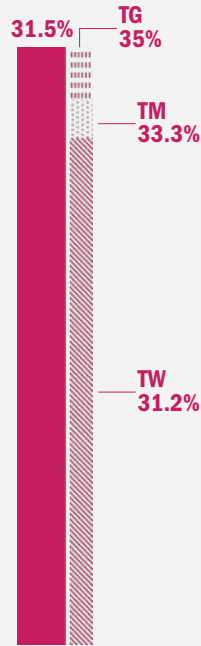
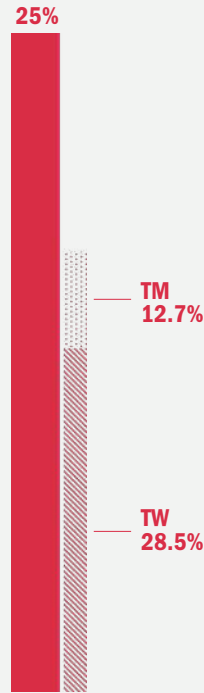
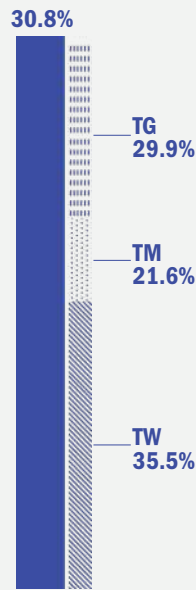
NEPAL

INDONESIA

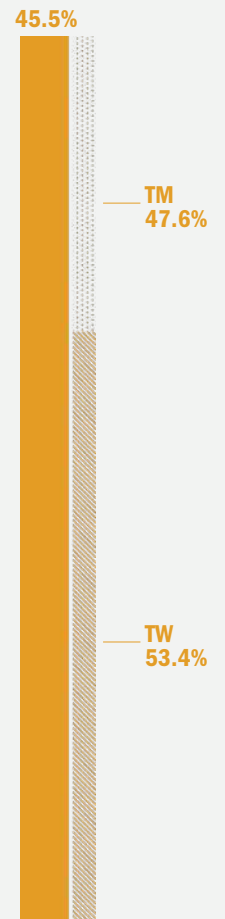
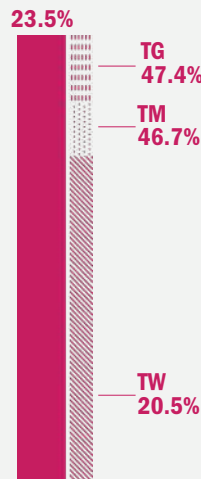
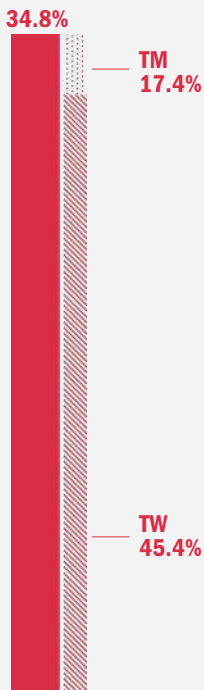
THAILAND

VIETNAM

In the past 6 months, have you delayed necessary treatment due to **past experience of invasive questions?**



In the past 6 months, have you delayed treatment due to **no guidance or standards** for transgender patients?



In addition, we considered two practical stressors that were not specifically related to being a gender minority. These variables were: not being able to afford treatment, and delaying treatment because the clinic was too far away.

Delaying treatment due to cost was most commonly experienced in Vietnam, with 23.2% of respondents (57 individuals) reporting this stressor, followed by Nepal (18.4% or 46 individuals), Thailand (10.4% or 26 individuals), and Indonesia (5.6% or 14 individuals). In Nepal, participants who identified as third gender were the most likely to report a cost barrier, and trans women the least likely. In Thailand, trans men were most likely to have delayed treatment due to cost.

Delaying treatment because of distance was most common in Indonesia, where 32% or 80 individuals reported experiencing this stressor, followed by Vietnam (23.2% or 57 individuals), Thailand (15.5% or 39 individuals), and Nepal (9.2% or 23 individuals). In Nepal, trans women were least likely to have delayed treatment due to distance. In Indonesia, trans women were most likely to have delayed treatment due to distance.

Frequency table for each potential practical stressor, by country and by gender

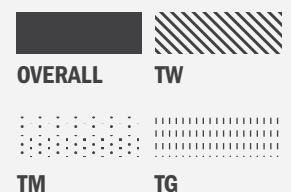
STRESSOR-PRACTICAL	NEPAL	INDONESIA	THAILAND	VIETNAM
Was there a time in the past 6 months when you needed to see a doctor but could not afford to because of the cost?	<p>OVERALL: 18.4%</p> <p>TM 18.9% TW 12.6% TG 26.5%</p>	<p>OVERALL: 5.6%</p> <p>TM 9.1% TW 4.9%</p>	<p>OVERALL: 10.4%</p> <p>TM 28.6% TW 10.3%</p>	<p>OVERALL: 23.2%</p> <p>TM 27.4% TW 22.4%</p>
In the last 6 months, have you delayed getting medical care you needed [for the reason that the] clinic is too far away?	<p>OVERALL: 9.2%</p> <p>TM 16% TW 3.8% TG 12.3%</p>	<p>OVERALL: 32%</p> <p>TM 13% TW 37.8%</p>	<p>OVERALL: 15.5%</p> <p>TW 15.8% TM 20% TG 10%</p>	<p>OVERALL: 23.2%</p> <p>TM 29.9% TW 25.7%</p>

*Nepal: Most cost stress for third gender participants; (TG) least for trans women

**Nepal: Least distance stress for trans women

***Indonesia: Trans women (TW) more likely to have delayed due to distance

*Thailand: Trans men (TM) most likely to have delayed treatment due to cost



CBO membership was highest in Nepal, with 64.8% of the respondents (162 individuals) associated with a CBO, followed by Indonesia (36.8% or 92 individuals), Thailand (36.3% or 91 individuals), and Vietnam (20.7% or 51 individuals). Trans women were most likely to be CBO members in both Nepal and Indonesia.

Pride in transgender identity was also highest in Nepal, followed by Thailand, Vietnam, then Indonesia. For example, 76% of respondents in Nepal fell into the category of Very High pride (109 individuals), compared to Thailand where 29.5% of respondents belonged to this category (74 individuals), Vietnam (2.4% or 6 individuals with Very High pride), and Indonesia (2.8% or 7 individuals). Trans women experienced higher levels of identity pride in Nepal, Indonesia, and Thailand.

Frequency table for each potential resilience factor, by country and by gender

RESILIENCE FACTOR	NEPAL	INDONESIA	THAILAND	VIETNAM
Are you a member of any trans or LGB or MSM community-based group?	<p>OVERALL: 64.8%</p> <p>TG 57.8%</p> <p>TM 41.5%</p> <p>TW 82%</p>	<p>OVERALL: 36.8%</p> <p>TM 10.9%</p> <p>TW 44.1%</p>	<p>OVERALL: 36.3%</p> <p>TM 6.7%</p> <p>TW 41.9%</p>	<p>OVERALL: 20.7%</p> <p>TM 18.9%</p> <p>TW 21.9%</p>
Pride scale (gender splits omitted for length and available on request)	<p>Very low: 0%</p> <p>Low: 0.4%</p> <p>Med: 2.4%</p> <p>High: 20.8%</p> <p>Very high: 76.0%</p>	<p>Very low: 0%</p> <p>Low: 6%</p> <p>Med: 44.8%</p> <p>High: 46.4%</p> <p>Very high: 2.8%</p>	<p>Very low: 0.4%</p> <p>Low: 4.4%</p> <p>Med: 14.7%</p> <p>High: 50.6%</p> <p>Very high: 29.5%</p>	<p>Very low: 1.2%</p> <p>Low: 2.4%</p> <p>Med: 40.2%</p> <p>High: 53.3%</p> <p>Very high: 2.4%</p>

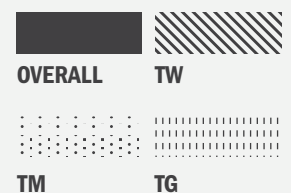
*Nepal: Trans women (TW) most likely to be CBO members

**Nepal: Trans women (TW) more likely to have High or Very High pride

***Indonesia: Trans women (TW) more likely to be associated with a CBO

****Indonesia: Trans men (TM) more likely to be Low in pride; Trans women more likely to be High in pride

*Thailand: Trans women (TW) higher in pride than other genders



MENTAL HEALTH AND HEALTHCARE USE

In this section, we explore stressors (experiences that may cause gender minority stress), resilience factors, and practical barriers associated with mental health and healthcare-seeking behaviour.^{xv} We also look at differences between gender, age, and sex work, as these are demographics of particular focus for APTN programming. Expanding on the main research question presented in the introduction, this section seeks to address the following question:

Which stressors and resilience factors are linked to mental health and healthcare use?^{xvi}

FOCUS VARIABLES IN THIS SECTION

o1 Mental Health *and* Healthcare

1. During the past 30 days how often do you feel sad, hopeless and worthless?
2. Have you ever been tested for and told by a doctor, nurse or other healthcare professional that you have depression?
3. During the past 30 days how often do you feel anxious, nervous, restless?
4. Have you ever been tested for and told by a doctor, nurse or other healthcare professional that you have anxiety?
5. Have you ever received professional counselling or mental health services?
6. Have you ever thought of ending your life? Did you ever seek help when you felt this way?
7. Have you ever attempted to end your life? Did you ever seek help when you felt this way?

o2 Gender Minority Related Stressors

1. Have you ever been refused treatment or turned away by a doctor or healthcare service provider because of your transgender identity?
2. Have you ever been physically assaulted such that you require medical treatment?
3. Have you experienced discrimination, or discriminatory behaviour from healthcare service providers, when accessing HIV services?
4. In the past 6 months, have you delayed treatment due to past experience of invasive questions?
5. In the past 6 months, have you delayed treatment due to no guidance or standards for transgender patients?

o3 Practical Stressors

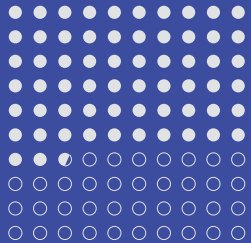
1. Delayed treatment in previous 6 months due to cost
2. Delayed treatment in previous 6 months due to distance

o4 Resilience Factors

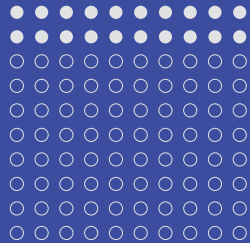
1. CBO membership (CBO member / Non-CBO member)
2. Identity pride (scale combination of 6 items, analysed as high/low)

NEPAL

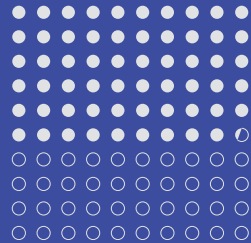
On depression:



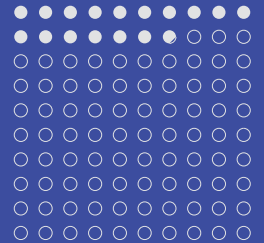
62.8%
of trans people in the Nepal Sample experienced at least some recent symptoms of depression



20%
had ever been tested for depression

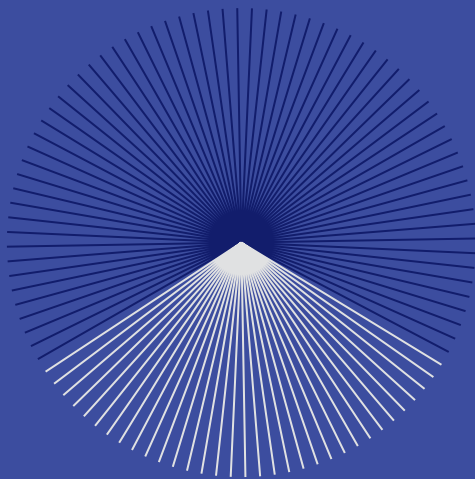


59.4%
experienced at least some recent symptoms of anxiety

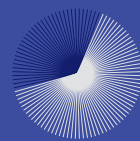


16.8%
had ever been tested and diagnosed with anxiety

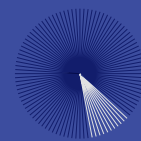
On suicide:



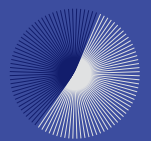
33.2%
participants had thought of ending their life



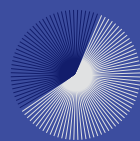
65.1%
had sought help when they felt this way



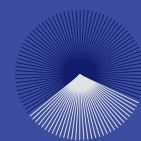
10.8%
always



54.2%
sometimes



59%
people who had attempted suicide



28.6%
had received help from professional counsellors or mental healthcare service providers afterwards.

of those

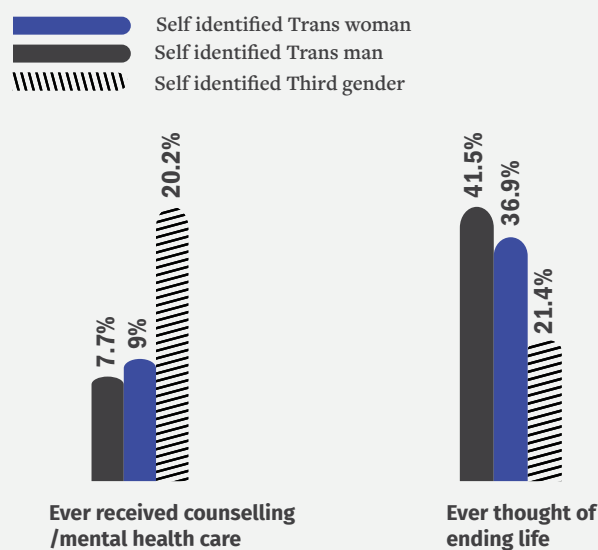
Gender was associated with all the mental health variables in Nepal, with a general pattern of trans men experiencing more recent symptoms of anxiety and depression but lower rates of mental healthcare utilisation.

There was also a gap between experiences of symptoms of anxiety and depression and having ever been diagnosed with anxiety or depression by a professional. Trans men were more likely to have experienced higher symptoms of depression and anxiety in the previous 30 days. For example, 15.1% of trans men in Nepal experienced symptoms of depression, such as feeling sad or worthless, in the previous 30 days (eight individuals), compared to 7.2% of trans women (eight individuals) and 10.7% of people who identify as third gender (nine individuals).

Trans men were also the least likely to ever have been diagnosed by a professional with anxiety or depression (for example, 11.3% had been tested and diagnosed with depression, compared to 16.2% of trans women, and 31% of people who identify as third gender). Trans men were the most likely to have ever thought of ending their life (41.5% or 22 individuals). Although 18.2% of those with suicidal ideation (four individuals) had always sought help after such thoughts, 54.5% (12 individuals) had never sought help, and 27.3% (six individuals) only sometimes. This suggests one of the following issues: lower past utilisation of mental healthcare services by trans men; lower prior experiences with anxiety and depression for trans men; or that mental health professionals are more reluctant to diagnose trans men with anxiety and depression. The data tentatively support the first conclusion, with trans men being the least likely to have ever received professional counselling or mental health services (7.7%, or four individuals), slightly lower than trans women (9% or 10 individuals). Third gender individuals were most likely to have received counselling (20.2% or 17 individuals). Trans men in Nepal had the highest rates of suicidal ideation and were less likely to have ever sought help afterwards than trans women (54.5% of trans men who had experienced suicidal ideation never sought help, compared to 19.5% of trans women).

Low use of mental healthcare services is also likely to be linked to the limited availability of such services. In the key informant interviews for this research project, stakeholders identified that only one CBO in Nepal provided mental health counselling to the trans community. They did so without specific training about working with trans people or about gender-affirming healthcare specifically.

Percentage of each gender who have ever received counselling compared to the percentage who have thought of ending their lives



Older (over 25) individuals had higher rates of both recent symptoms of anxiety and depression, as well as higher rates of lifetime diagnosis of anxiety or depression, and higher rates of suicidal ideation (35.3% of older adults compared to 28.8% of younger adults). Older adults were also more likely to have ever attempted suicide: over-25s comprised 73.5% of those in the sample who had attempted suicide. However, younger people were less likely to ever have been tested for anxiety or depression, with 36.3% of youth (29 individuals) having never been tested for either anxiety or depression. It is positive that 48.8% of young people (39 individuals) had experienced no symptoms of depression in the previous month, and 58.2% had experienced no symptoms of anxiety. However, it is concerning that nearly half the sample of young people experienced some mental health issues, especially given that only 10% (eight youths) had ever received professional counselling or mental health services.

Sex work was associated with fewer mental health outcomes in Nepal than gender or age, though sex workers were more likely to have ever been diagnosed with depression (30.4% of sex workers compared to 17% of non- sex workers), and anxiety (26.8% of sex workers compared to 14% of non-sex workers). Rates of ever having receiving counselling were low in general (12.8% of all participants), and there were no differences between sex workers and non-sex workers. Non-sex workers were more likely to have ever attempted suicide (64.6% or 42 individuals), compared to sex workers (38.9% or seven individuals). There were no significant differences in accessing professional help following attempts (5.6% of the total sample had sought help).

NEPAL: Stressors and Resilience Factors Around Mental Health

This section presents the Nepal data about stressors; both those related to a trans person’s gender identity and practical barriers, followed by resilience factors.

Gender Minority Stressors

The data strongly indicates that gender minority stress has an impact on mental health outcomes for trans people in Nepal. Each of the potential stressors were associated with either higher rates of anxiety or depression (recent symptoms and lifetime diagnosis). Those five gender minority stressors were: having been ever refused treatment or turned away by a doctor or healthcare service provider because of one’s transgender identity; having ever been assaulted; having ever experienced discrimination, or discriminatory behaviour, from healthcare service providers while accessing HIV services; having delayed treatment due to past experience with invasive or unnecessary questions, and delaying treatment due to lack of standards or guidance for transgender people.

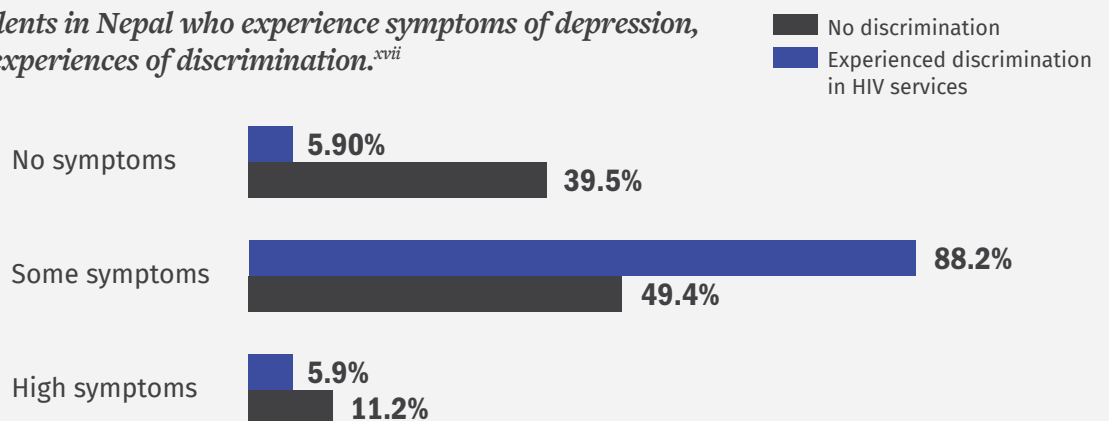
For example, having ever been refused treatment due to transgender identity was associated with increased symptoms of anxiety, depression, and suicide attempts. Only 19% of people who had been refused treatment because of their gender identity had no symptoms of depression (four individuals), compared to 38.8% of people who had not been refused treatment (eight individuals). Only one person who had experienced discrimination while accessing HIV services had no recent symptoms of depression, compared to 39.5% of people who had not experienced discrimination in HIV services (92 people).

On the other hand, experiencing refusal of treatment, discrimination when accessing HIV services, invasive questions, and no guidance or standards for trans patients, did not appear to decrease rates of accessing mental healthcare. 20 of those who had delayed treatment due to past experience of invasive questions (15 individuals) had ever received counselling, compared to 9.8% (two people) of those who had not experienced invasive questions. 33% (seven people) who had been refused treatment had also accessed counselling compared to 11.1% of those who had not been refused.

None of the gender minority stressor variables were significantly associated with suicidal ideation, though having ever being refused treatment or discriminated against during HIV services was associated with higher likelihood of having attempted suicide but also of having sought help following such attempts.

These findings highlight a potential thread between gender minority stressors and healthcare use: that often, increased accessing of healthcare will be associated with increased experienced of discrimination. As mentioned previously, since the survey was cross-sectional, we can only speculate on the direction of the relationship between the variables. In some cases, this will produce results showing that increased contact with a healthcare system also increases the likelihood of a negative experience for trans individuals seeking healthcare.

Percentage of respondents in Nepal who experience symptoms of depression, cross tabulated with experiences of discrimination.^{xvii}



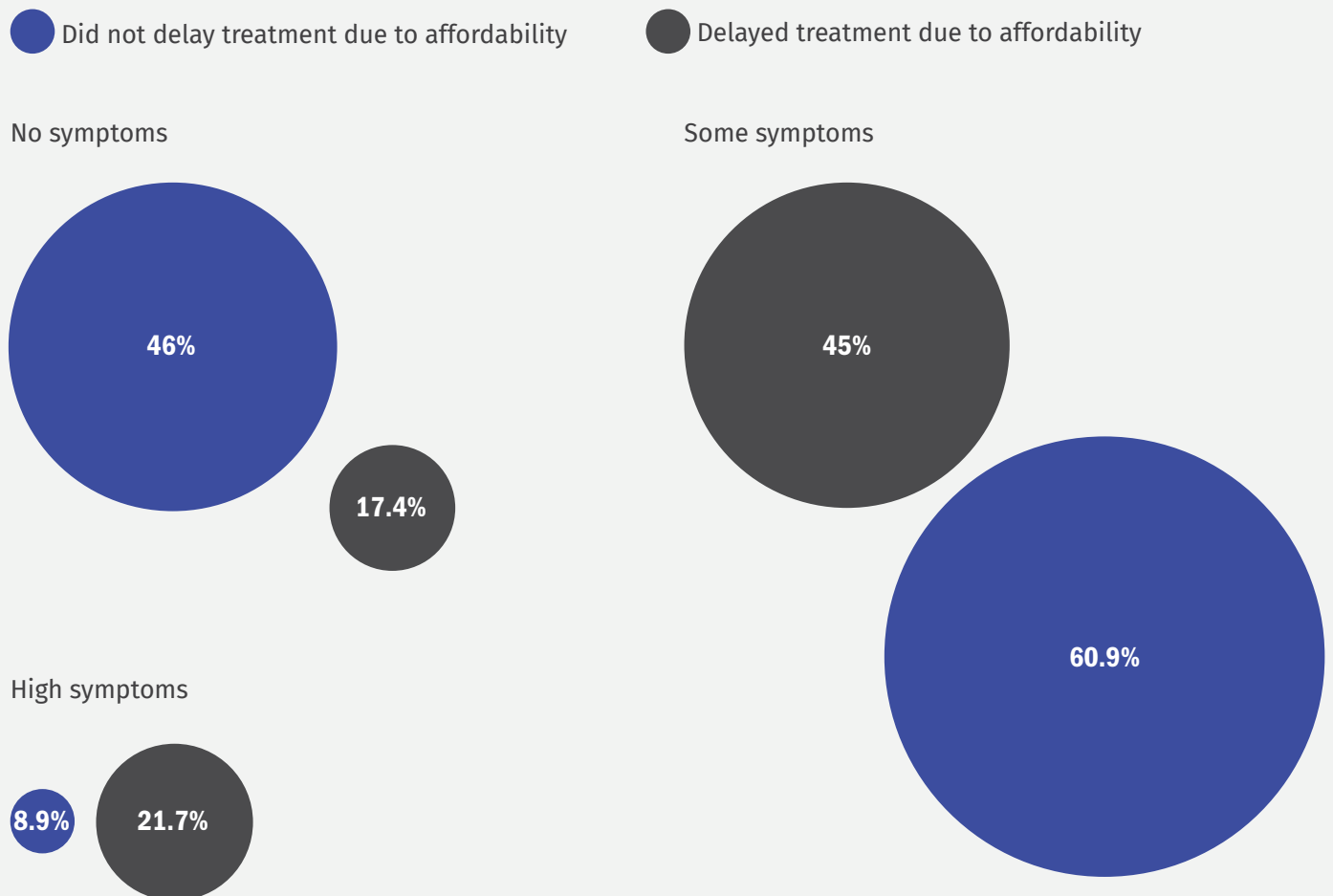
Practical Stressors

In terms of practical stressors, both cost and distance were associated with negative mental health outcomes in Nepal. For example, 21.7% of transgender people who had delayed treatment due to cost in the previous six months (10 individuals) also reported high symptoms of anxiety in the previous 30 days, compared to only 8.9% (18 individuals) who had not experienced a cost stressor. Of those who experienced a distance-related stressor, 21.7% (five individuals) also experienced high levels of anxiety, compared to 9.7% (21 individuals) who did not have a distance stressor.

Resilience Factors

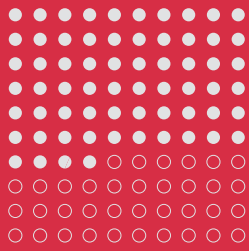
In Nepal, both CBO membership and higher levels of pride were linked to lower symptoms of depression and anxiety in the last 30 days. This suggests current CBO membership is a resilience factor against negative mental health outcomes. However, a slightly higher percentage of CBO members had ever attempted suicide (63.3% or 38 individuals) compared to non-CBO members (50% or 11 individuals), and only 23.7% (nine individuals) got help afterwards, compared to 45.5% of non-CBO members (five individuals). Again, we do not know whether this could be because people with past experiences of attempting suicide, who did not seek help at the time, may have subsequently joined CBOs to obtain peer support.

Percentage of respondents in Nepal who experience symptoms of anxiety, cross tabulated with experiences of cost stress.^{xviii}

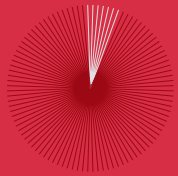


INDONESIA

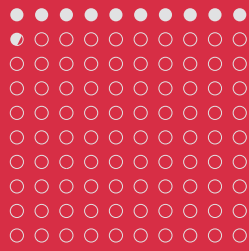
On depression:



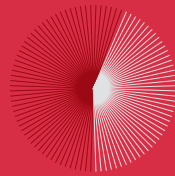
64%
of transgender people
in Indonesia reported
feeling sad, depressed
none of the time



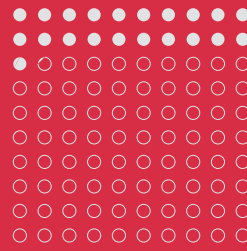
7.2%
were diagnosed
with depression



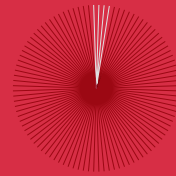
10.8%
a little of
the time



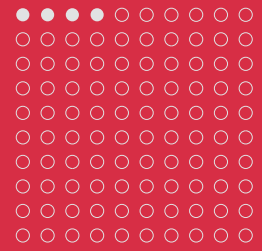
44.4%
were not
diagnosed with
depression



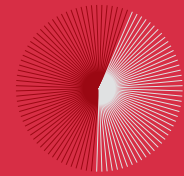
21.2%
some of
the time



3.6%
were not sure

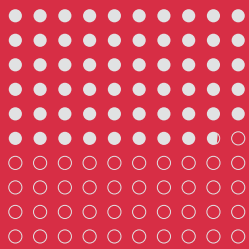


4%
most of the time

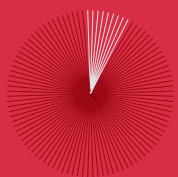


44.8%
were not tested

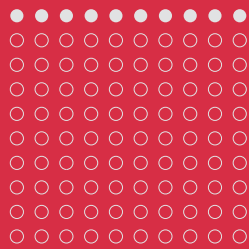
On anxiety:



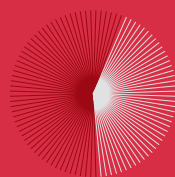
58.8%
feeling anxious,
nervous, or restless in
the last 30 days none of
the time



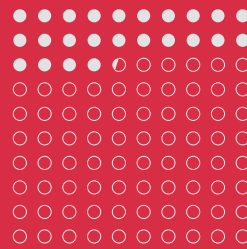
8.8%
were diagnosed
with anxiety



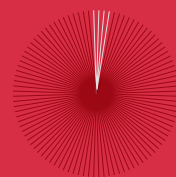
10%
experiencing these
feelings a little of
the time



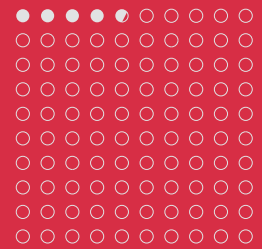
42.4%
not diagnosed



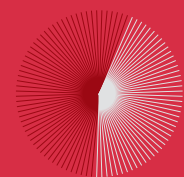
24.8%
some of
the time



3.6%
were not sure



4.8%
most of the time



45.2%
not tested

Only 18.5% (46 people) had ever received counselling or mental health services. 60 individuals (24%) had thought of ending their lives. Of them, 15% (9 people) had always sought help when they felt that way, 25% (15 people) sometimes, and 60% (36 people) never. 35 people had attempted suicide, representing 14% of the total sample, and of these people, 11 had received professional help afterwards (31.4% of those who had attempted).

In Indonesia, different genders reported different mental healthcare experiences. In Nepal, trans men experienced higher rates of recent symptoms of anxiety, depression, and suicidal ideation. Unlike Nepal, trans men in Indonesia also had higher rates of diagnosis due to higher rates of seeking care than trans women. 30.9% of trans men had ever been diagnosed with depression compared to 0.5% of trans women, and 25.5% of trans men diagnosed with anxiety compared to 4.1% of trans women).

More trans men in Indonesia had ever received counselling (68.5% of 37 individuals, compared to 4.6% of trans women or nine individuals). While trans men had much higher rates of suicidal ideation (74.5% of trans men compared to 9.7% of trans women), they were also more likely to have sought help afterwards (19.5% of trans men compared to 5.3% of trans women).

One outcome of the gender differences in mental healthcare utilisation in Indonesia is found in reported suicide attempts. Although trans men reported poorer mental health outcomes, trans women were more likely to have attempted suicide. 60.9% of trans women who answered the question had attempted suicide (14 individuals), compared to 51.2% of trans men (21 individuals). Overall, these rates of suicide attempts are very high, and comparable between Nepal and Indonesia. No trans women in Indonesia had accessed help after a suicide attempt, which poses a risk for future attempts.

Key mental healthcare variables in Indonesia, cross tabulated with gender.^{xix}

■ Trans man
■ Trans woman

Depression most of the time



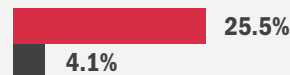
Not tested for anxiety



Depression none of the time



Tested & diagnosed with anxiety



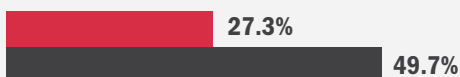
Tested and diagnosed with depression



Received counselling



Not tested for depression



Suicidal ideation



Anxiety none of the time



Suicide attempt



Younger adults in Indonesia reported both higher recent symptoms and lifetime diagnosis of anxiety and depression, with 17.3% of younger adults having been diagnosed with depression compared to 4.5% of those aged over 25, and 17.3% diagnosed with anxiety compared to 6.6% of older adults.^{xxx} Younger adults were more likely to have ever received counselling than older adults (29.4% of youth compared to 15.7% of older adults), and were also more likely to have experienced suicidal ideation (46.2% compared to 18.2% of older adults). It is positive that younger people are seeking mental healthcare at higher rates, suggesting increased awareness of mental health in the younger trans community in Indonesia. However, the high rates of mental illness, and overall relatively low rates of mental healthcare access, highlight the gaps still remaining for younger trans people.

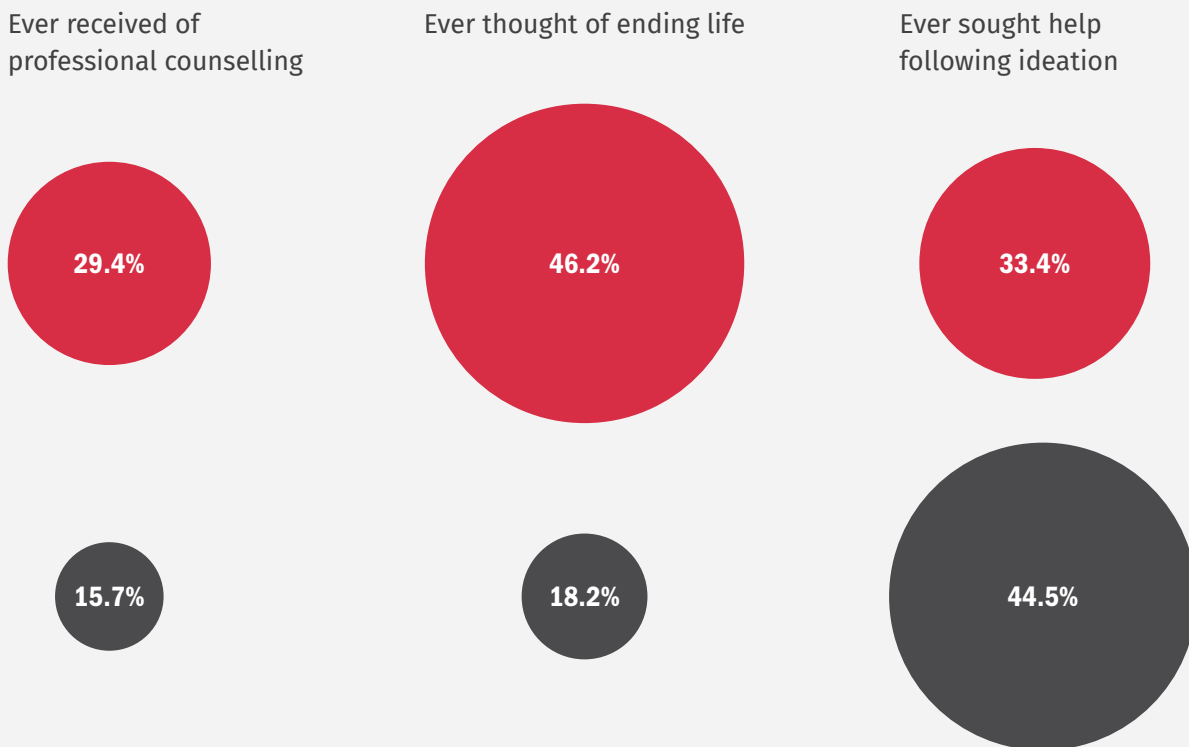
Sex work was associated with some mental health and healthcare outcomes, such as more common experiences of depression (37% of sex workers had some symptoms of depression in the previous month compared to 34.6% of

non-sex workers), though sex workers experienced lower symptoms of anxiety (62.1% had no symptoms, compared to 54.8% of non-sex workers).

However, in all measured examples, sex workers were less likely to have accessed mental healthcare services in Indonesia than non-sex workers. Overall, only 4.8% of sex workers had ever received counselling compared to 37.9% of non-sex workers. In addition, sex workers had lower rates of accessing help after suicidal ideation (72.7% of sex workers never had, compared to 57.1% of non-sex workers). None of the sex workers in Indonesia had accessed help after a suicide attempt (10 individuals), compared to 44% of non-sex workers (11 individuals) who sought help following an attempt. This suggests that being a sex worker is a barrier to seeking and accessing mental healthcare and receiving a diagnosis of anxiety and depression. This is likely to be associated with stigma and discrimination against sex workers within formal mental healthcare systems.

Percentage of respondents in Indonesia who have received counselling, experienced suicidal ideation, and received help after ideation, cross tabulated with age.^{xxxi}

● Youth <25 ● Older >25



INDONESIA: *Stressors and Resilience Factors Around Mental Health*

Gender Minority Stressors

The data indicates that gender minority stress impacts on mental health outcomes and mental healthcare-seeking behaviour for transgender people in Indonesia, though less uniformly than in Nepal. In Indonesia, having delayed treatment in the previous six months due to past experience of invasive questions or no guidance or standards for transgender care were both associated with poor mental health outcomes in terms of anxiety and depression symptoms. A slightly higher percentage of people who experienced invasive questions also reported suicidal attempts than those who had not (56.3%, 9 individuals, compared to 54.2%, 26 individuals), and 88.9% (8 people) had never sought help afterwards, compared to 61.5% (16 people) of those who had not delayed treatment due to experience with invasive questions.

Like Nepal, in Indonesia too, having delayed treatment due to past experience of invasive questions, or lack of clinical guidance for trans patients, were both linked to higher rates of having been tested for anxiety and depression. Unlike Nepal, in Indonesia, these stressors were also associated with lower rates of receiving counselling, with only 4.8% (three individuals) who had experienced invasive questions having had counselling, compared to 23.2% of those who did not experience invasive questions (43 people). In addition, only 9.2% of those who had delayed treatment due to no guidance or standards about trans patients have received counselling (eight people), compared to 23.5% of those who had not delayed treatment for this reason (31 people). Invasive questions were also associated with both higher suicide attempts, and lower help-seeking afterwards. Four of the five participants who had been refused treatment had no symptoms of depression in the past month, compared to 63.7% of those who had not been refused treatment

(156 individuals). However, three of five had never been tested for depression (the same as testing for anxiety). No individuals in Indonesia reported having been assaulted, though 15 had experienced discrimination while accessing HIV services. Experiencing this discrimination was also linked to lower rates of having been tested for depression (46.7% had not been tested, compared to 44.7% of those who had not experienced discrimination).

Practical Stressors

Cost was an important practical barrier in terms of mental health outcomes. Having delayed treatment in the previous six months due to affordability was linked to higher rates of symptoms and diagnosis of anxiety, and higher rates of suicidal ideation (50% of those having issues with cost (seven people) had thought about ending their life, compared to 23.3% of those who had not (52 people).

Having delayed treatment due to distance in the past six months had mixed effects in terms of mental health and healthcare in Indonesia. It was linked to lower symptoms of depression and anxiety in the last 30 days, lower rates of ever being diagnosed with either and to lower rates of receiving counselling (only 8.8% of those who had to delay treatment due to distance in the last six months had ever received counselling, compared to 22.9% of those with no distance barriers).

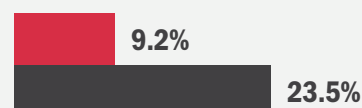
Drawing the analysis together, we found general support for the GMSR model in Indonesia. Broadly, gender minority stressors were associated with poor mental health outcomes, along with lower rates of seeking and accessing mental healthcare. However, in Indonesia, practical stressors were also an important contributing factor.

Percentage of respondents in Indonesia who have received counselling, cross tabulated with gender minority stressors - delaying treatment due to invasive questions or poor standards.^{xxii} ■ Delay ■ No Delay

Invasive questions



Poor clinic guidance / standards



Resilience Factors

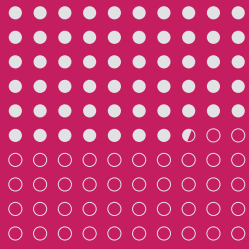
The proposed resilience factors of CBO membership and pride were associated with more positive mental health outcomes in Indonesia but did not translate into mental healthcare-seeking behaviour. For example, 78.3% of CBO members (72 individuals) had experienced no symptoms of depression in the previous 30 days as compared to 55.7% of non-CBO members (88 individuals); 75.8% (69 individuals) had experienced no symptoms of anxiety in the previous 30 days as compared to 49.4% of non-CBO members (78 individuals). In Indonesia, trans women were more likely to belong to a CBO than trans men, with either being a potential explanatory factor for these findings.

These patterns were also observed for pride, with higher pride associated with lower symptoms of anxiety and depression, and lower rates of suicidal ideation. This is a positive finding, suggesting that current CBO membership and feelings of pride may be protective against symptoms of anxiety and depression in Indonesia.

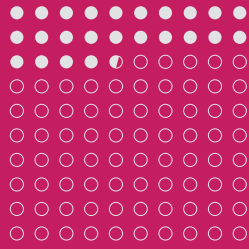
Despite experiencing symptoms of anxiety and depression less often, CBO members were more likely to have attempted suicide (62.5% of CBO members compared to 52.1% of non-CBO members). This may be linked to the lower rates of accessing mental health services. In fact, no CBO members had sought help following a suicide attempt, compared to 44% of non-CBO members. Potentially, CBO members support each other, and do not feel the need to access professional mental health services.

THAILAND

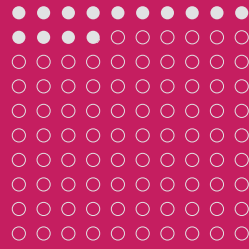
On depression:



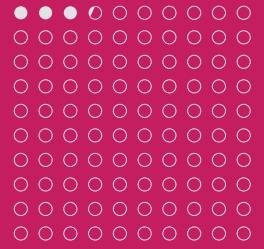
57.6%
had no symptoms of
depression in the
previous 30 days



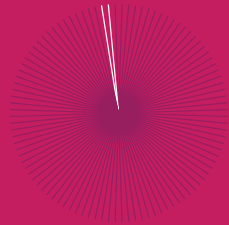
24.7%
experienced
symptoms a little
of the time



13.98%
some of the time



3.2%
most of the time



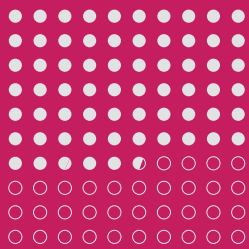
2.4%
said yes to being
diagnosed with
depression



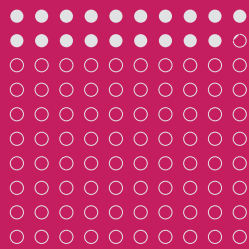
59%
said no to being
diagnosed with
depression

2 people
were not sure

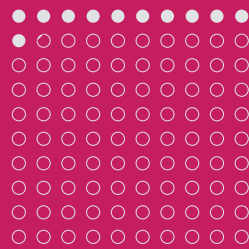
On anxiety:



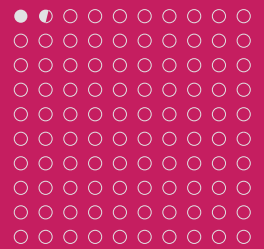
65.7%
had no symptoms



19.1%
had little symptoms



11.2%
some of the time



1.6%
most of the time



59%
not tested

2 people
unsure of testing

8 people
had been tested
and diagnosed

In total, 8.8% or 22 individuals had ever received counselling, despite 21.5% or 54 individuals having ever thought of ending their lives. Concurrent with this, only 15.1% of people who experienced suicidal ideation always sought help afterward (eight people), and 7.6% (19 people) sometimes. Of those who had experienced suicidal ideation, 32.2% had also attempted suicide (19 individuals). Of these, only three had received professional help afterwards.

Compared to Nepal and Indonesia, fewer trans men were surveyed in Thailand (15 in total). This reduces the power to detect statistically significant differences between genders in Thailand. Gender analysis presented here should be interpreted with caution, as many relationships are trends.

There were very low rates of receiving counselling across all genders, with one trans man, 20 trans women, and two third gender participants ever having received counselling. Trans men and people who identify as third gender were more likely to say they did not know if they had received counselling (13.3%, two individuals, and 50%, 10 individuals respectively). There were few significant associations between gender and suicidal thoughts or behaviours, though trends towards trans women having

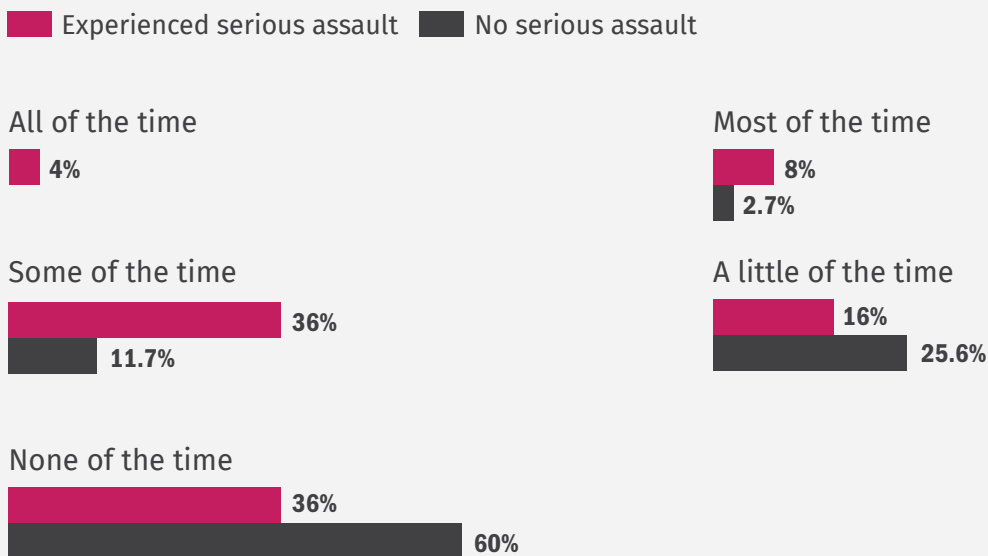
made more attempts (34%), and only three of 15 who had attempted seeking help afterwards. There were no clear patterns relating to age and mental health in Thailand. Non-sex workers in Thailand experienced symptoms of depression at higher rates compared to sex workers (44.4% of sex workers, 20 individuals, had no symptoms of depression compared to 60.5% of non-sex workers, 124 individuals), but there were few other significant relationships with the mental health variables.

THAILAND: Stressors and Resilience Factors Around Mental Health

Gender Minority Stressors

Gender minority related stressors were associated with negative mental health outcomes in Thailand. There were not enough people who had experienced refusal of treatment to analyse these data. Having ever been assaulted, discriminated against while accessing HIV services, and delaying treatment due to past experiences of invasive questions or no standards or guidance for transgender people were all associated strongly with higher recent symptoms of depression and anxiety. For example, people who had experienced serious assault were more likely to experience symptoms of depression.

Percentage of respondents in Thailand experiencing symptoms of depression, cross tabulated with gender minority stressor of experiencing serious assault.^{xxiii}



There were fewer links between gender minority stressors, and whether people had taken steps to seek mental healthcare support for depression or anxiety or to receive counselling. However, experiencing discrimination in HIV services was associated with never being tested for anxiety or depression. Specifically, 91.7% of those who had experienced such discrimination had never been tested for depression (22 individuals), compared to 56.2% of those who had not experienced discrimination, 127 individuals. A very similar pattern was seen with symptoms of anxiety.

This finding is interesting as it suggests that experiencing discrimination in a different healthcare domain (HIV services) may be associated with reduced seeking of mental health services. People who had experienced discrimination in HIV services were also more likely to have attempted suicide (60% of those who responded, or six individuals, compared to 26.5%, or 13 individuals, who had not experienced discrimination).

Practical Stressors

Trans people in Thailand who had delayed healthcare in the previous six months due to cost or distance were more likely to report symptoms of depression. Delaying treatment in the last six months due to costs was also linked to higher rates of suicidal ideation. 46.2% or 12 individuals who had cost issues had ever thought about suicide, compared to 18.9% of those without cost issues. Delaying treatment due to distance was associated with higher symptoms of depression, and higher rates of suicidal ideation, along with trends towards lower rates of help-seeking. Overall, cost and distance could be

considered risk factors for seeking healthcare services in Thailand.

Resilience Factors

In Thailand, CBO membership was associated with increased symptoms of anxiety and depression, and decreased rates of having been diagnosed with either. There were trends of CBO members experiencing higher rates of suicidal ideation and attempts, and CBO members trended towards more help-seeking behaviour. 36.4% had never sought help following ideation, compared to 58.1% of non-CBO members; 20% had sought help following a suicide attempt, compared to 11.1% of non-CBO members.

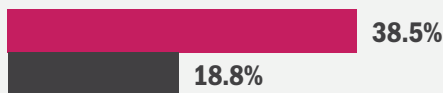
Feelings of pride showed some evidence of being a resilience factor. 69 percent of participants with very high pride had no symptoms of depression, compared to 54.3% of those with high pride and 40% of those with medium levels of pride. Higher pride was related to lower suicidal ideation and trended towards more help-seeking behaviour afterwards. However, higher pride was also linked to lower rates of accessing counselling.

Overall, demographic factors were less associated with mental health and healthcare in Thailand, compared to Indonesia and Nepal. There was strong evidence that gender minority related stressors were associated with negative mental health outcomes, but mixed evidence for the relationship between stressors and mental healthcare-seeking behaviour. CBO membership was not as significant. Resilience factors such as subjective feelings of pride, and cost and distance were barriers in terms of mental health.

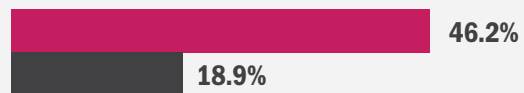
Percentage of respondents in Thailand who have experienced suicidal ideation, cross tabulated with practical stressors - delaying treatment due to cost or distance.^{xxvii}

■ Delay ■ No delay

Due to distance

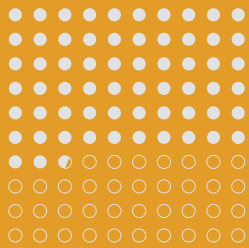


Due to cost

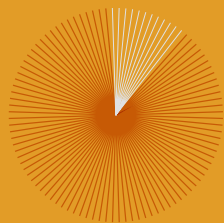


VIETNAM

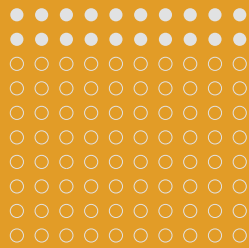
On depression:



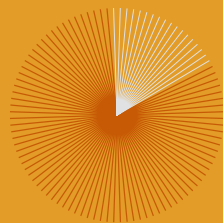
Nearly Half
had some symptoms
of depression in the
previous 30 days



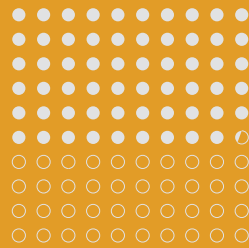
11.8%
had been diagnosed
with depression



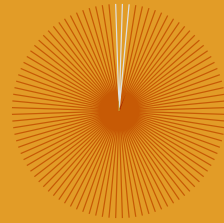
29.3%
experienced
symptoms a little
of the time



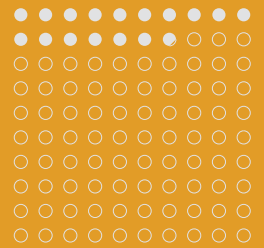
18.3%
were never tested



11.8%
some of the time

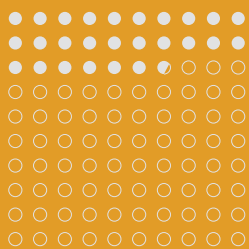


2.8%
were unsure

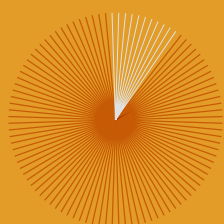


4.1%
most of the time

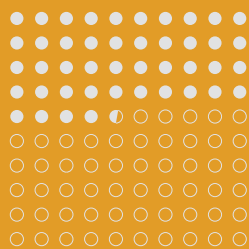
On anxiety:



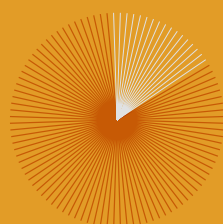
26.9%
had no symptoms
of anxiety



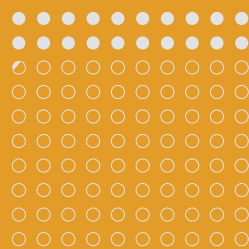
10.6%
had been diagnosed
with depression



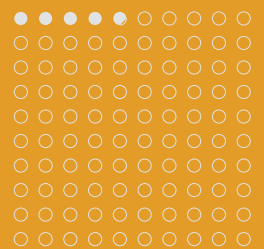
44.7%
experienced
symptoms a little
of the time



17.5%
were never tested



20.3%
some of the time



4.9%
most of the time

A relatively higher proportion of people in Vietnam than the other countries had received professional counselling, at 16.7% or 41 individuals. Still, a very high number had experienced suicidal ideation (37.8% or 93 individuals), and only 3.2% of them (three people) had always sought help when they felt that way, though 55.9% of people experiencing suicidal ideation sometimes sought help afterwards. Nearly 40 percent of those who had ever thought of ending their life had also attempted suicide; 39.8% (37 people) and none had sought help afterwards.

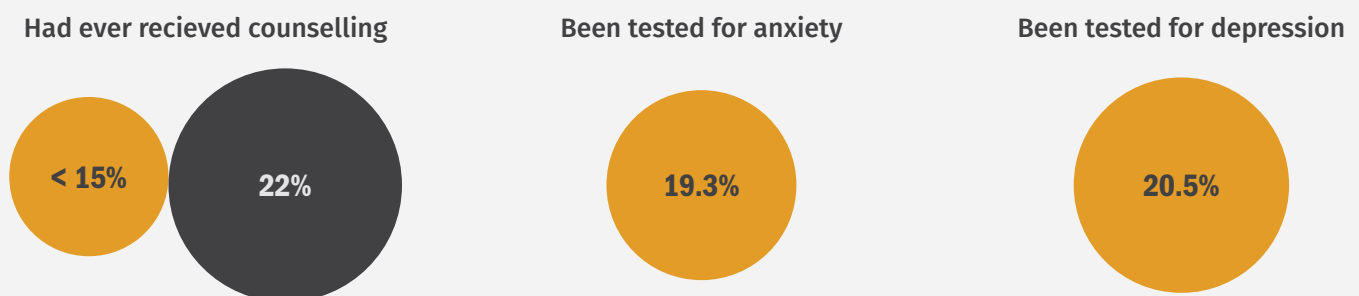
In Vietnam, demographic factors were less associated with transgender people’s mental health or the healthcare they received than in the other three countries. Younger people under the age of 25 trended towards less seeking and accessing of mental healthcare than older adults. Less than 15% of young people (26 individuals) had ever received counselling, compared to 22% of those aged 25 or older (15 individuals). Around one in five young people had never been tested for anxiety (19.3%) or depression (20.5%). Adults aged over 25 also tended to report higher rates of suicide ideation (47.1% compared to 34.7% of

young people), and a higher percentage of these older people said that they had never sought help when they felt this way.

There were also few significant differences in the experiences of sex workers and non-sex workers in terms of their mental health or use of mental health services in Vietnam. There were trends of sex workers accessing fewer mental health services. None had ever received counselling, compared to 17.3% of non-sex workers; and 50% had never sought help following suicidal ideation, compared to 40% of non-sex workers. However, there were low numbers of sex workers in the Vietnam sample (six people), which may be why these are trends and not statistically significant differences, compared to the other countries.

None of the service providers who were part of the KII in 2018/19 provided counselling or mental health support, reiterating concerns from the 2017 regional mapping that there were no counselling or youth mental health services for trans people in Vietnam.

In Vietnam, demographic factors were less associated with transgender people’s mental health or the healthcare they received than in the other three countries. ● People under 25 ● People over 25



VIETNAM: Stressors and Resilience Factors Around Mental Health

Gender Minority Stressors

Trans people who had previously been refused treatment due to their gender identity were more likely to have negative mental health, lower rates of receiving counselling, and higher rates of suicidal ideation and attempts. Experiencing discrimination in HIV services was linked to higher symptoms of anxiety and depression, though transgender people who had not been discriminated during HIV services were more likely to have not been tested.

Having delayed treatment due to past experience of invasive questions was associated with suicidal ideation, with 45.6% (57 individuals) with past experience of invasive questions also having thought of ending their life, compared to 30.4% of those who had not experienced invasive questions (35 individuals).

Practical Stressors

Trans people in Vietnam who face practical barriers trying to access healthcare were more likely to have negative mental health outcomes. There were strong overlaps between having delayed treatment in the previous six months due to cost, and recent symptoms of anxiety and depression. Cost barriers were particularly associated with symptoms of anxiety, with only 8.8% of people who had delayed treatment due to cost (five individuals) experiencing no symptoms of anxiety in the previous month, compared to 32.2% of those without cost barriers (58 individuals).

Among the 23 people who delayed treatment due to cost, 15.8% had symptoms of depression all or most of the time. Delaying treatment due to cost likely reflects an underlying factor of poverty, which is in itself linked to negative mental health outcomes. Cost barriers were associated with higher rates of suicidal ideation in participants but not with suicide attempts or help-seeking. Participants who had distance-related barriers were less likely to have received counselling than those who did not (6.3% had received counselling compared to 21.1% of those without distance barriers).

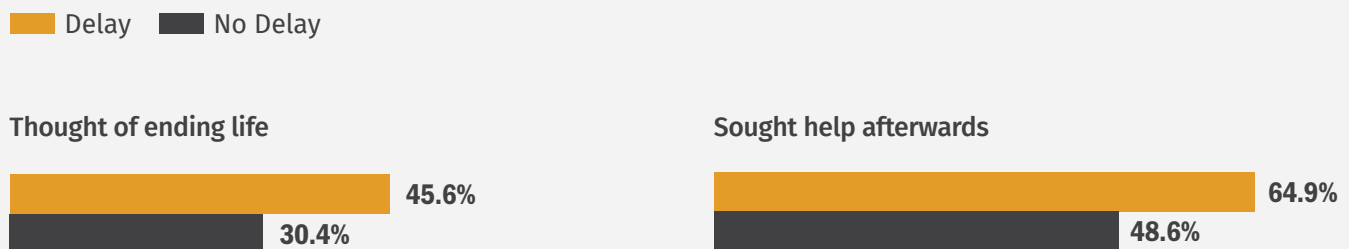
Resilience Factors

As in Thailand, CBO membership and pride in Vietnam did not show a straightforward relationship as a resilience factor. Neither pride nor CBO membership clearly protected trans people’s mental health or increased their use of mental health services.

CBO membership was associated with higher recent symptoms of anxiety and depression, and also with higher levels of ever receiving a diagnosis. CBO members were more likely to have received an anxiety or depression diagnosis from a health professional than were non-CBO members.

Higher pride was associated with an increase in anxiety and depression symptoms, and a decrease in having ever been tested for either. There was no clear direction in the relationship between feelings of pride and receiving or ever having received counselling, thinking about or attempting suicide, or seeking help after such attempts.

Percent of respondents in Vietnam who have experienced suicidal ideation and sought help afterwards, cross tabulated with the minority stress of delayed treatment due to invasive questions.^{xxxv}



KEY FINDINGS

In all four countries, there were high rates of recent and severe symptoms of depression and anxiety, contrasted with low rates of testing and diagnosis of depression and anxiety.

Most trans people surveyed in each country had experienced at least some recent symptoms of depression, with the lowest rates in Vietnam (46%) and highest in Nepal (63%). Between 10 and 20% of respondents across the four countries had ever been diagnosed with either depression or anxiety.

In all countries, there was a high prevalence of suicidal ideation and attempts, and little professional help after ideation/attempts.

For example, in Vietnam, nearly 40% of respondents had thought of ending their life; in Nepal, around 30%; in Indonesia, nearly 25%, and Thailand, over 20%.

Rates of accessing professional counselling and mental health services (lifetime prevalence) were very low, and only varied slightly between countries.

The highest rates of using professional mental health services were in Vietnam, where still only 17% had ever accessed counselling. The lowest was in Thailand, where only 9% had accessed counselling. Counselling rates also varied by groups: in Indonesia, only 4.8% of sex workers had accessed mental health services; in Vietnam, 6% of people with a distance barrier had accessed mental health services. In Thailand, 50% of third gender participants did not know if they had ever received counselling.

Trans men experienced more anxiety and depression in Indonesia and Nepal though mental healthcare utilisation varied across genders.

Although there were few trans men in Thailand, and no gender differences in mental health in Vietnam, the situation was different in Indonesia where nearly half of the trans men- but only 23% of trans women- experienced symptoms of depression. In Nepal, 15% of trans men experienced depression, compared to roughly 10% of trans women and third gender participants. In Nepal, trans men were less likely to have been tested and diagnosed. In Indonesia, trans men were more likely to be tested and diagnosed.

The most significant gender minority stressors affecting mental health varied by country.

In Nepal, experiencing discrimination in HIV services was linked to symptoms of depression. In Indonesia, delaying necessary treatment due to past experience of invasive questions was linked to higher rates of depression, anxiety, and suicide attempts. In Thailand, having ever been seriously assaulted was linked to higher rates of depression and anxiety. In Vietnam, having been previously refused treatment was linked to worse symptoms of anxiety, depression, suicidal ideation, and suicide attempts.

Gender minority stressors affecting mental healthcare use also varied by country.

In Indonesia and Thailand, discrimination in HIV treatment was linked to lower rates of testing for anxiety and depression. In Vietnam, having been refused treatment due to trans identity in the past was linked to lower rates of counselling. In Nepal and Indonesia, previous experience with invasive questions was actually linked to higher rates of testing for anxiety and depression. However, in Indonesia, the same stressor was linked to lower rates of counselling.

Practical stressors not related to belonging to a gender minority were associated with higher anxiety.

Underlying factors, such as poverty and social isolation, are stressors in and of themselves. They can be compounded by belonging to a gender minority. Delaying treatment due to cost was linked to higher anxiety in all four countries.

Proposed resilience factors show some promising signs of positive impacts on mental health.

In Nepal and Indonesia, trans people who were CBO members had lower rates of anxiety and depression. In Indonesia and Thailand, trans people high in pride had better mental health. In Thailand, higher pride was also linked to more help-seeking. More complex statistical analysis could reveal if these resilience factors are ameliorating the impact of stressors on mental health and healthcare use.

SEXUAL HEALTH AND HEALTHCARE USE

In this section, we explore demographics, gender minority stressors (experiences that may cause gender minority stress), practical stressors (stressors not necessarily specific to belonging to a gender minority, such as cost and distance from treatment), and resilience factors associated with trans people's sexual health and the steps they take to access sexual healthcare services.^{xxvi} Expanding on the main research question presented in the introduction, this section seeks to address the following question:

*Which stressors and
resilience factors are
linked to sexual health
and healthcare use?*^{xxvii}

FOCUS VARIABLES IN THIS SECTION

o1 Sexual Health *and* Use of Sexual Healthcare Services

1. Do you know of diseases that can be transmitted through sexual intercourse?
2. Have you ever been tested for a sexually transmitted illness (such as chlamydia, gonorrhoea, syphilis, warts etc)?
What would you say is the MAIN reason why you have not been tested for an STI?
3. How often do you visit a doctor/health care service provider for STI?
4. If you have ever tested positive for a STI, where did you go to seek treatment for the STI?
5. If you tested positive, then how many days did you wait before seeking treatment for the STI?
6. Have you ever been tested for HIV?
7. What was the result of your most recent HIV test?
8. How often do you visit a doctor/health care service provider for a HIV Test?
9. How often do you visit a doctor/health care service provider for Post-exposure prophylaxis (PEP)?
10. How often do you visit a doctor/health care service provider for Pre-exposure prophylaxis (PrEP)?
11. Are you currently on antiretroviral treatment – commonly known as ART?
12. Have you ever received any of the following recommended combination-prevention care services?
 - Counselling on HIV risk factors and co-infections
 - Counselling on sexual and reproductive health and rights
 - STI Screening

o2 Gender Minority Related Stressors

1. Have you ever been refused treatment or turned away by a doctor or healthcare service provider because of your transgender identity?
2. Have you ever been physically assaulted such that you require medical treatment?
3. Have you experienced discrimination, or discriminatory behaviour from healthcare service providers, when accessing HIV services?
4. In the past 6 months, have you delayed treatment due to past experience of invasive questions?
5. In the past 6 months, have you delayed treatment due to no guidance or standards for transgender patients?

o3 Practical Stressors

1. Delayed treatment in previous 6 months due to cost
2. Delayed treatment in previous 6 months due to distance

o4 Resilience Factors

1. CBO membership (CBO member / Non-CBO member)
2. Identity pride (scale combination of 6 items, analysed as high/low)

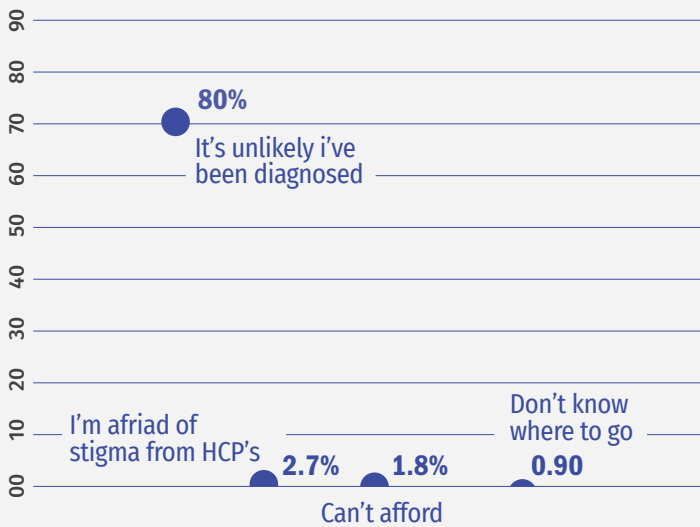
NEPAL

STI Testing and Treatment

The vast majority of trans people in Nepal knew about diseases that could be contracted through sexual intercourse (all but nine individuals), and a high number - 55.6% or 139 individuals - had ever been tested. The most common reason for those not being tested was thinking it was unlikely any STIs had been contracted (80% of people who had never been tested, or 88 individuals). Three people said they were afraid of stigma, two said they could not afford it, and one did not know where to go. For the majority, it was not stigma or discrimination that led to an under-utilisation of STI services but self-perception of low risk.

Reasons given by participants for not having been tested for an STI (percent of those who had not been tested).

What would you say is the main reason why you have not tested for an STI?



People who got tested tended to do so every three months (41.8% of the sample or 104 people), with 8.4% (21 people) going twice a year, 2.4% (six people) every two years, and 3.2% (eight people) not in the last three years. Of those who had been tested for an STI, 26.6% had never tested positive (37 people).

People in Nepal who tested positive for an STI were most likely to go to an NGO/CBO for treatment (56.8% of people who had been tested or 79 individuals), with 9.4% (13 people) going to a government health centre, 3.6% (five people) to a private health centre, one person to a pharmacist, and 2.9% (four people) not getting treatment. Many of those who tested positive sought treatment

immediately (49% or 49 people), 25% (25 people) within a week. Three people (3%) delayed treatment for 8-10 days, and a high number (23 people, 23%) waited more than 10 days.

Although only nine individuals were not aware of STIs, and this low number is very positive, those who did not know about STIs tended to be trans men (7.5% of trans men or five individuals did not know about STIs) and those who identified as third gender (4.8% of third gender people or 4 individuals). The difference between trans men and trans women was statistically significant. It represents a crucial barrier to safe preventive practices, and to seeking sexual healthcare.

In Nepal, respondents who identified as third gender and trans women were more likely to have been tested for STIs (78.6% of third gender people and 56.8% of trans women, compared to 17% of trans men). Of those who had not been tested, third gender people and trans women said more often that it was because it was unlikely they had contracted any STIs (94.4% of third gender people, 17 individuals and 93.6% of trans women, 26 individuals).

In Nepal, third gender respondents were tested the most often (63.1% or 53 individuals were tested every three months), and trans men were more likely to say they did not know when they were last tested (49.1% of trans men or 26 individuals).

Younger people were more likely to never have been tested, with only 37.5% of younger people or 30 individuals having been tested. Older adult participants in Nepal were both more likely to have ever been tested, and were also tested more frequently, with 47.9% of over-25s getting tested for STIs every three months.

Sex workers were also more likely to be tested every three months, with 66.1% of sex workers or 37 individuals getting tested every three months compared to 34.7% of non-sex workers. More non-sex workers (18.7% or 36 individuals) said they did not know how often they had been tested, while all sex workers knew how often they were tested. This suggests sex work programming in Nepal is working well in terms of awareness and testing for STIs.

HIV Testing and Treatment

In Nepal, a person's gender identity was linked to the steps they took to seek HIV-related healthcare. There were fewer differences between people based on their age or whether they were sex workers.

Overall, 77.6% of transgender people had been tested for HIV (194 people), and 8.8% of them (17) tested positive. There were higher rates of HIV testing among trans women (95.5% had been tested for HIV) and third gender people (82.1% had been tested for HIV), but less so among trans men in the sample (34% had been tested for HIV). Prevalence of testing was associated with frequency of testing, with 74.8% and 66.7% of trans women and third gender respondents being tested every three months, compared to 22.6% of trans men. Of respondents who had been tested, trans men reported higher positive diagnoses of HIV in their last test (16.7% or three individuals), along with third gender people (14.5% or 10 individuals).

There was also higher and more frequent use of combination-prevention services among trans women and third gender respondents. Trans men were less likely to have ever received counselling on HIV risk (80.8% had received counselling, compared to 98.2% of trans women and 94% of third gender participants), or counselling on SRHR (64.7% of trans men compared to 92.8% and 85.5% of trans women and third gender respondents respectively).

There was a trend of higher prevalence and frequency of HIV testing for older adult respondents in Nepal, but no statistically significant differences.

Sex workers were more likely to have been tested for HIV (100% of sex workers, compared to 71.1% of non-sex workers), and to be tested more regularly, with 94.6% of sex workers getting tested every three months compared to 51% of non-sex workers. Sex workers were not more likely to be HIV-positive, and there were no differences in accessing combination-prevention services.

The majority, 77.6% (194 people) had been tested for HIV, and 8.8% of those tested (17 people) had tested positive.

Like STI testing, people who had ever been tested for HIV tended to do so every three months (60.8% or 152 people got an HIV test every three months), though 13.6% (34 people) got tested twice a year, 1.6% (four people) every two years, and 2% (five people) not in the last three years. There were low rates of PEP use (48.4% or 121 people had never used it), with seven people using PEP every three months; and similar rates of PrEP use (42.8% or 107 people had never used it, and only eight individuals used it every three months). 14 of the 17 HIV-positive participants were on ART. Most in Nepal had received counselling on HIV risk factors and co-infections (231 individuals). 83.6% had received counselling on sexual and reproductive rights.

Mapping done in late 2018-19 alongside the FGDs for this KPRA report, confirmed the availability of HIV testing, treatment for STIs, and ART for free peer-led, community-based services. These included Blue Diamond Society's care and support team and female sex worker NGOs or through Save the Children's outreach field test service. Take and Bir hospitals provided testing and treatment for free, and free testing was available at the STD/AIDS Counselling and Training Services (SACTS). Each region in Nepal had at least one CD4 count centre available.

In the key informant interviews, most stakeholders said that targeted HIV treatment services for trans women mainly consisted of providing information as well as HIV testing and materials such as condoms and lubricants to promote changes in sexual behaviour. Viral load monitoring was available for those who were HIV positive. CBOs conducted community-based testing, including to trans people's homes and workplaces. Services were provided by both international NGOs and national CBOs through Global Fund grants, and by the government through its hospitals.

Gender Minority Stressors

STI Testing and Treatment

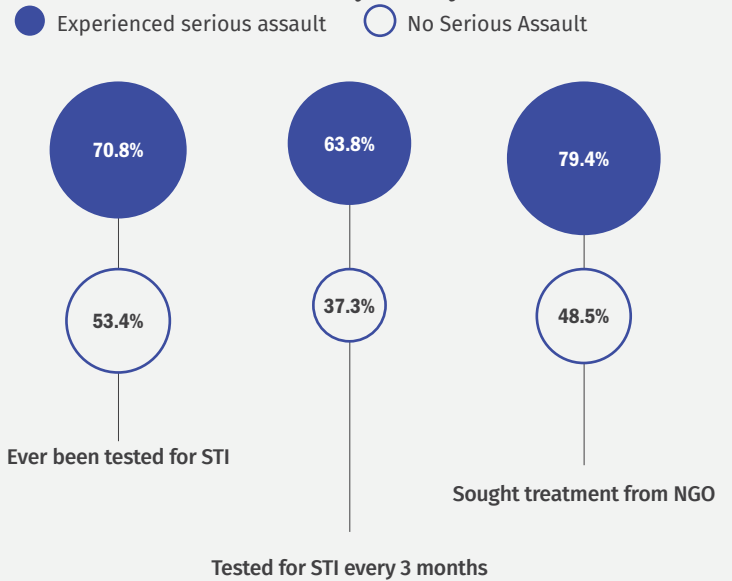
Unlike the Nepal mental health care findings, trans people in Nepal who had experienced gender minority stressors were more likely to take steps to seek sexual healthcare.

All gender minority stressors, except having delayed treatment due to no guidance for trans patients at clinics, were related to increased rates of testing for STIs. For example, 95.8% of people who had been refused treatment due to trans identity (20 people) had received an STI test, compared to 76.8% of people who had not been refused treatment (172 people).

Transgender people in Nepal who had experienced stressors were also more likely to get more frequent STI tests. This held across stressors that were less recent (having ever been refused treatment or having ever been assaulted), as well as more recent stressors (such as delaying treatment in the last six months due to invasive questions or no clinical standards). For example, 54.8% of respondents who had delayed treatment due to past experience with invasive questions (40 individuals) received an STI test every three months, compared to 35% of those who had not experienced invasive questioning (57 individuals). These findings may overlap with sex work, in that sex workers may be more likely to both experience gender minority stress, and to seek more STI testing.

However, gender minority stressors were also related to some specific behaviours around seeking STI-related advice and treatment in Nepal. Trans people who had been assaulted were more likely to seek treatment from an NGO (79.4% or 27 individuals, compared to 48.5% of people who had not been assaulted). Those who had been refused treatment in the past were more likely to wait a week before seeking treatment than those who had not, (52.9% compared to 19.3% of people who had not been refused treatment).

Percentage of respondents in Nepal seeking sexual healthcare, cross tabulated with the minority stress of serious assault.^{xxviii}



HIV Testing and Treatment

Participants who had been refused treatment in general, or experienced discrimination while accessing HIV services, were more likely to have recently tested positive for HIV. Among those who had tested positive in their most recent HIV test, 26.3% (five people) had ever been refused treatment because they were trans, and 37.5% (six individuals) experienced discrimination when accessing HIV services. This compares with 6.9% (12 individuals) and 6.2% (11 individuals) amongst those without a positive HIV test result. It's possible that trans people's HIV status itself influences whether they are refused treatment or face discrimination.

In Nepal, recent gender minority stressors (such as having delayed treatment in the previous six months because there was no guidance for trans patients or due to past experiences of invasive questions) were not significantly associated with whether someone took steps to seek HIV-related healthcare.

Practical Stressors

STI Testing and Treatment

The practical barriers of cost and distance had mixed effects on whether trans people in Nepal sought STI healthcare services. For example, people who had delayed a health treatment due to cost were more likely to seek their STI treatment from NGOs/CBOs (78.8% of people who had delayed treatment for this reason compared to 49.5% of people who had not).

HIV Testing and Treatment

In Nepal, trans people who faced practical barriers of cost or distance had taken fewer steps to seek HIV healthcare services. Yet those who had delayed treatment in the last six months because of cost or distance, were more likely to be HIV positive. For example, 18.9% of those experiencing such a cost barrier, or seven individuals, were HIV positive compared to 6.4% of those who did not face this issue (10 people).

Resilience Factors

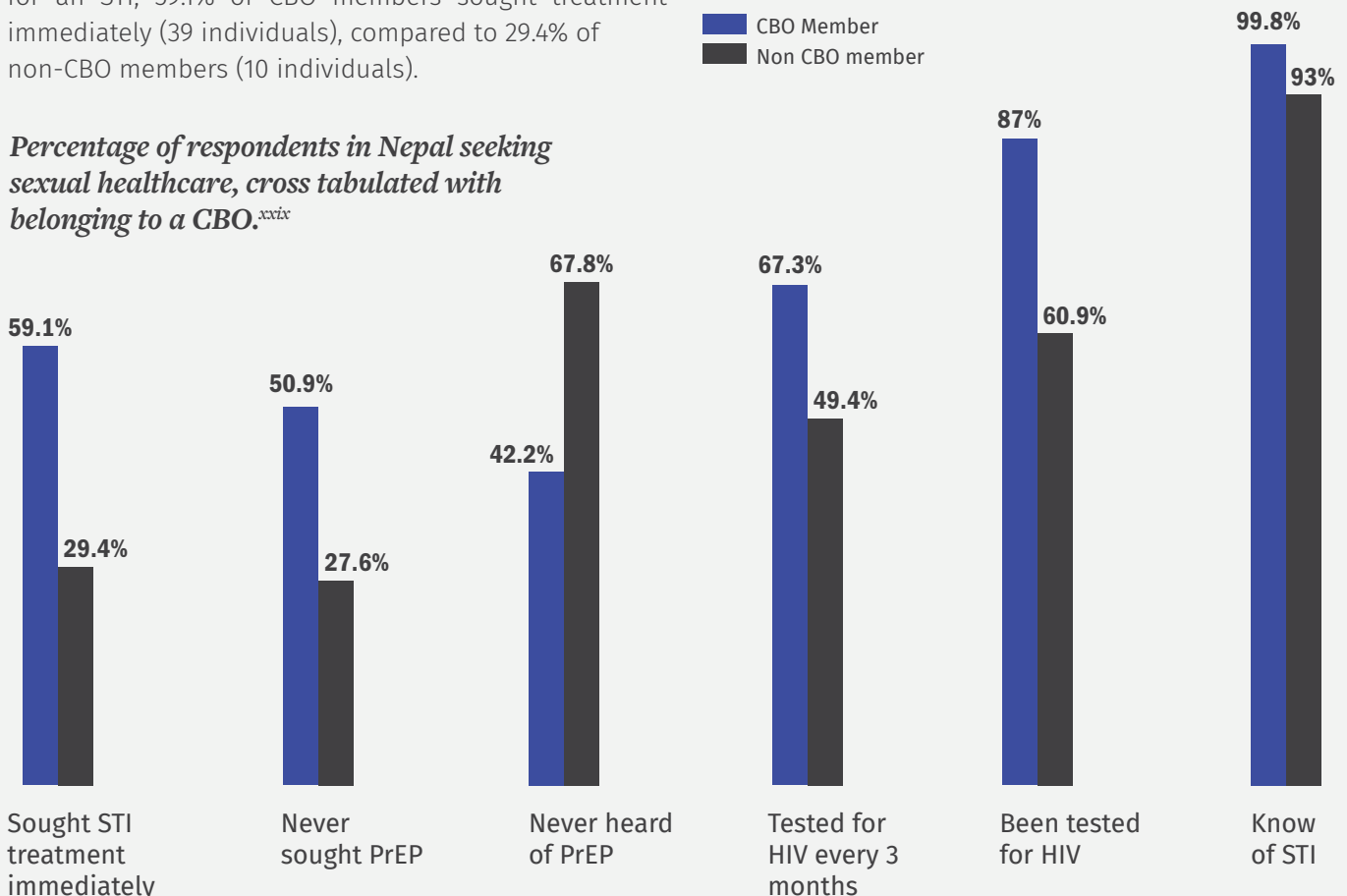
STI Testing and Treatment

Trans people who were members of CBOs saw their doctor more often for a STI test and waited less time after their diagnosis before seeking treatment. CBO members were more likely to visit their doctor twice a year for an STI test (11.8% or 19 individuals) compared to just 2.3% of those who were not CBO members (two individuals). Most CBO and non-CBO members knew about STIs, but CBO members were more likely to know (98.8% or 160 individuals, compared to 93% of non-CBO members, or 80 individuals). Of trans people in Nepal who tested positive for an STI, 59.1% of CBO members sought treatment immediately (39 individuals), compared to 29.4% of non-CBO members (10 individuals).

HIV Testing and Treatment

CBO members were more likely to have been tested for HIV (87% compared to 60.9% of non-CBO members) and tested more frequently, but interestingly were less likely to visit their doctor to get PEP or PrEP. Although there were trends towards CBO members receiving more combination-prevention services, the relationships were not statistically significant. Those with higher feelings of pride in being trans were more likely to have used ART, and more likely to have had counselling about HIV risk factors and co-infections.

Percentage of respondents in Nepal seeking sexual healthcare, cross tabulated with belonging to a CBO.^{xxix}



INDONESIA

STI Testing and Treatment

In Indonesia, 91.6% of the transgender people surveyed had heard of diseases that could be transmitted through sexual intercourse (229 individuals), and 77.9% (194 individuals) had been tested for an STI. The most common reason for those not being tested was thinking it was unlikely they had contracted any STIs (20.5% of people who had never been tested, or nine individuals). Six people said they were afraid of stigma, six did not know where to go, and most (52.3% or 23 individuals) said they had not been tested for an ‘other’ reason.

People who got tested tended to do so every three months (49.6% of the sample or 124 people), with 22% (55 people) going twice a year, 3.6% (nine people) every two years, and 2.8% (seven people) not in the last three years. Of those who had been tested for an STI, 79.2% had never tested positive (137 people). People in Indonesia who tested positive for an STI were most likely to go to an NGO/CBO for treatment (11.6% of people who’d been tested or 20 individuals), with 9.2% (16 individuals) going to a government health centre, and no one going to a private facility or not being treated. Many of those who tested positive sought treatment immediately (89.1% or 57 people), and 6.3% (nine people) within one week. Three people (4.7%) delayed treatment for more than 10 days.

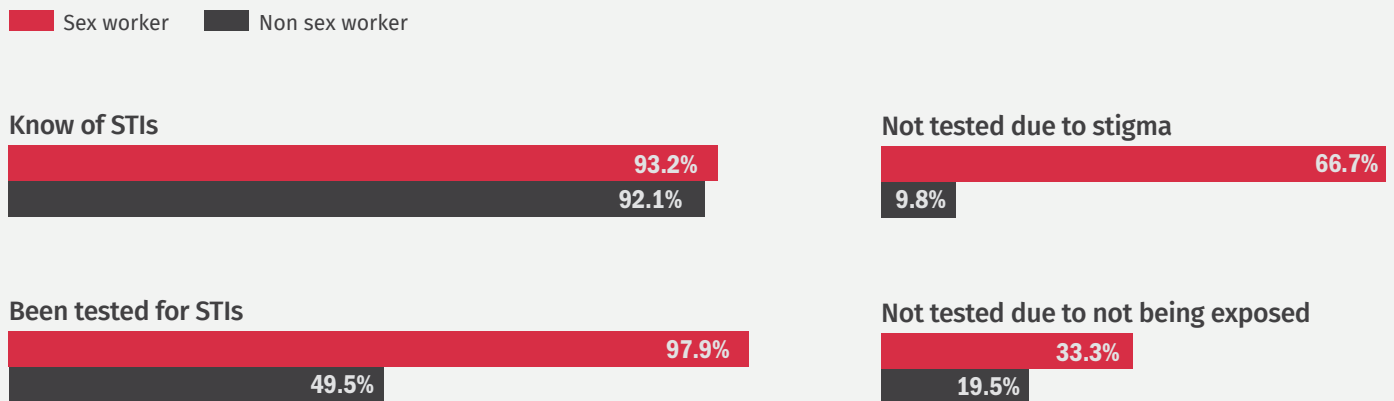
In Indonesia, there was a high level of knowledge about the existence of STIs (91.6%). This was even higher for trans women (93.3%), sex workers (93.2%), and CBO

members (95.75). This compares with slightly lower levels of knowledge amongst trans men (90.4%), and those who were not CBO members (91%).

While the results for STI knowledge were very similar across all these groups, that was not the case for STI testing. Overall, 77.6% of trans people had been tested for an STI. However, while this was almost a universal experience for trans women (96.9%, all but six of the 195 respondents), it was rare for trans men (9.3% or just five individuals). The small number of trans men who had received an STI diagnosis were more likely to seek treatment from NGOs. They were also more likely to wait more than 10 days for treatment.

Almost all sex workers had had an STI test (97.9%) compared to about half (49.5%) of non-sex workers. Sex workers were more likely to be tested every three months (67.8%), and to say they had never tested positive for an STI (80.9%), compared to non-sex workers (24% were tested every three months and 73.8% had never tested positive). Non-sex workers who had a positive STI test reported seeking treatment from government health centres (14.3%) at higher rates than sex workers (7.6%) and reported slightly higher use of NGO/CBO services for treatment (11.9% compared to 11.5% of sex workers). Non-sex workers were more likely to seek STI treatment immediately (95.2% or 20 individuals sought treatment immediately) compared to 86% or 37 sex workers.

Sexual healthcare knowledge and behaviour of sex workers and non-sex workers in Indonesia



Most CBO members had previously had an STI test (95.7%, 88 people) compared to just over two-thirds of those trans people who did not belong to a CBO (67.5%, 106 people). Older people were also more likely to have been tested for STIs (84.8% of over-25s compared to 51.9% of under-25s). Trans people in Indonesia who were CBO members, and those who had higher pride in being trans were also more likely to have been tested for STIs. All those with very high levels of trans pride and almost all CBO members (95.7%) had had a STI test compared to 67.5% of those who were not members of a CBO.

Older participants were more likely to be tested every three months (55.1% or 109 individuals, compared to 28.8% of 25-and-under), and young people more likely to have never been tested (46.2% compared to 15.7% of older adults). Older adults, aged 25 or over, were more likely to seek STI treatment from NGOs, with 13.6% of over-25s (20 people) having gone to an NGO for treatment. No one 25 and under had gone to an NGO for treatment, though two younger people had gone to a government facility.

HIV Testing and Treatment

There were high rates of HIV testing and treatment, with 81.1% (202 people) having been tested for HIV, and 23.3% of those tested (17 people) had tested positive, though 6.9% were unsure of their diagnosis. Like STI testing, people who had ever been tested for HIV tended to do so every three months, though less frequently than Nepal (46.4% or 116 people got an HIV test every three months), and 29.2% (73 people) tested for HIV twice a year, 2.4% (six people) every two years, and 2.8% (seven people) not in the last three years.

There was less awareness of PEP in Indonesia than Nepal, with 65.6% or 164 people not knowing if they had used it. Still 29.2% or 73 people had never used it, and 1.6% or four people not in the last 3 years. The majority did not know of PrEP (65.6% or 164 individuals), 32.8% (82 people) had never had it, and just four individuals had ever taken it, all of them not in the last three years. 43 of the 47 HIV-positive participants were on ART, which is 91.5%. Most in Indonesia had received counselling on HIV risk factors and co-infections (79.5% or 198 individuals), and 76.8% (189 individuals) had received counselling on sexual and reproductive rights.

Information collected through KIIs and FGDs in 2018-19 for this KPRA report confirmed that HIV-related services are available in most government primary health care service centres (Puskesmas) in Indonesia, and in some government hospitals and private clinics. Some FGD participants specifically expressed a preference for PrEP, which was not yet available in Indonesia.^{xxxx}

In Indonesia, different demographic factors had distinct behaviours in terms of seeking HIV-related healthcare. The steps trans people took to seek HIV-related healthcare were very similar to the gender identity, age, and sex work patterns already seen in relation to STIs.

Trans women were more likely than trans men to have had an HIV test (96.9%), to get tested more frequently (59% tested every three months), and to be HIV-positive (25%). Only 25.5% of trans men had ever had a HIV test, only one (1.8%) tested every three months, and none were HIV positive. Trans women were the most likely to say they did not know if they had ever visited a doctor for PEP (86.7%) or PrEP (87.1%) compared to just 7.3% of trans men, and this is a gap that needs addressing. Increased testing rates may be associated with the finding that trans women in Indonesia were more likely to have received counselling on HIV risk (95.4% compared to 23.6% of trans men) and sexual and reproductive health and rights (90.1% compared to 30.9% of trans men).

These findings were replicated for older participants, who were more likely to have been tested, get tested frequently, be HIV-positive, not know about PEP or PrEP – but also more likely to have received counselling on HIV risk and SRHR. The age findings here may reflect that trans women surveyed tended to be older, and therefore this may be a cohort difference, with trans masculine identities emerging relatively recently.

Sex workers in Indonesia were far more likely to have been tested for HIV (97.9% or 142 individuals), compared to non-sex workers (57.7% or 60 individuals), and were more likely to visit a doctor for an HIV test every three months. 13 percent of sex workers and 51% of non-sex workers had never visited a doctor for PEP, and 79.5% of sex workers and 46.2% of non-sex workers had never visited a doctor for PrEP. The majority of both groups did not know about PEP or PrEP. Of sex workers who were HIV positive, 93.3% were on ART (28 individuals), and 88.2% of non-sex workers (15 individuals).

Overall, this suggests that trans women, older participants, and sex workers – and the overlap between these demographics – are associated with higher HIV-related knowledge and healthcare seeking behaviour, though PEP and PrEP remain a gap for these groups.

The KII conducted alongside this survey mapped existing services including the role of trans-led organisations such as Yayasan Srikandi Sejati (YSS) and Sanggar Swara (SS). These two CBOs for trans women, based in Jakarta, provide health promotion programmes and facilitate referrals to ART services. Both offer counselling support to the trans community in particular around gender-based violence and legal aid (YSS), and financial crisis support and vocational training (SS).

Trans men, younger people, and non-sex workers – and the overlaps between these groups – remain at significant risk given these patterns of findings, in terms of both knowledge and behaviour relating to HIV prevention and management. For trans men who have sex with men, there are also risks of unwanted pregnancies in the absence of counselling about sexual and reproductive health and rights.

Gender Minority Stressors

STI Testing and Treatment

In Indonesia, people who experienced any of the stressors that might cause gender minority stress (being refused treatment, discrimination, assault, invasive questions or lack of standards for trans healthcare) were more likely to know about STIs.

Unlike Nepal, being refused treatment in the past meant Indonesian participants were less likely to have ever been tested for STIs (40% of those who had been refused had also been STI tested, compared to 78.7% who had not been refused treatment). However, like Nepal, the other stressors were each associated with higher rates of testing and treatment. Trans people were more likely to have had an STI test if they had:

- Faced HIV service discrimination (93.3% compared to 76.9% who had not faced discrimination);
- Delaying treatment due to invasive questions (87.1% compared to 75.5% who had not delayed due to invasive questions);
- Delayed treatment because there no standards or guidance for trans patients (90.8% compared to 73.5% who had never had a STI test)

In some circumstances, experiencing gender minority stressors meant trans people then delayed seeking health care. Specifically, trans people in Indonesia who experienced discrimination when accessing HIV services were more likely to delay seeking treatment for diagnosed STIs (11.1% of people who had experienced discrimination had waited more than 10 days for treatment, compared to 3.6% of those who had not experienced discrimination). This potentially suggests that, when trans people had negative experiences accessing one form of sexual healthcare, this impacted specifically on whether they would seek other forms of sexual healthcare.

There was not the same link between gender minority stressors when accessing healthcare generally and delaying STI treatment. Trans people who had ever been refused treatment because they were trans, or had delayed treatment after experiencing invasive questions or lack of trans-specific guidance, were actually less likely to delay seeking treatment for an STI.

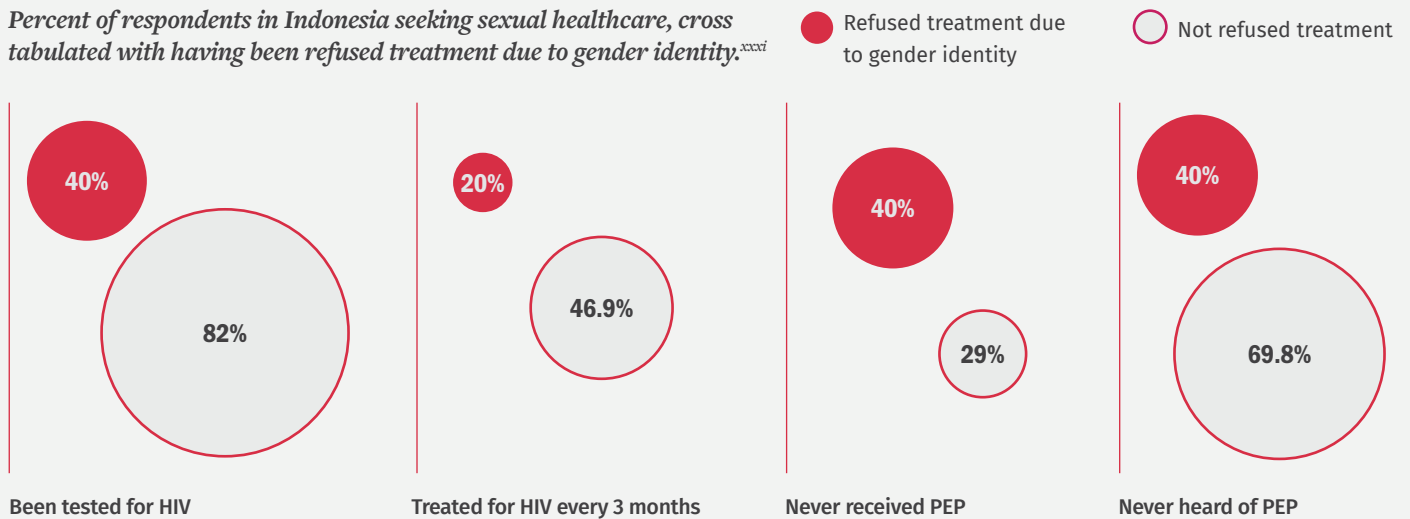
HIV Testing and Treatment

In terms of stressors, trans people who had ever been refused treatment due to their gender identity were less likely to have ever had a HIV test (three out of five had not). They were also having less frequent tests, and were more likely to have never received counselling on either HIV risk or on sexual and reproductive health and rights.

Other stressors displayed a pattern of results in the opposite direction. Trans people who experienced more recent stressors (such as invasive questions and no standards or guidance for trans patients), or who faced discrimination when accessing HIV treatment, were all more likely to have had an HIV test. Those who had experienced discrimination in HIV services were more likely to have never used PEP (40% had not) or PrEP (53.3% had not).

Trans people who delayed treatment in the previous six months because of these experiences were also having more frequent HIV tests. These variables may be linked, with respondents who are regularly seeking HIV services more likely to experience invasive questions and to notice if there is no trans-specific guidance available at clinics.

Percent of respondents in Indonesia seeking sexual healthcare, cross tabulated with having been refused treatment due to gender identity.^{xxvi}



Practical Stressors

STI Testing and Treatment

Trans people who delayed treatment in the last six months due to costs saw their doctor or healthcare provider less often for STI tests (35.7% or five individuals had never been tested, compared to 22% of those without a cost barrier). On the other hand, those who had delayed treatment because of the distance they had to travel actually had STI tests more frequently. Again, like Nepal, those with cost and distance barriers were actually more likely to have ever been tested. It is likely that this relates to underlying factors, such as CBO members or sex workers also being more likely to face practical barriers in accessing general healthcare, but still having more awareness around sexual health and healthcare.

HIV Testing and Treatment

In Indonesia, some practical barriers reduced the extent to which trans people had sought HIV-related healthcare. Those experiencing barriers due to cost were less likely to have ever had an HIV test (78.6% or 11 individuals compared to 80.6% or 179 individuals without a cost barrier). Otherwise, there were no clear relationships between practical stressors and HIV testing and treatment.

Participants from the FGDs described initiatives that had reduced practical barriers. Comprehensive HIV and STI services were available for free, though the operating hours were restricted and did not include evenings and weekends. FGD participants spoke positively about mobile clinics that travelled to areas where trans people lived, worked, or gathered.

Resilience Factors

STI Testing and Treatment

CBO members were more likely to seek treatment from NGOs (17.4%, compared to 7.7% of non-CBO members), though also sought treatment from government sources (15.9%). CBO members were also more likely to seek immediate treatment for STIs (92.7% sought immediate treatment compared to 82.6% of non-CBO members). There were no clear patterns in relation to feelings of pride, and STI awareness and testing.

HIV Testing and Treatment

In Indonesia, all but two CBO members had been tested for HIV (97.8% of the respondents), compared to 71.3% of non-CBO members. CBO members were also more likely to be HIV-positive (36.7% compared to 12.5% of non-CBO members), and to have received counselling on HIV risk and SRHR. These are some of the benefits of CBO membership for HIV service utilisation in Indonesia.

However, non-CBO members were more likely to be tested for HIV every three months (57.6% received a test every three months compared to 27.2% of CBO members). Over 90% of HIV-positive CBO and non-CBO members were currently on ART.

The results for trans people who had higher levels of pride in their gender identity were also very similar to those of CBO members. Overall, these findings suggest CBO membership in Indonesia is associated with some sexual healthcare seeking behaviour – especially those related to awareness.

THAILAND

STI Testing and Treatment

In Thailand, 90.4% of the trans people surveyed had heard of diseases that could be transmitted through sexual intercourse (226 individuals), and 76.1% (191 individuals) had been tested for an STI. The most common reason in Thailand for not being tested was fear of stigma (83.3% of people who had never been tested, or 50 individuals). This was a much higher rate of fear of stigma than in Nepal and Indonesia, highlighting this as a barrier in Thailand. Two people said they had not been tested because they could not afford it.

People who got tested tended to do so twice a year, less frequently than the other countries (44.6% of the sample got tested for STIs twice a year, 111 individuals). 20% (52 people) got tested every three months, 44.6% (111 people) twice a year, 7.6% (nine people) every two years, and 4.8% (12 people) not in the last three years. Of those who had been tested for an STI, 91.1% had never tested positive (173 people). Many of those who tested positive sought treatment immediately (35.3% or six people), 23.5% (four people) went within one week, 11.8% (two people) within 8-10 days, 23.5% (four people) delaying treatment for more than 10 days, and 5.9% (one person) not being treated.

As in the other countries, there were similar significant patterns or trends of sex workers and CBO members being more likely to have visited a health provider to get tested for STIs. In Thailand, 100% of sex workers were aware of STIs, compared to 88.3% of non-sex workers. There were differences in reasons for not being tested for STIs, with 88.7% of non-sex workers who had not been tested saying the reason was that they were afraid of discrimination from providers, compared to 42.9% of sex workers.

Noting again the small number of trans men surveyed, 85.1% of trans women (183 people) had been tested for STIs, compared to 26.7% of trans men (four people) Two

trans men were not sure if they had been tested (13.3%), along with six trans women (2.8%), but there were no gender differences in place of treatment, or in delaying STI treatment after getting a positive diagnosis. There were no other significant differences between how often different groups of trans people sought treatment for STIs, or where they went for that treatment.

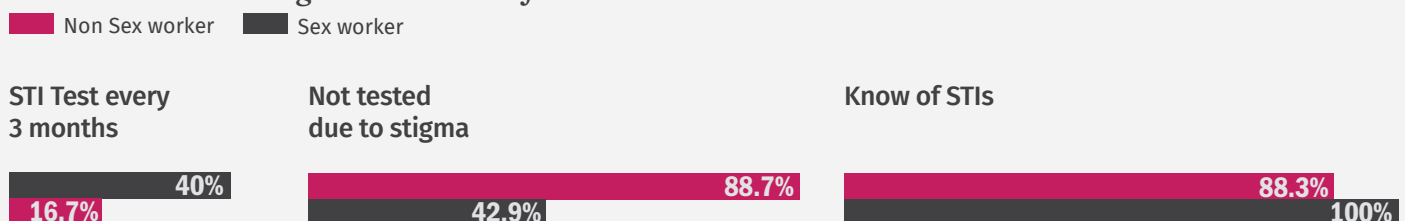
HIV Testing and Treatment

There were relatively high rates of HIV testing and treatment, with 79.2% (198 people) having been tested for HIV, and 5.1% of those tested (10 people) had tested positive, though two people did not receive their results. People who had ever been tested for HIV tended to do so twice a year (45.6% or 114 people got tested for HIV twice a year), while 22.4% or 56 people got an HIV test every three months, and 7.2% (18 people) every two years, and 4.8% (12 people) not in the last three years.

There was little use of PEP and PrEP in Thailand. 79.6% (199 people) had never visited a doctor for PEP, and 72.3% (180 people) never visited for PrEP. 13 people or 5.2% of those surveyed, visited a doctor for PrEP every three months, and no one visited for PEP every three months. All of the 10 HIV-positive participants were on ART, 74.4% (186 people) had received counselling on HIV risk factors and co-infections, and 57.6% (144 individuals) had received counselling on sexual and reproductive rights.

In Thailand, there were significant differences in the HIV services that trans women accessed compared to trans men. Trans women were more likely to have been tested for HIV (87.9% compared to 33.3% of trans men), to be tested more frequently (25.6% of trans women tested every three months, compared to no trans men), and to have received counselling on HIV risks or on SRHR (65.1% of trans women, 140 people, compared to 13.3% of trans men, two people).

Sexual health knowledge and treatment for sex workers and non-sex workers in Thailand



In Pattaya, where this study was centred, there is a high concentration of trans women engaging in sex work and within the entertainment industry. As the KIIs documented, in Pattaya organisations such as the Foundation of Transgender Health Service provide community-based HIV and STI testing and screening alongside prevention services such as PrEP, condoms and lubricants and counselling services.

Four trans men did not know about either PEP or PrEP, though trans women were not using either consistently. In Thailand, there were no significant differences in the HIV healthcare sought by those under 25 and those who were older. Sex workers had more frequent HIV tests and took PEP and PrEP at higher rates, but still infrequently (at intervals of more than three years).

Gender Minority Stressors

STI Testing and Treatment

In Thailand, there were trends towards gender minority stressors impacting the steps that trans people were taking to access sexual healthcare. One significant relationship showed that trans people who had delayed treatment in the last six months, because there was no guidance about supporting trans patients, were also more likely to have not had an STI test for more than three years (11.9% compared to 2.2% of people who had not faced a barrier relating to clinic guidance). In recent years, Thailand has developed relatively more trans-competent guidance for medical practitioners than other countries in the region. This may explain why this finding emerged in Thailand. When guidance and standards are lacking, trans people in Thailand may be more likely to notice.

HIV Testing and Treatment

There were few gender minority stressors that had a significant impact on the steps trans people in Thailand took to seek HIV-related healthcare. One significant finding was that people who had experienced discrimination accessing HIV services were more likely to have never visited a provider for PEP (95.8%) as compared to those who had not experienced such discrimination (77.9%).

Practical Stressors

STI Testing and Treatment

Trans people who had delayed seeking treatment in the last six months because of the distance they would have to travel were more likely to seek treatment from government clinics (15.6% compared to 3.2% of people

with no distance barrier). Otherwise, there were no clear links between practical barriers trans people faced and the steps they took to seek STI-related healthcare.

HIV Testing and Treatment

There were no clear patterns relating to practical barriers trans people in Thailand faced and the HIV healthcare they sought. Those who had delayed seeking treatment in the last six months due to cost had higher and more frequent rates of HIV testing, while those who had delayed treatment due to distance were more likely to be HIV-positive. Trending relationships within this section did not paint a clear picture of practical barriers impacting on the HIV-related treatment that trans people in Thailand seek.

Resilience Factors

STI Testing and Treatment

Like the other countries, in Thailand too, CBO membership and higher levels of trans pride were highly associated with higher frequency of STI testing.

All CBO members were aware of STIs (compared to 84.9% of non-CBO members), and 98% of people with high or very high pride knew about STI, compared to 70.3% of people with medium levels of pride. This is likely due to the overlap between pride and CBO membership in Thailand.

CBO membership was not associated with a preference to seek STI treatment at CBOs/NGOs rather than a government clinic. Nor was there a link between CBO membership, and whether a trans person delayed treatment after getting a positive STI diagnosis. Participants with higher levels of trans pride were more likely to be tested more frequently, and to seek that STI treatment from an NGO.

HIV Testing and Treatment

In Thailand, as in other countries, CBO members were more likely to have been tested for HIV (94.5%), than non-CBO members (70.4%), and were more likely to do so more frequently. CBO members were more aware of PEP and PrEP (non-CBO members were more likely to say they did not know what PEP or PrEP were). However, this was not reflected in increased usage, with most CBO members (90.1%) saying they never took PEP. Use of PrEP was higher than PEP in Thailand, with 12.2% of CBO members seeking PrEP every three months. Both CBO membership and higher levels of trans pride were linked to higher rates of receiving counselling on HIV risk and on SRHR.

VIETNAM

STI Testing and Treatment

In Vietnam, 98% of the transgender people surveyed had heard of diseases that could be transmitted through sexual intercourse (239 individuals), and 62.7% (153 individuals) had been tested for an STI. The most common reason in Vietnam for not being tested was when people felt it was unlikely they had contracted an STI (79.5% of those not tested, or 70 individuals) followed by fear of stigma (6.8% of people who had never been tested, or six individuals). Two people said they had not been tested because they could not afford it.

People who got tested tended to do so twice a year (37.1% of the sample got tested for STIs twice a year, 89 individuals). 18percent (43 people) got tested every three months, 8.3% (20 people) every two years, and 2.9% (7 people) not in the last three years. Of those who had been tested for an STI, 85.2% had never tested positive (127 people). People in Vietnam who tested positive for an STI were most likely to go to an NGO/CBO for treatment (10.7% of people who had been tested or 16 individuals), with 2.7% (4) going to an NGO, and 1.3% (two people) going to a private sector health centre. Many of those who tested positive sought treatment immediately (37.5% or 6 people), 50% (eight people) went within one week, and 6.3% (one person) within 8-10 days.

Vietnam was the only country where trans men were more likely than trans women to have ever been tested for STIs, with 73% of trans men (65 individuals) having been tested compared to 57.1% of trans women. Trans men were also more likely to visit a doctor for PrEP every three months (23.9%, compared to 12.3% of trans women).

There were no differences in the sexual healthcare sought by those under the age of 25, and those who were older. Sex workers were more likely to be tested for STIs more frequently, with 60% (three individuals) being tested every three months (noting the low numbers in this section).

HIV Testing and Treatment

There were relatively high rates of HIV testing and treatment, with 74.3% (182 people) having been tested for HIV, and 1.1% of those tested (two people) had tested positive. Both HIV-positive participants were on ART. People who had ever been tested for HIV tended to do so every three months (31.8% or 78 people), with an equal number getting tested twice a year (31.8% or 78 people). Much fewer people had an HIV test only every two years (8.2% or 20 people), and just 2.4% (six people) had not been tested in the last three years.

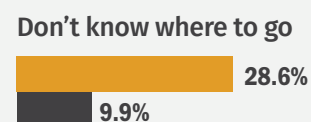
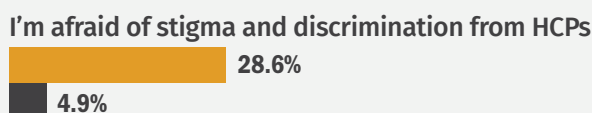
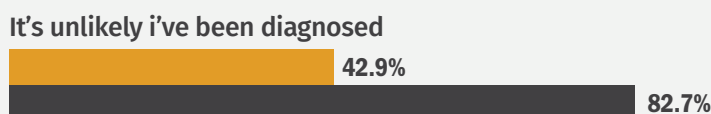
There was little use of PEP and PrEP in Vietnam: 70.6% (173 people) had never visited a doctor for PEP, and 63.5% (155 people) never visited for PrEP. 40 people, or 16.4% of those surveyed, visited a doctor for PrEP every three months, and 5.7% (14 people) visited for PEP every three months. More than half the Vietnam survey participants (55.4% or 128 people) had received counselling on sexual and reproductive health and rights, and 86% (202 people) on HIV risk factors and co-infections.

Information collected through KIIs and FGDs in 2018-19 for this KPRA report confirmed that HIV-related information is readily available online either on personal Facebook pages or closed groups of trans women.

Reasons given by respondents in Vietnam for not getting an STI test, cross tabulated with having previously been refused health treatment due to gender identity.^{xxxvii}

What would you say is the MAIN reason why you have not been tested for an STI?

■ Refused treatment due to gender identity
 ■ Not refused treatment due to gender identity



However, information from KIIs highlighted that only a limited number of service providers and sites targeted HIV interventions to trans women, or disaggregated data about MSM and trans women using their services was absent. While trans women are nominally part of the HIV and PrEP Programme in Vietnam, the survey data suggests few were using PrEP.

In Vietnam, there were trending patterns towards trans men having increased rates of testing for HIV, and trans men were more likely to take PrEP every three months, but there were no statistically significant gender relationships. There were also no significant relationships between age and HIV-related healthcare. There were some trends, but not pointing to a coherent pattern.

Although there were only six sex workers in the Vietnam sample, one was not aware of STIs. Non-sex workers who had not been tested said the reason was that it was unlikely that they had contracted any. STIs (81.4% or 70 individuals). Two sex workers took PEP and three took PrEP every three months. However, sex work was not associated with other HIV-related healthcare behaviours.

Gender Minority Stressors

STI Testing and Treatment

There was evidence in Vietnam that gender minority stressors affected the steps that trans people were taking to access sexual healthcare. For example, of those who had not been tested for an STI, people who had previously been refused treatment due to their gender identity were more likely to say it was because they fear discrimination from providers (28.6% compared to 4.6% of people who had not been refused treatment, noting only seven people had previously been refused treatment). A higher proportion of people who had been refused treatment had not had an STI test in more than three years (12.5% compared to 2.2% of those not refused), and a higher proportion of those refused treatment had tested positive (45% compared to 13% of those not refused treatment, noting again low numbers here), and sought treatment through NGOs and the private sector.

Trans people who had experienced discrimination while seeking HIV services had less frequent STI testing (20% had not been tested in last three years compared to 2.2% of people who had not experienced discrimination). They also had higher diagnosis rates, with less than half (42.9%, three out of seven participants) never receiving an STI diagnosis, compared to 86.9% of people who had not experienced discrimination (119 individuals).

There were clearer patterns between recent gender minority stressors and the sexual healthcare that trans people sought. Those who had delayed treatment in the last six months because of invasive questions, or the lack of trans-specific health guidance, had more frequent STI testing. They were more likely to get tested for STIs every two years, though those who delayed treatment due to lack of trans-specific guidance were also more likely to wait longer than three years for an STI test.

HIV Testing and Treatment

In Vietnam, there was an overall trend towards gender minority stressors affecting what HIV-related healthcare trans people sought, though most relationships were not significant. Trans people who delayed treatment in the last six months because of no guidance at clinics were tested for HIV less frequently, and they took PrEP less frequently. However, people who had experienced discrimination while accessing HIV services had more awareness of PrEP and were more likely to take PrEP every three months. There were no significant relationships between stressors, and whether trans people accessed counselling on HIV risk or on SRHR.

Although the actual numbers of HIV-positive cases were very small in Vietnam, it was concerning that participants in the FGDs reported a reluctance to be tested because they feared stigma and discrimination at health care facilities, and that a positive HIV status would not be kept confidential.

Practical Stressors

STI Testing and Treatment

For trans people who had recently delayed treatments because of cost, there were no clear impacts on the frequency of STI tests, waiting time before following up on a STI diagnosis, or on their preferred treatment location. However, those who recently delayed treatment because distance was a barrier were more likely to say they had not been tested because they feared discrimination from providers (23.5% or four individuals, compared to 2.9% or two individuals who had not). Two individuals who faced distance barriers sought their last STI treatment from the private sector, compared to zero individuals who did not face distance barriers.

HIV Testing and Treatment

Trans people who had experienced cost barriers in Vietnam were less likely to have been tested for HIV (57.9% had been tested, compared to 78.9% who did not face a cost barrier), and less likely to have received counselling on HIV risk (74.5%, compared to 89% of people without a cost barrier). There were also trends towards cost barriers resulting in less frequent HIV testing in Vietnam.

Information collected through KIIs and FGDs confirmed that some community organisations provide rapid HIV tests that can be delivered to trans people's home at a small cost or free of charge.

Distance did not appear to be a significant barrier to accessing HIV services in Vietnam. Here significant relationships were observed, people who had to delay treatment due to distance were actually more likely to access PEP, and to have received counselling on HIV risk.

Resilience Factors

STI Testing and Treatment

Unlike other countries, in Vietnam, non-CBO members were more likely to have been tested for STIs, with 67% of non-CBO members tested (23 individuals), as compared to 46% of CBO members (23 individuals). This may reflect the higher percentage of trans men who were non-CBO members. CBO members who had not been tested were more likely to say it was because they were afraid of discrimination (12%, three individuals, compared to 4.8% of non-CBO members, three individuals). Non-CBO members were more likely to say they were not sure why they had not been tested. CBO members were also more likely to have sought treatment from government clinics (9.1% or two individuals compared to 1.6% of non-CBO members, two individuals).

There were links between higher levels of trans pride, and the likelihood of ever having an STI test. This suggested that pride, and other factors like gender identity, were more predictive of STI-related healthcare use than CBO membership itself in Vietnam. This is an interesting finding that separates Vietnam from the patterns observed in the other countries.

HIV Testing and Treatment

In Vietnam, although CBO members were more likely to have accessed counselling on HIV risks (24.5% or 12 individuals, compared to 11.3% of non-CBO members), the same pattern was not observed in other countries when it came to increased use of HIV services even though higher trans pride was associated with increased frequency of HIV testing. Otherwise, the protective factors encouraging HIV service use in CBO members in other countries were not observed in Vietnam, inviting similar conclusions as in STI-related healthcare: that other factors are more related to these behaviours.

KEY FINDINGS

Most trans people across all countries were aware of STIs and HIV, and most had been tested for STIs and HIV at some point.

The proportion of respondents who had ever been tested for an STI ranged from 56% in Nepal to approximately 76% in Indonesia and Thailand (and 63% in Vietnam). The majority in all countries had received an HIV test, with the highest in Indonesia (81% had been tested for HIV, and 17 participants tested HIV-positive), and the lowest in Vietnam (74%, and two individuals tested positive). There were similar rates of HIV testing in Nepal (78%, with 17 people testing HIV-positive) and Thailand (79%, with five individuals testing HIV-positive).

Low self-perceived risk of exposure was the most common reason for not being tested for an STI— other than in Vietnam.

Approximately 80% of trans people in Nepal and Vietnam who had not been tested for an STI said it was because it was unlikely that they had been exposed (in Indonesia this figure was 20%, with 50% giving 'other' responses). In Thailand, fear of stigma was the most common reason, with 80% of those not tested giving this reason.

CBOs were common sources of treatment for STIs.

CBOs were the most common source of treatment in Nepal, Indonesia and Vietnam, while in Thailand most went to the government health centre, clinic or hospital. This is a potential explanatory factor for why so many in Thailand were not tested due to fear of stigma. Sex workers in Thailand were the group most likely to say this was the reason why they were not tested (89% who had not been tested said this was due to fear of stigma).

Trans women were tested for STIs and HIV at higher rates, and with higher frequency, than trans men— other than in Vietnam.

In Nepal, third gender participants had the highest rates of testing, and higher frequency of testing, and trans women were also tested much more than trans men (56% compared to 17%). In Indonesia, there was a huge gender difference in STI testing: 97% of trans women had been tested compared to 9% of trans men. There was also a large gender difference in Thailand in having been tested for STIs (88% trans women, compared to 33% of trans

men). In Nepal and Thailand, trans women accessed more HIV combination-prevention services. Vietnam was the only country where more trans men than trans women were tested for STIs.

Sex workers were more likely to be tested for STIs, tested more frequently, and sought treatment immediately.

This finding was replicated across Nepal, Indonesia, and Thailand. There were too few sex workers in the study in Vietnam for reliable analysis.

Use of preventive and prophylactic treatments like PEP and PrEP were low across the four countries.

In all countries, the majority had either never used, or were not aware, of PEP and PrEP. The highest rates of PEP and PrEP use were in Nepal, where approximately 40% of trans people had used either.

For STI and HIV healthcare, stressors were mostly linked to higher rates of awareness and treatment— with some notable exceptions.

We suggest this means that respondents who are regularly seeking sexual health services are more likely to experience gender minority stressors while accessing their testing or treatment. There were some exceptions:

- In Nepal, having been assaulted made it more likely to seek treatment from an NGO, and having been refused treatment was linked to longer delays before seeking treatment.
- In Indonesia, previous experience with discrimination in HIV services was linked to delayed treatment for STIs.
- In Thailand, delaying needed treatment due to poor clinical standards was linked to a longer time period since having an STI test. Also, participants who experienced discrimination accessing HIV services were more likely to have never visited a provider for PEP.
- In Vietnam, people who had been refused treatment previously were more likely to say they had not got an STI test because they feared stigma and discrimination. Those who had previously experienced discrimination accessing HIV services also had less frequent STI tests.

HIV status itself may influence whether trans patients are refused treatment.

HIV-positive respondents in Nepal and Indonesia were more likely to say they had experienced gender minority stress—a potential exacerbation of discriminatory treatment related to being both trans and HIV-positive.

Trans people associated with CBOs had more awareness of STIs and HIV, were more likely to be tested, tested more frequently, and to access combination-prevention services – other than in Vietnam.

In Nepal, CBO members had more awareness of HIV and STIs, more testing, more recent testing, and less delays in seeking STI treatment. HIV-positive CBO members were more likely to be on ART, and to have had more counselling about HIV risk factors. In Indonesia, CBO members had more frequent HIV testing, more counselling on HIV risks; and these results were similar for those high in pride. In Thailand, CBO members had higher rates of testing for STIs and HIV and more frequent testing. Only in Vietnam were CBO members less likely to be tested for STIs than non-CBO members, though this may reflect the higher percentage of trans men who were non-CBO members in Vietnam.

There were small numbers of HIV-positive participants in each country, but nearly all were on ART.

-03-

SEEKING GENERAL HEALTHCARE

In this section, we focus on trans people's behaviours around seeking general healthcare. The relevant questions from our survey are the length of time since their last check up, having a regular healthcare provider, or having delayed general healthcare due to the fear of discrimination. Specifically, this section seeks to address the following question:

*Which stressors and
resilience factors are
linked to use of
general healthcare?*

FOCUS VARIABLES IN THIS SECTION

o1 General Health *and* Healthcare

1. About how long has it been since you last visited a healthcare service provider for a routine check-up?
2. Do you have a health care service provider that you regularly visit for advice or when you are sick?
3. In the last 6 months, have you delayed getting medical care you needed because of fear of discrimination?

o2 Gender Minority Related Stressors

1. Have you ever been refused treatment or turned away by a doctor or healthcare service provider because of your transgender identity?
2. Have you ever been physically assaulted such that you require medical treatment?
3. Have you experienced discrimination, or discriminatory behaviour from healthcare service providers, when accessing HIV services?
4. In the past 6 months, have you delayed treatment due to past experience of invasive questions?
5. In the past 6 months, have you delayed treatment due to no guidance or standards for transgender patients?

o3 Practical Stressors

1. Delayed treatment in previous 6 months due to cost
2. Delayed treatment in previous 6 months due to distance

o4 Resilience Factors

1. CBO membership (CBO member / Non-CBO member)
2. Identity pride (scale combination of 6 items, analysed as high/low)

NEPAL

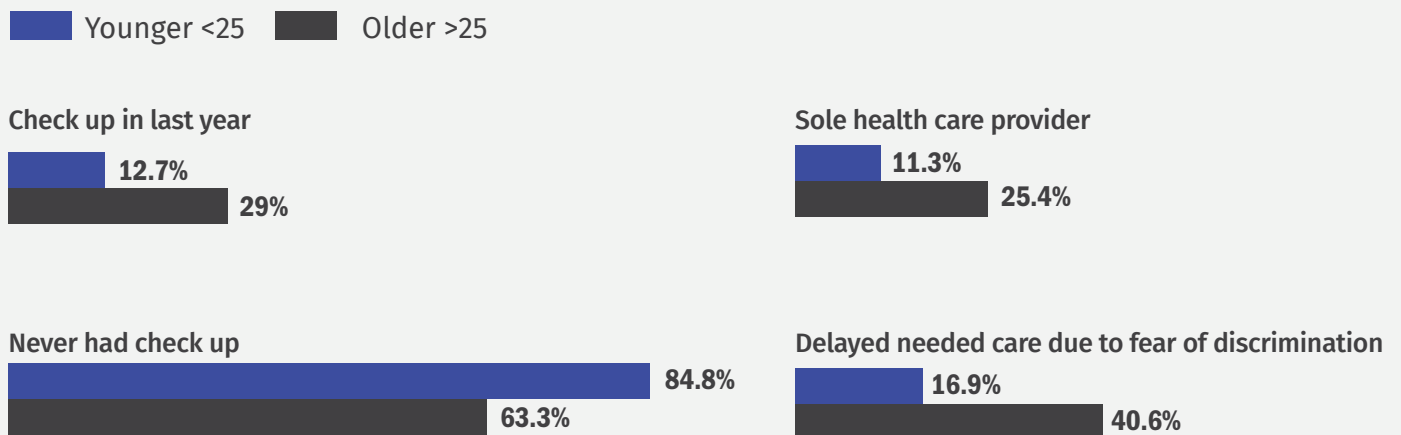
In Nepal, the majority had never visited a healthcare service provider for a routine check-up (69.6% or 174 individuals), though those who had tended to have visited within the past year (23.8% or 59 individuals), and smaller numbers within the two years (3.2%, eight individuals), 1.2% in the last five years (three individuals), and 1.6% more than five years ago. The majority of trans people in Nepal did not have a particular health care service provider that they regularly visited for advice when they are sick (72.7% or 181 individuals), with 20.9% (52 people) having one provider, 4.4% (11 people) more than one provider, and 2% (five people) having no provider at all. Many transgender people had delayed treatment in the previous six months due to fear of discrimination, 35.6% or 89 individuals.

Age was more associated with general healthcare-seeking behaviour for trans people in Nepal than other demographic factors. Trans people aged 25 or older were more likely to have sought a check-up in the previous year than younger people (29% or 49 individuals, compared to 12.7% of under-25s, or 10 individuals). These older adults

were also more likely to have just one regular healthcare provider (25.4% or 43 people compared to 11.3% or 9 younger people). However, 25.9% of older adults had delayed treatment in the previous six months due to fear of discrimination, compared to 11.3% of younger people. Being a trans man or trans woman did not impact general healthcare behaviour as much as age, or as much as gender impacted mental health and healthcare use. One significant difference was that trans men were less likely to delay getting medical care they needed due to fear of discrimination, with 24.5% of trans men, or 13 individuals, having delayed treatment, compared to 35.1% of trans women (39 individuals) and 42.9% of third gender participants (36 individuals).

Sex workers were more than twice as likely to have never had a routine check-up (66.1% or 74 individuals) than to have had one in the last year (31.3% or 35 individuals), and were significantly more likely to have delayed treatment due to fear of discrimination (57.3%) than non-sex workers (42.7%).

Percent of respondents in Nepal using general healthcare, cross-tabulated with age.^{xxxiii}



Gender Minority Stressors

21 transgender people in the Nepal sample had ever been refused healthcare treatment, and 47.6% of this group (10 individuals) had received a routine check-up in the past year. This was more than double the proportion (amongst people who had never been refused treatment (21.3% or 48 individuals). A similar number also had one regular healthcare provider (42.9% or nine individuals), a higher proportion than among people who had not been refused treatment who said they had one regular healthcare provider (19% or 43 individuals). Together, these data suggest that those who seek general healthcare more frequently are more likely to have ever been refused treatment because of their gender identity. It also suggests that one way people respond to such discrimination is to find a regular provider who will not discriminate against them, and to continue to seek out their care.

For trans people in Nepal, the gender minority stress they experienced had an impact on recent decisions to delay necessary general medical care, due to fear of discrimination. As already mentioned above, those who had previously been refused treatment because of their gender identity were more likely to delay ongoing treatment due to fear of further discrimination. In addition, 70.6% of respondents who had ever experienced discrimination while accessing HIV services (12 individuals) were more likely to have delayed getting general medical care in the previous six

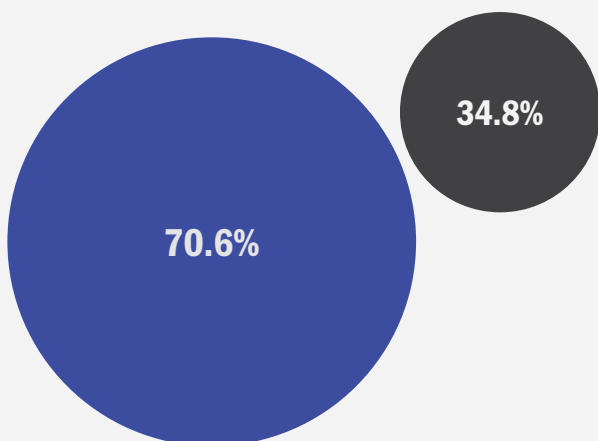
months due to fear of discrimination than people who had not faced discrimination when accessing HIV services (34.8% of respondents, or 77 individuals). This finding supports the idea that experiencing gender minority stress when accessing another form of healthcare can impact on whether trans people in Nepal sought general healthcare services. Trans people who had delayed treatment due to past experiences of invasive questions were also more likely to delay getting medical care they needed because they feared discrimination. 85% of trans people who had delayed treatment due to invasive questions in the past had also delayed treatment due to fear of discrimination (60 individuals), compared to 17.2% of people who had not experienced invasive questions (28 individuals). Similarly, a higher proportion of people who had delayed treatment because there was no guidance for transgender patients had also delayed necessary medical care due to fear of discrimination (81.2% or 56 individuals, compared to 18.9%, or 30 individuals, who had not experienced issues with lack of such guidance). These findings suggest patterns of trans people in Nepal avoiding seeking medical care if they have experienced gender minority stress in healthcare settings.

Participants from FGDs in Nepal reported feelings of humiliation when they had to share their stories multiple times, and how a provider laughed at a trans woman when reviewing her X-rays and learning that the trans woman did not have ovaries.

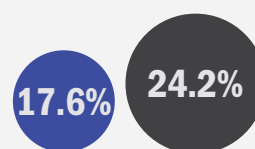
Percentage of respondents in Nepal reporting general healthcare use, cross-tabulated with previous experience of discrimination in HIV services.^{xxxiv}

- Experienced discrimination accessing HIV services
- No discrimination accessing HIV services

Delayed needed recent healthcare due to fear of discrimination



Check up in last year



Practical Stressors

On their own, practical barriers faced by trans people in Nepal did not appear to be negatively impacting general healthcare seeking behaviour. Having delayed treatment in the previous six months due to distance (potentially a proxy for those living in more rural areas) was actually associated with having a more recent medical check-up, and with having one regular healthcare provider.

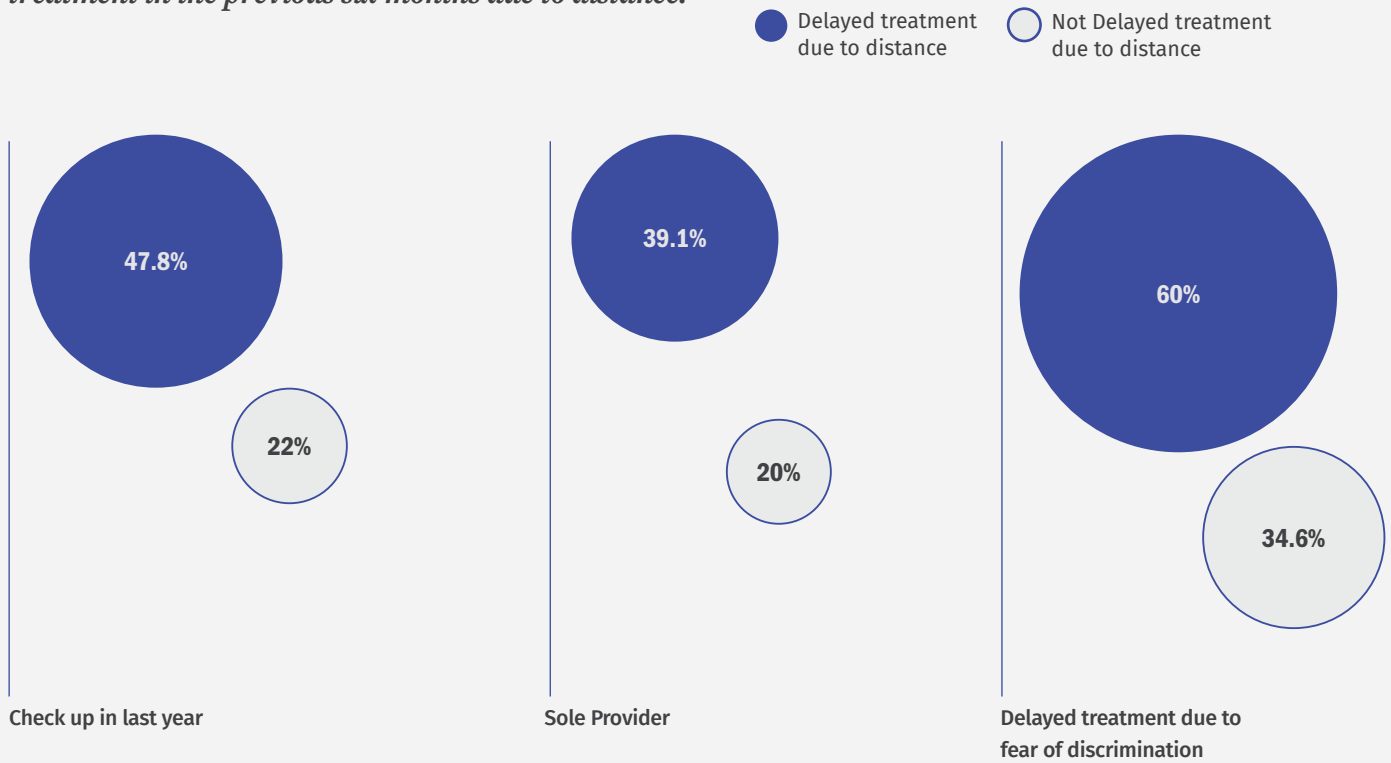
However, trans people in Nepal avoided seeking gender healthcare because of a mix of both gender minority stressors and some practical barriers. Both cost and distance barriers were related to having delayed treatment due to fear of discrimination. For example, 56.5% of people who had delayed treatment due to cost, had also delayed necessary medical care due to fear of discrimination (26 individuals), compared to 33% of those without cost barriers (62 individuals). 60 percent of those who had delayed treatment due to distance had also delayed needed medical care due to fear of discrimination (12 individuals), compared to 34.6% of those without distance barriers (74 individuals).

Resilience Factors

Unlike findings about sexual healthcare, being affiliated with a CBO in Nepal was not generally related to the steps trans people took to access general healthcare. This may be partly because trans people were more likely to seek STI treatment from a CBO than go there to get general healthcare if they fell ill.^{xxxv} Many CBOs may only offer STI testing and other sexual healthcare services, and not offer general healthcare services.

However, people who did not belong to a CBO were more likely to have no general healthcare provider (4.6% or four individuals had no provider, compared to 0.6% of CBO members, representing one individual). Trans people who had higher feelings of pride were less likely to seek general healthcare, with 74.5% of those in the highest category of pride (140 individuals) having never gone for a routine check-up, compared to 57.7% of those in the lower category of pride.

Percentage of respondents in Nepal reporting general healthcare use, cross-tabulated with having delayed treatment in the previous six months due to distance.^{xxxvi}



INDONESIA

In Indonesia, 31.9% or 79 individuals had never visited a healthcare service provider for a routine check-up. Those who had tended to have visited within the past year (39.9% or 99 individuals), and also within the last 2 years (20.6%, 51 individuals). Five percent (13 individuals) had visited in the past five years (three individuals), and 2.4% more than five years ago. Many trans people in Indonesia did not have a particular health care service provider that they regularly visited for advice when they are sick (42.5% or 105 individuals), with 24.7% (61 people) having one provider, 32% (79 people) more than one provider, and 0.8% (two people) having no provider at all. Many trans people had delayed treatment in the previous six months due to fear of discrimination, 39.9% or 99 individuals.

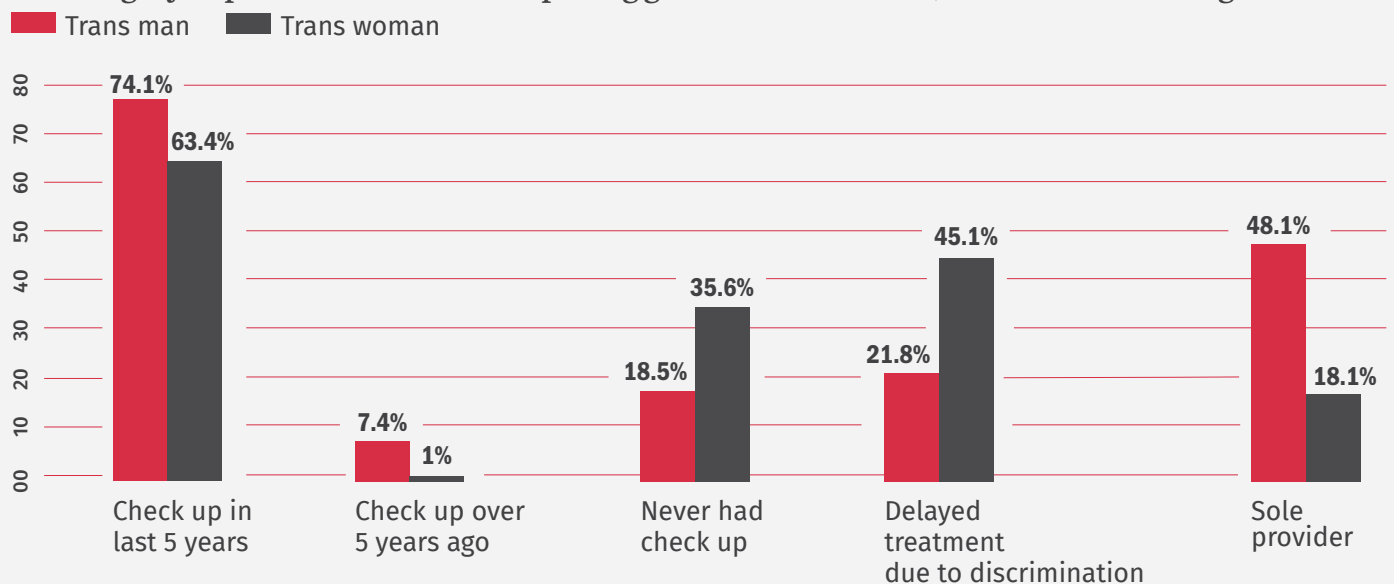
In Indonesia, unlike Nepal, there were many differences between the extent to which different groups of trans people sought general healthcare. Roughly equal proportions of trans men and women had gone for a check-up in the last year (42.6% of trans men and 39.2% of trans women), or the last two years. However, a higher proportion of trans women had never had a check-up (35.6% or 69 individuals) than trans men (18.5% or 10 individuals). More trans men had received a routine check-up between two and five years ago (18.5% of trans men or 10 individuals, compared to 1.5% of trans women, three individuals). More trans men than trans women in Indonesia had also had a check-up more than five years ago (7.4% compared to 1% of trans women). This pattern suggests that trans women tend to either go for recent check-ups or not at all, whereas routine check-up patterns for trans men are more varied.

Older transgender adults were more likely to have one regular healthcare provider, though there were no other relationships between age and general healthcare-seeking behaviour in Indonesia. Roughly equal proportions of sex workers and non-sex workers had never had a routine check-up (33% and 31% respectively), though non-sex workers were more likely to have one regular healthcare provider (32% or 33 non-sex workers, compared to 19.4% or 38 sex workers). Importantly, sex workers were more likely to have delayed treatment due to fear of discrimination than non-sex workers (47.6% of sex workers, or 76 individuals, compared to 29.1% of non-sex workers, or 30 individuals).

Gender Minority Stressors

The main findings from Indonesia were the impact of avoiding healthcare due to either past experience with invasive questions or due to no guidance for transgender patients. 85% of people who had experienced invasive questions had also delayed treatment due to fear of discrimination (53 individuals), compared to 24.7% of people who had not experienced invasive questions, (46 individuals). 69% of people who had delayed treatment due to no guidance for transgender patients had also delayed treatment due to fear of discrimination. This suggests a link between past experiences of gender minority stress in healthcare settings, and current avoidance of general healthcare due to fear of discrimination.

Percentage of respondents in Indonesia reporting general healthcare use, cross-tabulated with gender:^{xxvii}



Trans people in Indonesia who had ever been refused treatment due to their gender identity were just as likely to access general healthcare overall than people who had not been refused treatment in the past. However, only five individuals had ever been refused treatment in the past, which likely means the data were insufficient to observe significant relationships.

The FGDs conveyed the broader context of trying to obtain trans-inclusive healthcare in Indonesia, given the prevalence of conversion therapy practices in the country. Participants in the Indonesian FGDs described how even a supportive healthcare provider would try to convince them to not identify as trans.

Practical Stressors

While most trans people in Indonesia had not delayed treatment due to costs, those who did were more likely to have ever had a routine check-up. Specifically, 64.3% of those who had faced affordability issues (nine individuals) had had a medical check-up in the last year, compared to 38.5% who had not had this cost barrier. Also, only one person who had delayed treatment because of the cost had never had a check-up, compared to 34.8% of those with no experience of no cost barriers who had never had a check-up (77 individuals). This suggests that cost is not the primary barrier preventing trans people in Indonesia from accessing general healthcare. People experiencing cost barriers were more likely to have one regular healthcare provider, 42.9% or six individuals) compared to 24.1% or 53 individuals without cost barriers. Perhaps, experiencing a cost barrier means that a trans person in Indonesia is more likely to stick with an affordable provider.

However, there were links between trans people delaying treatment due to cost or distance and delaying medical care they needed because they feared discrimination. About half of those who faced a cost barrier had delayed necessary medical care due to fear of discrimination (7.1% or eight individuals, compared to 36.7% of people without a cost barrier, or 81 individuals). A similar proportion of people facing distance barriers had also delayed medical care due to fear of discrimination (58.8% or 47 individuals, compared to 31.1% or 53 people who did not face a distance barrier).

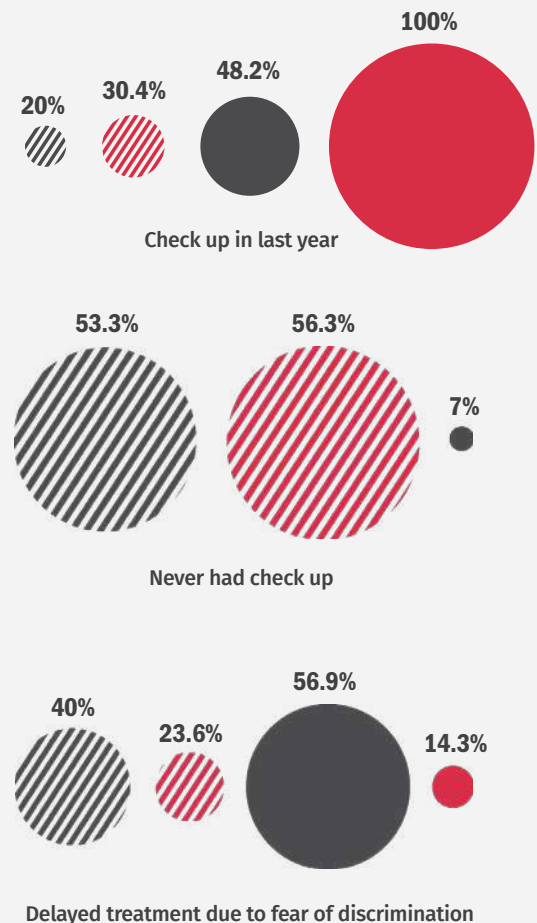
Resilience Factors

Trans CBO members in Indonesia were less likely to have delayed treatment due to fear of discrimination compared to people who did not belong to a CBO. Only 10.9% or 10 CBO members had delayed seeking necessary medical treatment, compared to 57.1% of non-CBO members, or 89 individuals. However, 63.7% of CBO members overall (58 individuals) had never had a routine check-up (compared to 13.4% of non-CBO members or 21 people). CBO members were also less likely to have a specific provider (17.4% compared to 29% of non-CBO members).

Pride appeared to have a more direct link to trans people’s behaviour seeking general healthcare. Trans people in Indonesia who had higher levels of trans pride were more likely to have ever seen a provider for a routine check-up. In particular, there were much higher levels of never having had a general medical check-up amongst those with low pride (53.5% or eight individuals), and those with medium pride (56.3% or 63 individuals), In contrast, only 7% of those with high pride and no one with very high pride had never had a medical check-up.

Percentage of respondents in Indonesia reporting general healthcare use, cross-tabulated with levels of pride.^{xxxviii}

● Low pride ● Medium pride ● High pride ● Very high pride



THAILAND

Overall, more trans people in Thailand had visited a healthcare service provider for a routine check-up than in Nepal or Indonesia, though 16.4% (41 individuals) still had not. They tended to have visited more recently: within the past year (52% or 130 individuals), and also within the last two years (18.8%, 47 individuals). 7% (17 individuals) had visited in the last five years (17 individuals), and 6.8% more than five years ago (15 people). Many trans people in Thailand had a particular health care service provider that they regularly visited for advice when they were sick (26.9% or 67 individuals), with 27.7% (69 people) having more than one regular provider, 39.8% (99 people) no particular provider, and 5.6% (14 people) having no provider at all. In Thailand, relatively few trans people had delayed treatment in the previous six months due to fear of discrimination compared to Nepal and Indonesia, though this was still 8.8% or 22 individuals.

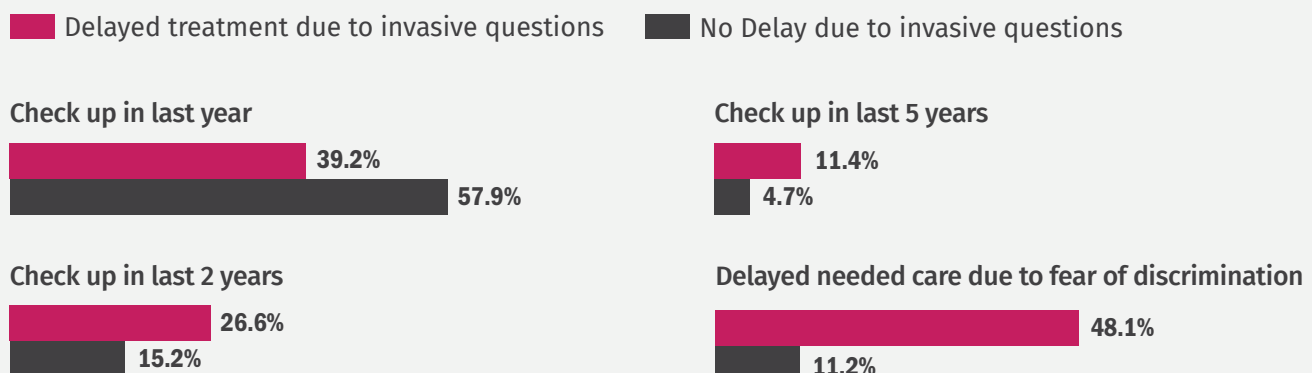
In Thailand, there were only a few differences between the experiences of different groups of trans people when seeking general healthcare. It is important to note the previously mentioned low number of trans men in the Thai sample (15 people). Trans men (20% or three people) and trans women (12.6% or 27 people) were less likely to have never had a medical check-up than those who identified as third gender (55% or 11 people had never had a check-up). In addition, 60% of trans men and 54.4% of trans women had a check-up in the previous year, compared to 20% of people who identified as third gender (four individuals). Sex workers were more likely to have had a recent check-up than non-sex workers (73.3% of sex workers or 33 individuals, compared to 47.3% of non-sex workers, 97 individuals). Age did not significantly impact whether trans people sought general healthcare services

Gender Minority Stressors

There was no clear pattern of gender minority stressors linked to trans people seeking or avoiding healthcare in Thailand. There were some significant differences, for example, a higher proportion of trans people (48.1% or 38 individuals) who had delayed treatment due to experiencing invasive questions, had also delayed treatment due to fear of discrimination (compared to 11.2% of people who had not delayed treatment because of invasive questions, 19 individuals). People who delayed treatment in the last six months due to invasive questions were less likely to have had a check-up in the last year, and more likely to have had a check-up in the previous two and five years. This finding suggests that experiencing gender minority stress through invasive or unnecessary questioning reduces more recent use of general healthcare services.

A higher proportion of transgender people who had delayed care due to no guidance for trans patients had their last check-up more than five years ago (13.6% or eight individuals, compared to 3.2% or six individuals who had not delayed care for this reason). The proportion of people who had never had a medical check-up were similar for both those who had delayed treatment where there was no guidance available and those who had not. This suggests that the gender minority stressor of having no guidance for trans patients is associated with delaying treatment, but not with overall avoidance of care.

Percentage of respondents in Thailand reporting general healthcare use, cross-tabulated with delaying treatment due to invasive questions.^{xxxix}



Practical Stressors

In Thailand, few practical barriers were associated with whether trans people sought general healthcare services. Trans people who experienced barriers relating to distance were more likely to have delayed treatment due to fear of discrimination (1.6% or 16 people had delayed seeking care due to this fear, compared to 19.5% of people without a distance barrier, 41 individuals). There were trends of cost barriers being linked to healthcare behaviour, but no significant relationships.

Resilience Factors

There was a general trend of CBO members seeking more recent general check-ups, and they were less likely to have delayed treatment due to fear of discrimination (13.2% or 12 individuals had delayed treatment, compared to 28.5% or 45 non-CBO members). CBO members were more likely to have one or several regular providers, with 44.9% of non-CBO members or 71 individuals saying that they had no usual provider, compared to 30.8% or 28 CBO members without one).

Never having had a routine check-up was related to levels of trans pride, with 81.8% of trans people with low pride (9 individuals), and 27% of people with medium pride (10 individuals) having never had a check-up, compared to 10.2% of people with high pride (13 people) and 12.2% of those with very high pride (nine people). There were no other clear directions in the links between trans pride, and whether people sought general healthcare services.

VIETNAM

Overall, many trans people in Vietnam had visited a healthcare service provider for a routine check-up, the highest rate of all the countries, with only 5.3% or 13 individuals never having visited for a routine check-up. The majority of trans people surveyed in Vietnam had visited within the past year (82.9% or 203 individuals), and also within the last two years (8.9%, 22 individuals). 2% (five individuals) had visited more than five years ago, and 0.8% in the past 5 years (2 individuals). Most had no particular health care service provider (76.6% or 187 individuals), with 12.3% (30 people) having one regular provider, 6.1% (15 people) more than one provider, and 4.9% (12 people) having no provider at all. In Vietnam, over half the trans people who responded (51.9% or 126 people) had delayed treatment in the previous six months due to fear of discrimination.

In terms of demographic factors, trans women were more likely to say they did not have a provider for general healthcare (7.1% or 11 individuals, compared to one trans man representing 1.1% of those surveyed who did not have a provider). Age and sex work status were not linked significantly to any of our measures of general healthcare behaviours (having a regular healthcare provider, how long since the last visit, and delaying getting medical care because of feared discrimination).

Gender Minority Stressors

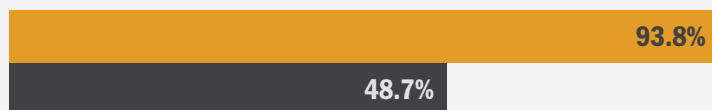
In Vietnam, unlike the other countries, trans people who had ever been refused treatment due to their gender identity were more likely to have delayed recent treatment due to fear of discrimination: 93.8% of trans people who had been refused treatment (15 individuals) had also delayed treatment in the previous six months due to fear of discrimination. In Vietnam, like the other countries, having delayed treatment due to past experience with invasive questions meant that trans people were less likely to have been for a check-up in the previous year (77.6% or 97 individuals, compared to 89.7% or 104 individuals who had not experienced invasive questions). This was associated with a delay in treatment rather than outright avoidance: 15.2% (19 individuals) had their most recent check-up within one to two years (compared to 1.7% or two people who had not experienced invasive questions) – resulting in similar combined totals for the two groups within the last two years.

As in Nepal, Indonesia, and Thailand, trans people in Vietnam who had delayed treatment in the last six months due to past experience of invasive questions were also more likely to delay needed medical care over that time period because they feared further discrimination.

Percentage of respondents who delayed treatment due to fear of discrimination, cross-tabulated with having been previously refused treatment.^{x1}

- Previously refused treatment
- Not refused treatment

Delayed due to fear of discrimination



No Delay due to fear of discrimination



In Vietnam, this was a large difference, with 81.3% of people who had experienced invasive questions also delaying medical care due to fear of discrimination (100 individuals), compared to 20.7% of people who had not experienced invasive questions (24 individuals). Similarly, people who had delayed treatment in the last six months because there was no guidance for trans patients were also more likely to delayed necessary medical care over that time period due to fear of discrimination – 79.7% or 82 individuals, compared to 31.5% or 35 individuals who had not delayed treatment due to the absence of guidance at clinics.

The FGDs for this research project confirmed concerns about intrusive questions and examinations, including within public hospitals where there was very limited privacy.

“They asked me to take off my top. Then they gave me a stigmatised look and gossiped. Other patients joined the gossiping too. The nurse told other people too. I was ashamed.”

TRANS MAN, VIETNAM

The main message that many FGD participants stressed repeatedly was that they wanted to be treated equally when accessing healthcare services.

“I want many things, but the core thing is that I want to be treated equally just like everyone else, with a clearly defined gender. When I say I’m a trans man and want to use these services, I will be able to access those services. There must be a law to protect people like us.”

TRANS MAN, VIETNAM

Practical Stressors

Cost was not an important stressor preventing trans people from accessing general healthcare services in Vietnam. However, as in the other countries, trans people who experienced a distance barrier were more likely to also have delayed treatment due to fear of discrimination (73.4% or 47 individuals), compared to those without this practical barrier (42.5% or 74 individuals – still a high proportion). People experiencing a barrier related to distance were less likely to have one regular provider (4.6% had a particular provider compared to 15.5% of people without a distance barrier). This final finding may indicate that trans people in Vietnam who face a distance barrier have to be more opportunistic in the healthcare providers they see.

Resilience Factors

There were no clear patterns of evidence that resilience factors had an impact on whether trans people in Vietnam sought general healthcare services. Neither being a member of a CBO, nor feelings of trans pride, produced clear differences in trans people’s responses to each of the general healthcare questions.

KEY FINDINGS:

General healthcare check-ups can be the front line for preventing serious or longer-term health issues, and rates of general healthcare usage varied by country.

In Nepal, 70% of trans people had never had a check-up (and most who had a check-up were older). In Indonesia, 31.6% had never received a health check-up (mostly trans women); while the proportion of participants who never received a general health check-up was lower in Thailand (16.4%) and Vietnam (5.3%).

Gender was less prominent in shaping behaviours around general healthcare than in mental and sexual health settings.

Gender was less important in predicting general healthcare use in Nepal than age, and there were few gender differences in Thailand and Vietnam. However, in Indonesia, it was gender- rather than age or sex work that was linked to increased check-ups, having a sole provider, or delaying treatment. Trans women were behind trans men in terms of prevalence and frequency of general healthcare use.

Delaying treatment due to fear of discrimination was a common outcome in the general healthcare setting.

In Nepal, 35% of respondents had delayed needed healthcare due to fear of discrimination, and this figure was higher for trans women, sex workers, and older people. In Indonesia, nearly 40% delayed for this reason, with more sex workers fearing discrimination. The lowest rate of delaying treatment due to fear of discrimination was in Thailand, where only 9% said they had delayed for this reason. (This is an interesting contrast to the finding that fear of stigma and discrimination was the most cited reason for avoiding STI and HIV tests). In Vietnam, nearly 52% of survey participants had delayed treatment because of anticipated discrimination. In Vietnam, most people had check-ups at some point in their life, but gender minority stressors were linked to delaying necessary treatment more recently in life.

Delaying treatment due to invasive questions was a significant stressor reducing healthcare-seeking behaviour across the four countries.

Experiencing discrimination in HIV services led to delays in accessing general healthcare in Nepal and Indonesia, but not Thailand or Vietnam.

Experiencing the stressor of previous assault did not impact general healthcare use (unlike mental healthcare).

The only exception to this finding was Thailand, where people who had been assaulted were also more likely to have delayed needed treatment due to fear of discrimination.

People who delayed general healthcare for one reason were more likely to delay it for other reasons as well.

In Nepal, delaying due to cost/distance or invasive standards was associated with delaying due to fear of discrimination. In Indonesia, people who delayed seeking healthcare due to invasive questions or poor clinic standards were also likely to have delayed due to fear of discrimination. In Thailand, people who delayed seeking healthcare due to cost, distance, invasive questions, or poor standards were also more likely to delay due to fear of discrimination. In Vietnam, people who delayed due to invasive or poor standards, or distance, had also delayed due to fear of discrimination. This is potentially an important finding. Perhaps these individuals are just more avoidant in general. We also propose that avoiding care can lead to further avoidance in the future, with reasons for delaying or avoiding treatment compounding and making seeking healthcare less likely.

SEEKING ADVICE ABOUT GENDER-AFFIRMING HORMONES

Gender-affirming healthcare refers to any form of medical or surgical step that a trans person may take to align their body with their gender, from the point they begin to consider a medical transition. In this section, we focus on differences in trans people's behaviours around seeking and accessing gender-affirming healthcare. Many trans people in this region have very limited access to gender-affirming health services, so the survey data in this section focuses more narrowly on people's behaviour when accessing or considering access to hormones. This section seeks to answer the question:

*Which stressors and
resilience factors are
linked to gender-affirming
healthcare use?*

FOCUS VARIABLES IN THIS SECTION

o1 Gender-affirming Health *and* Healthcare

1. Are you planning to take hormones in the future?
[If Yes] Do you intend to seek medical advice before taking hormones?

o2 Additional Gender-affirming Health Questions Compared *by* Groups

1. Have you ever used hormones?
2. Who first advised you about taking hormones safely?
3. Are you currently taking hormones?

o3 Gender Minority Related Stressors

1. Have you ever been refused treatment or turned away by a doctor or healthcare service provider because of your transgender identity?
2. Have you ever been physically assaulted such that you require medical treatment?
3. Have you experienced discrimination, or discriminatory behaviour from healthcare service providers, when accessing HIV services?
4. In the past 6 months, have you delayed treatment due to past experience of invasive questions?
5. In the past 6 months, have you delayed treatment due to no guidance or standards for transgender patients?

o4 Practical Stressors

1. Delayed treatment in previous 6 months due to cost
2. Delayed treatment in previous 6 months due to distance

o5 Resilience Factors

1. CBO membership (CBO member / Non-CBO member)
2. Identity pride (scale combination of 6 items, analysed as high/low)

NEPAL

Hormone Use Among Survey Participants

Overall, 34% of trans people who participated in the survey had ever used hormones (85 individuals), and 18.8% were currently taking hormones (47%). Of people who had ever taken hormones, 81.7% (67 individuals) received advice from trans friends, 9.8% from a medical/health professional (eight individuals), 7.3% from trans colleagues (six individuals) and one person received no advice. Of people not currently on hormones, 25.1% intended to take hormones in the future (45 individuals). None of the services interviewed for the key informant interviews in Nepal provided trans people with access to hormones or information about their use. This reinforces the reliance on trans friends for advice about gender-affirming hormones.

In Nepal, trans women and people who identified as third gender were more likely to have ever used hormones and were currently on hormones. 43 percent of trans women had ever used hormones (48 individuals), and 36.9% of people who identify as third gender (31 individuals), compared to 9.4% of trans men (five individuals). A lower proportion of trans people were currently on hormones: 25.5% of trans women (28 individuals), 19% of people who identify as third gender (16 individuals), and 5.7% of trans men (three individuals).

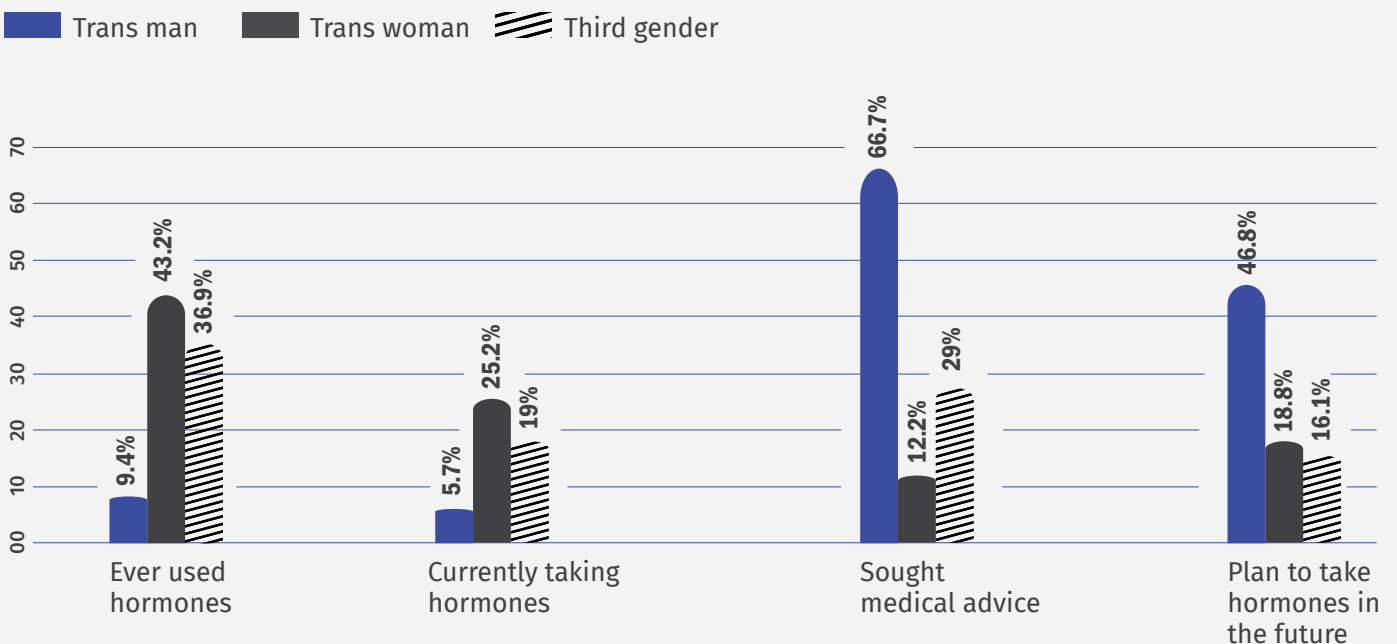
Trans men who had ever taken hormones were more likely to have sought medical advice first (four or five individuals, or 80%), than people who identify as third

gender (two individuals or 6.9%), or trans women (one individual or 2.1%). Instead, trans women and people who identify as third gender sought advice from transgender friends (87.2% of trans women and 86.2% of people who identify as third gender). Likely reflecting lower rates of current use of hormones, a higher proportion of trans men in Nepal intended to take hormones in the future, with 46.7%, or 22 individuals, saying they intended to take hormones, compared to 18.8% of trans women (13 individuals) and 16.1% of people identifying as third gender (10 individuals). 10 percent of trans men were not sure if they wanted to take hormones in the future (five individuals), along with four trans women, and two individuals identifying as third gender.

Sex workers were more likely to have ever taken hormones (66.1% or 37 individuals, compared to 24.7% of non-sex workers or 48 individuals) and to currently be on hormones (42.9% or 24 individuals, compared to 11.9% of non-sex workers, 23 individuals). There were no significant differences in intention to take hormones in the future (22.2% of sex workers and 25.7% of non-sex workers), though 92.3% of non-sex workers intended to seek medical advice prior (36 individuals), compared to 50% or three sex workers who intended to.

In Nepal, there were no differences in the extent to which trans people under the age of 25 were taking hormones or seeking medical advice about hormones, compared to those aged 25 or older.

Percentage of respondents in Nepal reporting general healthcare use, cross-tabulated with gender:^{xii}



Stressors and Resilience Factors Around Hormone Use

Trans people who experienced stress related to belonging to a gender minority were no more or less likely to use hormones, and no more or less likely to intend to seek medical advice. Those decisions do not appear to be affected by trans people's previous experiences of discrimination or invasive questions by a health service provider, lack of guidance for trans patients or assault.

Likewise, the one resilience measure used in this section, CBO membership, was not linked to trans people's behaviour or intentions around hormone use and medical advice. Nor did practical barriers of cost or distance affect whether trans people sought medical advice about current or intended hormone use.

This suggests that, in Nepal, trans people's behaviour in terms of seeking gender-affirming healthcare is linked

to factors other than gender minority stress, resilience or practical barriers, unlike behaviours around mental, sexual, and general healthcare.

The next section explores the broader context of gender-affirming care in Nepal, to further explore the barriers trans people in Nepal face trying to access such care. It draws from the FGDs for this project and baseline data that APTN collected just prior to the **From Barriers to Bridges**^{xiii} conference held in September 2017 and subsequently published as the **Regional Mapping Report on Trans Health, Rights and Development in Asia**. The concluding discussion at the end of this report further explores other potential factors that influence trans people's experiences trying to access gender-affirming care in Nepal, Indonesia, Thailand and Vietnam.

Qualitative Findings About Access To Gender-Affirming Care

Given the limited quantitative findings concerning gender-affirming care, we flesh out quantitative data using findings from FGDs conducted during the KPRA project to bring visibility to an issue frequently identified by participants as an important facet of inclusive trans healthcare.

In Nepal, gender-affirming healthcare is legal but unregulated. In late 2017, it was reported that the only form of hormones available in Nepal for trans women and third gender people, such as metis, were birth control pills from the pharmacy. A few doctors prescribed these and provided bloodwork to monitor hormone levels, but only in the capital city of Kathmandu. They were not available through CBOs but were generally affordable. Other forms of estrogen and anti-androgens were not available for trans women. There were no forms of testosterone available within Nepal for trans men. When specific hormones were not available domestically, and had to be purchased overseas, they were expensive and unaffordable. There is no insurance cover for gender-affirming hormones or surgeries in Nepal.

Participants in the FGDs for this KPRA research project in late 2018-2019 confirmed that they could not find or afford transition-related services. Almost all the trans youth had no information about hormones, and did not think there was a hormone specialist in Nepal. Therefore, people relied on each other for information. If people could afford to buy hormones, it was usually from overseas. People self-medicated, often taking higher doses in the hope that it would speed up changes. It was often hard for people to afford the advised three monthly checks of their hormone levels. One HIV+ trans woman stopped taking hormones after her doctor said it might damage her liver. Another trans woman shared this experience:

“I took female hormones for six months. Instead of one pill, I had two pills per day just because I wanted to grow breasts. I was not aware about side effects. Everyone used to have so I followed them. Though it's already been 10 years that I had hormones, the side effects have not left me yet.”

TRANS WOMAN, NEPAL

There is only one private clinic in Kathmandu that provides limited gender-affirming surgeries; the Cosmed Laser and Cosmetic Surgery Centre. It performs breast augmentation surgeries and orchiectomies for trans women, and top surgery for trans men.

The clinic does not provide genital reconstruction surgeries. While it provides pre-surgery referrals and post-surgery treatment, the clinic does not provide any counselling services to clients either before or after surgeries. With no explicit gender-affirming healthcare providers in Nepal, there are also no formal eligibility requirements (such as a diagnosis) or regulations governing the provision of this care. Most young people in the FGDs wanted hormones and gender-affirming surgeries, but all said it was not accessible for them due to the cost and lack of family support. Trans women knew friends who had breast augmentation surgery (implants) in Nepal, though people would usually go to Bangkok or India.

As this material shows, the most pressing barriers to accessing gender-affirming healthcare in Nepal are the very limited availability of services, lack of information about possible options, and the high costs.

INDONESIA

Hormone Use Amongst Survey Participants

A larger number of trans people in Indonesia had used hormones than in Nepal, with 73.6% of people surveyed saying they had ever used hormones (184 individuals). The majority who had ever taken hormones had sought advice from transgender friends (90.1% or 164 individuals), with 2.7% (five individuals) receiving no advice, and 1.1% (two individuals) seeking medical advice.

In Indonesia, warias providing access to hormones are known as mak-makan. Participants in the FGDs for this KPRA research described the relative ease of accessing hormones through mak-makan compared to potential barriers at more regulated clinics. These barriers included less knowledge about gender-affirming hormones and prejudice against trans women and warias.

“...After several times visiting the place, the clinic people forbade me. Sis, sorry, now the doctor is here. The doctor said waria are not allowed to be here. Waria are against nature. . . . The midwife told me that she was only passing a message from the doctor that, “Contraceptives are for women, not for men.” In the end, I need to find another place, a friendly place... I tried to seek again, to a midwife. She used to work in PKM Kramat Jati. She knew that I am a waria. She takes me as I am. She said, “If you want to take an injection, it is no problem, but it must be dose-appropriate. Do not take more than that.” So, it is difficult to find a friendly midwife...”

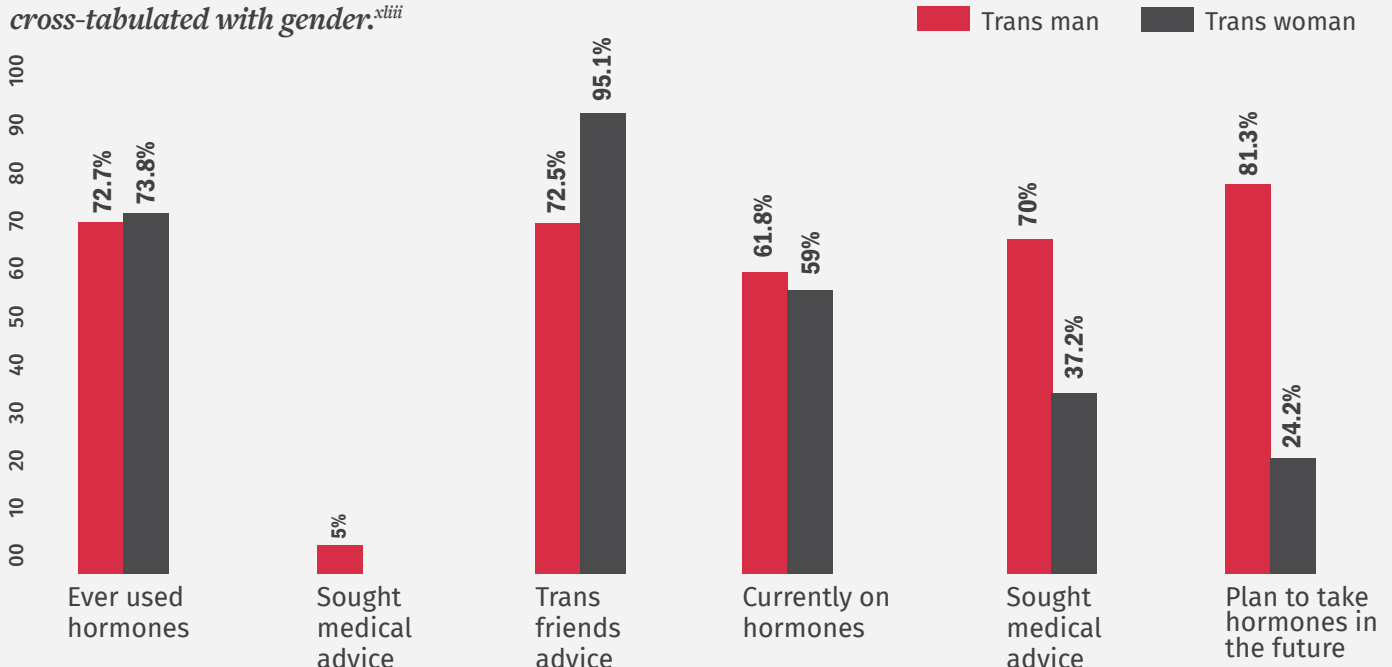
WARIA, INDONESIA

Currently, 59.6% were taking hormones (149 individuals), and 29.3% (53 individuals) intended to take hormones in the future. The majority of those who intended to take hormones in the future intended to seek medical advice first (73.6% or 39 individuals), though 7.5% (four individuals) did not intend to, and 18.9% (10 individuals) were not sure.

Similar proportions of trans men and women in Indonesia had ever taken hormones (72.7% of trans men, 40 individuals; and 73.8% of trans women, 144 individuals). More trans women had sought advice from trans friends (95.1% or 135 individuals, compared to 72.5% of trans men or 29 individuals). Two trans men had sought medical advice first, and no trans women had sought medical advice.

Similar proportions of trans men and women were currently on hormones (61.8% of trans men, 34 individuals; and 59% of trans women, 115 individuals), though 81.3% of trans men who had never taken or were not currently on hormones, intended to take hormones in the future (13 individuals), compared to 24.2% of trans women (40 individuals). The majority of trans women who had never taken or were not currently on hormones, were not sure if they wanted to take hormones in the future (66.1% or 109 individuals). All 13 trans men who intended to take hormones in the future also intended to seek medical advice first, compared to 65% of trans women intending to take hormones in the future (26 individuals)

Percentage of respondents in Indonesia reporting hormone use and medical advice, cross-tabulated with gender.^{xliii}



There were no age differences in past or current use of hormones in Indonesia, though more trans people under 25 intended to take hormones in the future (54.8% or 17 individuals, compared to 24% of people over 25 years old, or 36 individuals). Trans people under 25 were more likely to say they did not know whether they would seek medical advice before taking hormones in the future (35.3% or six individuals, compared to 11.1% or four individuals over 25).

Unlike in Nepal, trans sex workers in Indonesia were no more likely than non-sex workers to have ever taken or currently be on hormones (e.g., 77.4% of sex workers had ever taken hormones, 113 individuals, and 68.3% of non-sex workers, 71 individuals). However, sex workers were more likely to have sought advice from transgender friends beforehand (98.2% of those who had taken hormones, or 110 individuals, compared to 77.1% of non-sex workers, or 54 individuals). Non-sex workers also did self-research (4.3% or three individuals) and sought other non-specified sources of advice (8.6% or six individuals). Equal proportions of trans sex workers and non-sex workers in Indonesia intended to take hormones in the future (26% and 37% respectively, and this difference was not statistically significant). However, more non-sex workers who intended to take hormones in the future also intended to seek medical advice first (90.5% or 19 individuals), compared to sex workers (62.5%, or 20 individuals, intended to seek medical advice first). 30 of sex workers who intended to take hormones in the future were not sure whether they would seek medical advice.

Stressors And Resilience Factors Around Hormone Use

Like in Nepal, it does not appear that trans people who experienced stressors relating to their gender minority status changed their behaviours around intention and use of hormones, or intention to seek medical advice before starting hormones. Those decisions do not seem to be affected by trans people's previous experiences of discrimination or invasive questions by a health service provider, lack of guidance for trans patients, or assault.

CBO members in Indonesia were less likely to have ever used hormones than non-CBO members (66.3% or 61 individuals, compared to 77.8% or 123 non-CBO members), and people who had never taken or were not currently on hormones were more likely to wish to use them in the future (40.6% of CBO members or 26 individuals, compared to 23.1% of non-CBO members or 27 individuals).

Practical barriers of delaying treatment due to cost or distance were not associated with seeking medical advice before taking hormones.

These findings reinforce the conclusion from Nepal that when trans people avoid medical advice prior to taking hormones, it is not necessarily due to their experiences of gender minority stress. Instead, other factors, such as the availability and accessibility of well-informed and trans-inclusive healthcare providers, are likely to drive whether trans people seek out such advice.

Qualitative Findings About Access To Gender-Affirming Care^{xiv}

Gender-affirming healthcare is also legal but unregulated in Indonesia. In late 2017, it was reported that estrogens and anti-androgens were available for trans women and testosterone for trans men. This included some access to hormones through CBOs, and through prescriptions from doctors who could monitor blood test results. For trans women, a diagnosis was not always needed to access hormones and estrogen was affordable but anti-androgens were not. Gender-affirming surgeries were available but there was no health insurance covering the cost of surgeries or hormones.

The FGDs organised for this KPRA project in late 2018-2019 provided further details about access to gender-affirming hormones and surgeries. While some trans women and warias had accessed the KB contraceptive injection from a midwife at the family planning clinic, there was a risk. They would be denied access if the doctor was aware this was happening.

“ . . . when there was a doctor here, he said there should be no waria here because they violated nature, KB was for women not for men...”

WARIA, INDONESIA

FGD participants said that there are some midwives who provide hormones. They may also buy them directly from fellow warias, known as mak-makan who provide hormone and silicone injections in salons or in their home. Most adult warias access hormones from pharmacies or drugstore stores in one of the big markets in Jakarta.^{xiv} These hormones may be fake or past their expiry date. FGD participants relied on the belief that, if packaged hormones had Thai script on the outside, it guaranteed that they would be safe. One participant shared that trans people have to accept the risk of taking these hormones because it costs too much to go to a medical facility to check if they are safe.

For most trans women and warias, the silicone injections or implants were the sole preferred option to enlarge their breasts. This raises very significant health risks and quality concerns. Only a few warias can afford a breast surgeon. Even then, this is not usually done in Indonesia because of high costs.

Younger trans men still lack information about what gender-affirming care and rely on advice and contacts through older community members. However, access to gender-affirming care is at the discretion of individual health professionals, and needs to be done discreetly. As one participant explained:

“ . . . there are doctors who are friendly to transgender people, but because of the political situation in this country, once there is an LGBT issue, they say please do not contact again”

TRANS MEN, INDONESIA

Most trans men in Indonesia started their medical transition by consulting a psychiatrist, in order to access testosterone or a recommendation letter for surgery. Doctors often rejected such requests, saying that these conflicted with their values or the laws of nature. Some tried to convince trans people to not transition. This means trans men buy hormone drugs from online stores, and inject the hormones themselves to save money. FGD participants stressed that they followed the written dosage instructions, particularly because they knew that higher doses of testosterone would not be helpful as their body would convert it into estrogen and become more feminine.

THAILAND

Hormone Use Amongst Survey Participants

The majority of trans people in Thailand had used hormones at some point during their lives (80.9% or 203 individuals). Most relied on advice from trans friends (65% or 132 individuals), though more trans people in Thailand said they had never received advice (19.7% or 40 individuals), sought help from trans colleagues (5.9% or 12 individuals), or done self-research (3.9% or eight individuals). Most who had ever taken hormones were currently on hormones (69.5% or 141 individuals). Of people who had never taken hormones, 29.9% intended to take them in the future (45% or 49 individuals did not intend to take them in the future, and 25.7% were not sure).

Roughly equal proportions of trans people in Thailand not currently on hormones either intended to take them in the future (29.4% or 32 individuals) or were not sure (25.7% or 28 individuals). The majority of those wanting to take hormones in the future also intended to seek medical advice first (68.8% or 22 individuals), though 28.1% did not intend to seek medical advice (nine individuals). One individual did not know whether they wanted to seek medical advice in the future.

As mentioned in previous sections, there were only 15 trans men surveyed in Thailand, limiting conclusions about gender differences in hormone use and medical advice. More trans women (91.6% or 197 individuals) had ever taken hormones, compared to 40% of trans men (six individuals), and no people who identified as third gender. Trans women who had taken hormones tended to seek advice from trans friends (66% or 130 individuals, compared to 33.3% of trans men or two individuals). Two trans men did self-research (33%) compared to six trans women (3%), and one trans man sought online support. There were no gender differences in intention to use hormones or seek medical advice.

Age and sex work did not consistently change rates of hormone use or related medical advice. More trans people under 25 were currently on hormones (79.7% or 55 individuals) than people over 25 (64.3% or 86 individuals). Fewer sex workers (55% or 22 individuals) were currently taking hormones than non-sex workers (73% or 119 individuals), though more sex workers were planning to in the future (56.5% or 13 individuals, compared to 22.1% or 19 people not in sex work). There were no differences in past or future intention to seek medical advice.

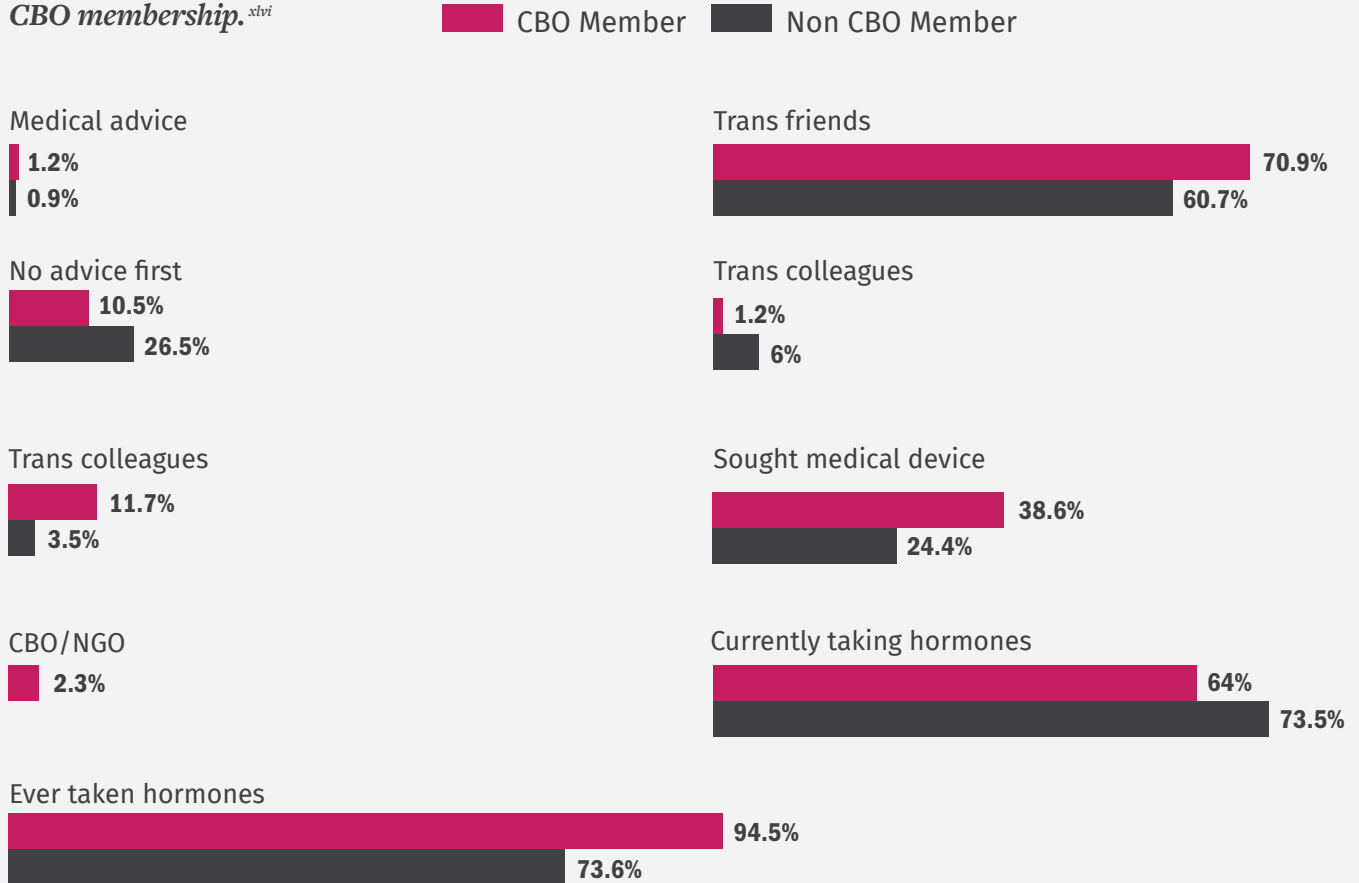
Stressors And Resilience Factors Around Hormone Use

In Thailand, there were no differences in patterns of hormone use, including seeking related medical advice, between trans people who had experienced gender minority related stressors and those who had not faced such discrimination or invasive questions by a health service provider, assault, or lack of guidance for trans patients. This echoes the results from Nepal and Indonesia.

More CBO members had taken hormones in the past than non-CBO members (94.5% or 86 individuals compared to 73.6%, or 117 individuals, who did not belong to a CBO). CBO members were also more likely to have received at least some advice prior to taking hormones in the past, with 26.5% of non-CBO members receiving no advice (31 individuals), compared to 10.5% of CBO members (9 individuals). Instead, CBO members in Thailand sought advice at higher rates from trans colleagues than non-CBO members (10.5% compared to 2.6%). This is a clear relationship between having support structures available, such as trans colleagues, and being able to seek informal advice about gender-affirming care that might not otherwise be available. There were no other differences between CBO and non-CBO members.

In Thailand, trans people experiencing cost barriers were less likely to currently be on hormones than those without (41.7% of people with cost barriers, 10 individuals, compared to 73.2% of people without cost barriers, 131 individuals). Otherwise, facing practical barriers, including distance from care or lack of insurance) did not appear to impact trans people's use of hormones or intentions to seek medical advice. These findings support conclusions from Nepal and Indonesia that trans people's use of hormones and seeking of associated medical advice are motivated by factors other than gender minority stress, resilience or practical barriers.

Percentage of respondents in Thailand reporting hormone use and medical advice, cross-tabulated with CBO membership.^{xlvi}



Qualitative Findings About Access To Gender-Affirming Care^{xlvii}

Gender-affirming healthcare is legal in Thailand but remains unregulated for those living in Thailand. Hormone therapy is mentioned briefly in a 2009 Medical Council Regulation, which does not require a diagnosis before someone can be prescribed hormones. Trans people can purchase many types of estrogen, anti-androgens and testosterone from drug stores in Thailand. Cheaper hormones are affordable, but the regional mapping report in 2017 noted concerns that some of these are no longer recommended because of possible side-effects. Some doctors prescribe hormones and monitor blood test results. The Gen-V clinic was working with adolescents aged from 10-24. The 2017 regional mapping report noted that hormones were not available through CBOs at that time, and that the costs of getting access to hormones or having surgeries were not covered by health insurance.

Guidelines around access to gender-affirming surgeries only apply to people travelling to Thailand from other countries for these procedures. Surgeons in Bangkok require trans people from overseas to provide a referral letter from one, possibly two, mental health professionals before they can access gender-affirming surgeries.

Information from the KPRA FGDs in 2018-19 confirmed the wide range of gender-affirming healthcare services in Thailand from general beauty clinics, plastic surgery clinics, and more expensive private hospitals for those who could afford them. Often trans people would search for information from their peers or online, even though some of this information was not reliable.

VIETNAM

Hormone Use Among Survey Participants

A smaller number of trans people used hormones in Vietnam than in the other countries. 39% of trans people had ever used hormones (96 individuals), and 34.1% (84 individuals) currently took hormones.

Like in other countries, most people who had ever taken hormones had sought advice from trans friends (34.4% or 33 individuals). Unlike other countries, in Vietnam, trans people were more likely to consult other sources of advice: self-research (25% or 24 individuals), trans colleagues (16.7% or 16 individuals), and online support groups (12.5% or 12 individuals). Three individuals had sought medical advice before taking hormones in the past. Of people not currently on hormones, 55.3% intended to take them in the future (104 individuals), and 78.6% of those intending to take hormones in the future also intended to seek medical advice (81 individuals).

In Vietnam, gender identity and age were not associated with behaviours for trans people around hormone use and seeking related medical advice. There were only six sex workers surveyed in Vietnam. All but one currently used hormones (compared to 32.9% of non-sex workers who were using hormones, or 79 individuals).

Stressors And Resilience Factors Around Hormone Use

As in the other countries, trans people in Vietnam who experienced stressors associated with belonging to a gender minority typically did not indicate different behaviours around use of hormones, or intention to seek related medical advice. However, a higher proportion of trans people who had delayed treatment in the previous six months due to past experience of invasive questions were unsure about seeking medical advice about taking hormones in the future (12.1% or seven individuals). Those who had not experienced invasive questions had much higher intentions of seeking medical advice (86.4% or 38 individuals) than not (13.6% or six individuals).

Trans people who faced practical barriers (both distance and cost) were more likely to currently be on hormones than people who did not face practical barriers. Facing practical barriers did not have an impact on trans people in Vietnam seeking medical advice around using hormones in the past, or intentions to seek it in the future.

Overall, few patterns were associated in Vietnam between demographics, stressors, resilience factors, and the use of hormones. Potentially the smaller proportion of people who used hormones in Vietnam meant that the patterns could not be observed at a level that reached statistical significance. Alternatively, it may be the case that for trans people in Vietnam, hormone use and associated medical advice sit outside the explanatory factors that could be measured in this model, and are influenced by broader issues including the very recent shift from gender-affirming care being illegal and the yet to be developed health frameworks supporting access to hormones and surgeries.

Qualitative Findings About Access To Gender-Affirming Care^{xviii}

Vietnam stands out from the other three countries in this report because it is emerging from a situation where gender-affirming healthcare for trans people, specifically surgeries, were illegal under Article 37 of its Civil Code until 2015.^{xix} On 24 November 2015, the Vietnamese National Assembly approved a bill that amended the Civil Code, legalising such surgeries and introducing the right to legal gender recognition for trans people who have undergone these procedures.ⁱ

In late 2017, it was reported that hormones are available through private pharmacies, online, or by purchasing from overseas. The types of hormones mentioned were contraceptive pills for trans women, and injections (presumably testosterone for trans men and possibly estrogen for trans women). While hormones were not available through CBOs, several in the two largest cities of Hanoi and Ho Chi Minh City provide counselling on hormone use. There is very limited access to doctors for prescriptions, bloodwork, or monitoring of hormone use. There is no health insurance available to cover the cost of access to hormones.

An FGD in late 2018-19, as part of this KPRAs research, identified major gaps in official information available in Vietnam about gender-affirming healthcare. Under current Vietnam law, it is only legal to prescribe hormones to someone who is diagnosed with an endocrine disorder. While testing of hormones levels is routinely available in hospitals, doctors do not have expertise on trans health. In this legal context, which does not authorise doctors to provide consultations or prescribe hormones for trans people, only a few medical facilities do so unofficially. The cost excludes many trans people. As a result, trans people access hormones informally, in a way that is unregulated and unmonitored. Most trans people relied on other community members for information about hormones, and how to self-inject them. FGD participants who wanted medical advice, before or after starting hormones, struggled to find health professionals in Hanoi with the relevant knowledge.

While it is no longer illegal to perform gender-affirming surgeries in Vietnam, the Bill in 2015 was just the first step in the long process for developing laws under Vietnam's legal system. Although the Civil Code took effect in 2017, an additional law must be enacted to give effect to Article 37. This is not officially scheduled in the law-making agenda of the National Assembly as of 2018-2019, and therefore this right cannot practically be realised. The

KPRA report summarising material from the FGDs in 2018-19 confirmed that medical facilities began to openly and unofficially provide gender-affirming surgeries to trans people after the Civil Code 2015 was passed, even though the relevant provision arguably applies only to intersex people. Gender-affirming surgeries are considered to be cosmetic procedures so, for hospitals to meet the Civil Code requirements, a trans person's medical records would need to show evidence of a congenital defect or disease justifying removal of tissue and/or reconstructive surgery.

The key informants interviewed for the KPRAs research identified only one private healthcare facility providing gender-affirming surgeries in Hanoi. However, they noted that this hospital did not provide counselling or mental health support. A representative from the hospital stated in their interview:

“At the moment, I do not have any applicant who is a psychologist. For trans people, we need a very specified counsellor/psychologist who knows and understands the needs of this community. I do not know anyone that is qualified for recruitment.”

HEALTH PROFESSIONAL, VIETNAM

This reliance on unofficial practices also has implications for Vietnam's current legal gender recognition proposals. Without any confirmation from medical facilities that they have undergone gender-affirming surgeries, trans people will not be able to change their civil status.ⁱⁱ

The legal steps required to develop a draft law is still ongoing in 2020. Until it is completed, there is no guidance available to the Ministry of Health on implementation of the draft provisions, or to healthcare providers about how to provide gender-affirming healthcare services.ⁱⁱⁱ In addition, there is no post-surgery care or legal framework to protect trans people and their right to sue if there are any surgical complications. Instead, such underground surgeries are typically a one-time arrangement between the trans person and the doctor or medical facility, with no guarantees or contractual terms to protect the health of trans people. Trans people who can afford surgeries often choose to go Thailand where the costs are lower, and surgeons are likely to be more experienced.

KEY FINDINGS:

Hormone use was highest in Thailand and Indonesia, and more people had taken hormones in the past than currently used them.

In Thailand, 80% of respondents had ever used hormones, and 52% used them currently; in Indonesia, 74% had ever used hormones, and 60% used them currently; and in Nepal, 34% had ever used hormones, and 19% currently used them. Likely due to the very recent availability of gender-affirming hormones in Vietnam, 39% of respondents had ever used hormones, and 34% used them currently.

The important variable of interest-seeking medical advice prior to taking hormones was not linked to experiencing gender minority stress or resilience factors across the four countries.

Noting the limited data in this section, we did not find that gender minority stress was linked to decreased use of medical advice around taking hormones. Nor did the proposed resilience factors encourage use of medical advice around hormone use. Further research is recommended in this area to explore whether gender minority stressors other than those in this report, applied to a broader range of gender-affirming healthcare services, may reveal further insights around requirements for creative trans-inclusive gender-affirming healthcare for those who want it.

First use of hormones is the most medically unregulated.

Across the four countries, first hormone use tended to be through informal sources, though more transgender people sought medical advice before currently taking hormones.

In Nepal, advice on first hormone use was largely from trans friends (80%), with only 10% seeking medical advice first. For those currently on hormones in Nepal, the proportion seeking medical advice before starting hormones rose to 30%. In Indonesia, 92% sought advice from transgender friends on first hormone use and only 1.1% sought medical advice, but this rose to 44.3% of those currently taking hormones. In Thailand, the majority (65%) sought advice from friends on first hormone use, or from no one (16%), but 30% of those currently on hormones sought medical advice first. In Vietnam, respondents consulted more diverse sources on hormone use (internet, friends, colleagues, self-research), but only 3.1% sought medical advice. For those taking hormones currently, 38% sought medical advice first. Increased medical consultation is promising, where it is helpful and inclusive, but the first use of hormones is where the largest risk lies.

CONCLUDING DISCUSSION

This report has sought to address one core research question: What are the stressors and resilience factors that impact on trans people's health, and their use of different healthcare services?

The findings presented above convey a rich, multi-faceted story. This concluding discussion reflects on some of the key findings, within the context of what we know about healthcare services in Indonesia, Nepal, Thailand and Vietnam, as the evidence base for recommendations that follow. These focus on ways to reduce the practical barriers and stressors that trans people are facing across this region, and to bolster their resilience, in order to improve trans people's health outcomes and ability to access trans-competent general, mental, sexual and gender-affirming healthcare.

TRANS PEOPLE'S RIGHT TO HEALTH IS COMPROMISED ACROSS THE REGION.

Human rights standards require that healthcare and the underlying determinants of health must be available, accessible, and acceptable to all people, and of quality^{lviii}. This is referred to as the AAAQ framework for the right to health and requires health services to be:

Available: Enough functioning public health services and programmes are available.

Accessible: Services and facilities do not discriminate, are physically accessible, affordable, and people are aware of them.

Acceptable: Services must respect medical ethics, be culturally appropriate and respect confidentiality.

Quality: Services must be scientifically and medically appropriate, and of good quality.

This report has highlighted gaps in the availability of services, particularly gender-affirming care; discrimination and cost barriers that undermine accessibility; and acceptability issues due to lack of guidance about providing services in ways that are culturally competent for trans people.

This research is the first to proactively seek to quantify whether there are differences between the health experiences of trans men and trans women (including those who identify with culturally specific terms such as waria / transpuan and meti). The clear answer is yes, as explained in more detail in each of the sections below.

There are lessons to be learnt from some successful targeted interventions for trans women, including those linked to strong CBOs led by trans women. There is also the need to develop initiatives that respond to the different needs of trans men.

STIGMA AND DISCRIMINATION LIMIT TRANS PEOPLE'S ACCESS TO GENERAL HEALTHCARE SERVICES.

In all four countries covered by this regional report, trans people conveyed their experiences of discrimination, and how they had delayed seeking necessary general healthcare because they continued to fear negative treatment. This was despite international human rights obligations and domestic provisions confirming trans people's right to access health services. For example, In Indonesia, access to healthcare is covered under Law No. 36 on Healthcare, which sets out the right of every citizen to receive healthcare, have access to healthcare services, and determine the healthcare services they need.^{lviv} These provisions expect healthcare professionals to provide necessary services without any discrimination.

Trans women, trans men and other gender diverse people all shared similar experiences of discrimination and exclusion within general healthcare settings, with few of the gender distinctions that emerged when looking at sexual, mental and gender-affirming healthcare.

For trans people in these four countries, discrimination (including refusing to provide treatment) was a stronger barrier preventing access to healthcare services than practical issues such as cost, distance and lack of health insurance. This discrimination is expressed both in the personal interactions of healthcare professionals and by systemic healthcare barriers. For example, many trans people in Indonesia, particularly waria / transpuan, have been rejected by their families, and therefore have no access to the household's Kartu Keluarga / Family Card that is needed to register for healthcare, including HIV services.

The Nepal country report highlighted the systemic lack of access to health insurance. While Nepal legislated a new public health insurance plan that started in 2016-2017, data from the Health Insurance Board showed that, by June 2018, the programme was yet to cover 38 districts out of 77.^{lv} Of the 250 trans people who were interviewed for this Nepal study in November-December 2018, the vast majority (88.8% or 222 participants) reported having

no health insurance. Only nine trans people interviewed in Nepal were covered by the national health insurance scheme.

Trans people expressed fear of discrimination as a main reason for delaying general healthcare treatment. This anticipatory discrimination results in trans people not getting the healthcare they need because they do not access health services, do not provide the relevant information to their health service provider and, as a result, the healthcare provider cannot meet their needs. In the FGDs, participants reported stigma and discrimination (including use of derogatory and mocking terms) when accessing general health services. Others shared stories of breach of privacy, ridicule, and lack of knowledge about trans healthcare.

Previous studies have found that healthcare providers generally lack training about meeting the health needs of trans people.^{lvi} Providing such trans-competent care requires both trans cultural competency and technical, clinical competency:

1. Trans-cultural competency: the ability to understand, communicate with, and effectively interact with trans people, in a respectful, non-judgemental, compassionate manner, in settings free of stigma and discrimination^{lvii}
2. Trans-clinical competency: encompasses both training in the specific medical needs of trans people and helping providers understand that many aspects of medical care for trans people (including hormone treatment and basic primary and preventive care) are similar to the services they offer to cisgender patients^{lviii}

The absence of knowledgeable service providers, and their lack of training in providing trans-competent care, is a formidable barrier that needs to be addressed and eliminated.^{lix}

TRANS PEOPLE DESPERATELY NEED MENTAL HEALTH SUPPORT SERVICES.

This research shows that discrimination has strongly affected trans people's mental health, and whether they have sought mental health services. These impacts were particularly stark for young people but also potentially have long-term impacts throughout trans people's lives. Country reports highlighted that trans young people typically knew they were different from their peers at a young age. They identified as trans for an average of at least two years, sometimes much longer, before they disclosed their identity to anyone else. This suggests that

many faced the initial challenges of developing their identity and life as a trans person alone.

In Vietnam, for example, trans people typically self-identified their gender at the age of 14 but did not reach out to another person until they were aged 17 or 18. The Vietnam country report highlighted the need for early counselling support, particularly because 15 years old was the average age when trans people in Vietnam had first attempted suicide. Young people, aged 18 to 25, also had worse mental health outcomes in both Nepal and Indonesia, compared to those over the age of 25.

GENDER MINORITY STRESSORS

Mental health outcomes were worse in all four countries for trans people who experienced the stressors analysed in this report. Those who have ever been refused treatment because of their gender identity were more likely to have depression or anxiety symptoms currently or to have received such a diagnosis. In most countries, those who had ever been refused treatment were also more likely to have thought about or attempted suicide. Across all four countries, low numbers of trans people reported having sought help after contemplating or attempting suicide.

Discrimination experienced in one area of health (e.g. when seeking HIV services) impacted negatively on whether trans people would seek other forms of healthcare (such as mental health services), and on their mental health outcomes. Repeated encounters with a discriminatory healthcare system increased the likelihood of having further negative experiences. This vicious cycle undermined trust in healthcare providers and meant that, even where mental health services were available, many trans people were likely to avoid them. High numbers of trans people in all countries experienced symptoms of anxiety and depression, yet much less than one-fifth of all participants had ever received counselling. Few had ever received a depression or anxiety diagnosis. Those who had delayed healthcare treatment when there was no guidance about supporting trans patients were also more likely to have negative mental health outcomes. Providing such guidance is an obvious gap that needs to be filled.

PRACTICAL STRESSORS

Practical stressors reduced accessibility further. Those facing cost and distance barriers generally had worse mental health outcomes, and were less likely to use mental health services.

RESILIENCE

This study looked at CBO membership and feelings of identity pride as possible measures of resilience for trans people. In all countries, but Nepal, CBO members were slightly more likely to have accessed counselling. However, there were no consistent links between CBO membership and mental health outcomes or use of mental health services. This suggests there may be specific counterbalancing stressors linked to being a CBO member or proud trans person, particularly in countries where trans communities and identities are under attack. In Indonesia specifically, there was little evidence for resilience associated with CBO membership or feelings of identity pride. CBO members and participants with higher levels of pride in Indonesia experienced worse mental health, and were less likely to have accessed mental health services. Healthcare professionals in Indonesia who had stronger links to CBOs were identified as being more trans-friendly, in contrast to those who refused to provide treatment on religious morality grounds.

DIFFERENT GROUPS OF TRANS PEOPLE

Overall, gender was the most important demographic factor when comparing which groups of trans people had the worse mental health outcomes or how likely they were to seek out mental health services. Typically, trans men had worse mental health outcomes and were less likely to have sought mental healthcare, especially in Nepal and Indonesia. Trans men were particularly at risk in Nepal, with higher rates of anxiety and depression symptoms, and less access to professional mental health services. Trans men in Nepal were the group most likely to have ever thought about ending their life, but least likely to have sought help afterwards. Sex work status had mixed effects on mental health and healthcare outcomes. There is some suggestion that HIV services targeted at sex workers may provide some protective support for sex workers' mental health.

In summary, the discrimination that people had experienced from a doctor or HIV service provider was a key reason why mental healthcare services were not accessible for many trans people. Lack of trans-competent guidance or practices also reduced the acceptability of such services. One healthcare provider interviewed for the Vietnam country report expressed interest in

developing trans competency training for psychologists, through Masters and doctorate level curricula, once the new legal framework that applies to gender-affirming healthcare there is finalised. Finally, there were simply not enough mental health services available in any of the countries, including for young people who desperately needed that support.

THERE ARE GAPS IN SEXUAL HEALTH SERVICES FOR TRANS WOMEN AND NO SERVICES TARGETED AT TRANS MEN.

Across the four countries, HIV and STI services are provided by hospitals, private clinics and CBOs. The public health focus on targeted interventions for trans women relies heavily on testing and treatment, with limited prevention services apart from condoms and lubricants. PrEP is available to trans women in three of the countries -- Nepal, Vietnam and Thailand.

HIV AND STI TESTING AND TREATMENT SERVICES

Across all four countries, the majority of trans people were aware of HIV and STI transmission and over 50% had been tested, especially trans women and sex workers. In Indonesia and Nepal, sex workers were more likely to have been tested for HIV, confirming that targeted initiatives were reaching populations most at risk for acquiring HIV. According to the results in the survey 75 to 80% had been tested for HIV, and a high percentage were getting tested either every three months or twice a year. Trans people typically preferred to be tested through CBOs, where they were familiar with the people and services.

Of concern were those respondents that did not get tested and expressed confidence that they had not been exposed or did not want to think about HIV, demonstrating the continued and urgent need for outreach. In all four countries, few if any trans men were accessing HIV-related information or testing. This is particularly concerning in Nepal where 16.7% of the trans men who had been tested (three individuals) were HIV-positive. This finding is not surprising given the lack of research or targeted information focused on trans men's sexual health, bodily diversity, or risks in relation to their sexual practices. In FGDs, trans men disclosed that, due to limited finances, they stored and reused needles for hormone injections, and sometimes even shared them with other trans men. They also shared needles for tattooing. These findings suggest that targeted community-led sexual health promotion and testing strategies are needed for trans men.

HIV COMBINATION-PREVENTION SERVICES

Target 6 of the UNAIDS Fast-Track strategy 2016-2021 aims to reach 90% of key populations, including trans people with combination prevention strategies.^{lxv} However, this target is not being met in any of the four countries. Around 10% of respondents were not utilising any physical or psychological prevention methods. Less than one quarter to one-half of the respondents were utilising three of the six physical prevention methods.^{lxvi} Trans women used more prevention methods (3.2) than trans men (1.0), and those aged over 25 used more (2.9) than 18-25 years old (2.2). The lower number of physical prevention methods used by young people is concerning, given that UNAIDS target 4 is to reach 90% of young people with combination prevention and SRH services.

Similarly, the regional summary confirms higher and more frequent use of combination-prevention services among trans women and third gender respondents in Nepal. Trans women, older participants, and/or sex workers in Indonesia had higher HIV-related knowledge and healthcare-seeking behaviour. However, PEP and PrEP remain a gap for these groups. In Thailand, there were significant differences in the HIV services that trans women accessed compared to trans men, including that trans women were more likely to receive counselling on HIV risks or on SRHR. Trans men, younger people, and non-sex workers – and the overlaps between these groups – remain at significant risk given these patterns of findings, in terms of both knowledge and behaviour relating to HIV prevention and management.

GENDER-AFFIRMING HEALTHCARE IS VERY LIMITED AND UNREGULATED.

Access to gender-affirming healthcare is largely unregulated in three of the countries covered by this report (Thailand, Indonesia and Nepal), and is in the process of being regulated in Vietnam after a history of being illegal. In all four countries, this means that trans people are typically navigating access to gender-affirming care with very limited information and few, if any, formal health pathways.

This concluding discussion focuses on use of gender-affirming hormones, as that is the initial priority in the region. Many trans people have no access to any forms of gender-affirming surgeries. It is also the measure used in our analysis to see whether discrimination and other stressors or practical barriers have an impact on whether trans people try to access to gender-affirming

care, and any difference that resilience makes. The specific measure we considered is whether trans people seek, or intend to seek, medical advice from a doctor before starting hormones. For example, do trans people who experience gender minority stress when they access general healthcare or HIV-related services then avoid seeking medical advice prior to taking hormones?

What is clear from trans people's survey responses and the FGDs is that gender-affirming healthcare stands apart from experiences in other healthcare settings. Obtaining access to gender-affirming hormones is a high priority for trans people in Nepal, Vietnam, Indonesia and Thailand, yet may involve little contact with formal healthcare settings. The journeys are quite distinct for trans women and trans men, for two key reasons – relative availability of hormones, including access to information about them, and affordability.

Till the last decade, the only visible trans communities within all four countries were trans women, metis, and warias/transpuan. In each of the countries involved in this research, trans women have access to estrogen through oral contraceptives.^{lxvii} While these are not the medically recommended form of estrogen,^{lxviii} over the counter and online purchases have made it possible for more trans women in the region to start physically transitioning. They have also built strong networks of experienced trans women who pass on information to others about finding and taking hormones.

The standard medical advice for gender-affirming hormones is for trans women to have access to anti-androgens, and more appropriate forms of estrogen. These remain prohibitively expensive for many trans women in the region, especially in Nepal. In Thailand, trans women purchased hormones through healthcare services because they trusted SISTERS Foundation who were part of the Tangerine Centre (a model trans health clinic).^{lxix} In general, hormones produced in Thailand were considered the best by trans people in other countries, who would look for brands locally that had Thai script on the packaging. However, the source and quality could not be verified. This is concerning as drug stores in Thailand are unregulated, and they sell hormones that may no longer be approved for sale in other countries.^{lxx}

The one hormone that trans men take (testosterone) is very expensive. It is not available within Nepal, and has been difficult to obtain in Vietnam.

Across the region, there are fewer visible trans men who others can approach for advice about sourcing and taking testosterone when they are starting out. Therefore, many individuals relied on accessing testosterone through health professionals or online. Many health professionals in Vietnam were hesitant to prescribe hormones because of the uncertain legal framework there. In the FGDs, a trans man in Indonesia described how doctors stopped seeing trans people when there was political or media criticism of LGBT people.

Trans women in Thailand had the lowest mean age for starting hormones (14.6 years), possibly because of the greater access to hormones there. In other countries the mean age for trans women was higher (19.2 years in Indonesia, 21.8 in Vietnam, and 22.9 in Nepal). For trans men, the first use of hormones took place closer to their mid-20s. It is important that trans people, CBOs, and community-based health centres as well as healthcare providers can access accurate guidance on initiating hormone use, correct dosing, monitoring of blood levels for possible side effects, and harm reduction. Such guidance exists in the Asia Pacific Trans Health Blueprint^{lvii} and should be widely distributed. This is particularly timely in Vietnam as hormone use becomes regulated and could support the development of health guidelines based on informed consent, with trans people fully aware of both the benefits and risks associated with taking hormones.

This report is being completed in 2020, in the context of the COVID-19. Many trans people have lost jobs, and lockdowns have had a high impact on sex workers and other street-based workers. In some countries, including Nepal, trans people can no longer access hormones directly from overseas, and are reliant on purchasing these from health professionals at much higher costs. The economic vulnerability of trans people at this time means hormones have become even less affordable and accessible for trans people in Asia.

RECOMMENDATIONS

This KPRA project has provided new and additional knowledge on barriers to HIV and other health services for trans people in Indonesia, Nepal, Thailand, and Vietnam. It has identified some critical gaps in the availability, acceptability, accessibility and quality of healthcare for trans communities in all four countries. The four country reports contain detailed recommendations specifically aimed at policymakers and governments, healthcare service providers, and CBOs. The recommendations below are summarised from these reports. Together they have the potential to reduce discrimination and other compounding stressor experiences that transgender people face because of their gender identity, remove practical barriers, and bolster the resilience of trans people and trans communities.

01 Address Discrimination *and* Improve Responsiveness of Healthcare Services to Trans People

HEALTH DECISION MAKERS AND MINISTRIES, AND HEALTH PROVIDERS INCLUDING CBO-BASED SERVICES

Acknowledge the diversity of trans communities, and identify trans people as a priority group with unique needs within other health programmes (including those providing nutrition, mental health and addiction services).

HEALTH PROVIDERS INCLUDING CBO-BASED SERVICES

Expand clinic timings or provide services at hours that are convenient for trans people.

HEALTH AND JUSTICE DECISION MAKERS AND POLICY MAKERS, HEALTH PROFESSIONAL BODIES, AND HEALTH PROVIDERS

Provide complaints mechanisms for when trans rights have been violated in healthcare settings, a process for receiving feedback from trans people, and evaluating and acting on that information in order to improve services.

HEALTH PROFESSIONAL BODIES, HEALTH PROVIDERS AND CBOS

Sensitise personnel on supporting the health and well-being needs of trans people, especially youth, and emphasise that 'conversion' or 'reparative' therapy practices designed to change, repress or 'cure' someone from being trans are unethical and harmful.

GOVERNMENTS, INCLUDING HEALTH AND JUSTICE MINISTRIES, HEALTH PROFESSIONAL BODIES, AND THE MEDIA

Reduce stigma and transphobia in society by introducing public awareness campaigns that respect gender diversity and counter outdated views (such as that being trans is a mental illness or that unethical 'conversion therapy practices' are a possible remedy).

GOVERNMENTS, INCLUDING HEALTH AND JUSTICE MINISTRIES AND HEALTH PROFESSIONAL BODIES

Introduce protective laws and policies that ban 'conversion therapy' practices.

HEALTH PROVIDERS, INCLUDING CBO-BASED SERVICES

Create environments that are respectful of gender diversity, and are trans-positive, including by introducing forms that enable trans people to choose their appropriate name, gender and pronoun, based on their identity and not limited to the details on ID cards.

GOVERNMENTS INCLUDING RELEVANT AGENCIES (E.G. JUSTICE MINISTRIES AND THOSE RESPONSIBLE FOR IDENTITY DOCUMENTS IN CONSULTATION WITH HUMAN RIGHTS BODIES)

Introduce protective laws and policies that recognise trans people's rights and enable them to change their name, gender and salutation on official documents.

02 **Address Significant Information Gaps** *About Trans People's Health*

HEALTH MINISTRIES, HEALTH PROFESSIONAL BODIES AND HEALTH PROVIDERS

Adopt and tailor regional guidance that are based on an informed model such as the Blueprint for the Provision of Comprehensive Care for Trans People and Trans Communities in Asia and the Pacific into national guidelines that are consistent with international guidance from WPATH Standards of Care and WHO.

HEALTH ACADEMICS, HEALTH PROFESSIONAL BODIES, AND HEALTH PROVIDERS

Integrate material about trans-competent health services and gender-affirming care into health curricula across many disciplines (e.g. medicine, nursing, social work and psychology), including as continuing education for the current health workforce.

HEALTH AND OTHER RELEVANT MINISTRIES, HEALTH ACADEMICS, AND HEALTH PROFESSIONAL BODIES

Conduct additional research on trans peoples' health needs, and barriers to healthcare, particularly under-researched communities i.e. trans men, trans people who use drugs.

HEALTH PROFESSIONAL BODIES, AND HEALTH PROVIDERS INCLUDING CBO-BASED SERVICES

Build awareness on trans issues and health needs in clinical settings by providing trainings and developing guidelines, in partnership with trans people and CBOs

03 **Ensure Trans People's Equal Access to Mental Health Services**

HEALTH MINISTRIES, HEALTH PROFESSIONAL BODIES, AND MENTAL HEALTHCARE PROVIDERS

Develop mental health interventions that recognise the mental health impacts of gender minority stress on trans people, affirm gender diversity, and are gender-sensitive and trans-competent.

HEALTHCARE, INCLUDING MENTAL HEALTHCARE, PROVIDERS (WHETHER GOVERNMENT, PRIVATE OR CBO-BASED SERVICES)

Support the mental health and well-being of trans people including those exploring their gender identity, understand the impact of minority stress on trans people, and share positive information about gender diversity.

HEALTHCARE, INCLUDING MENTAL HEALTHCARE, PROVIDERS (IN GOVERNMENT, PRIVATE OR CBO-BASED SERVICES)

Build awareness among trans communities of any existing trans-competent counselling and mental health support service.

HEALTH MINISTRIES, HEALTH PROFESSIONAL BODIES, AND MENTAL HEALTHCARE PROVIDERS, INCLUDING CBO-BASED SERVICES

Develop and distribute information on mental health needs and services for trans people, particularly youth, especially on suicide ideation and where to find personal and community support.

HEALTH MINISTRIES, HEALTH PROFESSIONAL BODIES, AND MENTAL HEALTHCARE PROVIDERS

Train cadres of community counsellors and establish and maintain confidential mental health telephone counselling services within CBOs and/or competent NGOs.

GOVERNMENTS INCLUDING HEALTH MINISTRIES, HEALTH PROFESSIONAL BODIES, AND MENTAL HEALTH PROVIDERS, CBOS

Create mental healthcare pathways that enable CBOs to refer members to trans-competent mental health services and vice versa where mental health providers can refer their patients to CBOs for peer support.

04 **Ensure Trans People's Equal Access to HIV *and* Sexual Health Services**

GOVERNMENTS INCLUDING HEALTH MINISTRIES, NATIONAL AIDS PROGRAMME MANAGERS, AND HEALTH PROVIDERS

Sensitise public officials in the Ministry of Health and national AIDS programmes on trans people's specific gender-affirming health needs and the importance of trans competency across all types of healthcare and develop guidelines for non-discriminatory HIV and sexual health services.

HEALTH PROVIDERS (IN GOVERNMENT, PRIVATE AND COMMUNITY-BASED HEALTH SERVICES)

Create welcoming, non-judgmental and stigma-free HIV and healthcare settings that ensure privacy and confidentiality and respect the rights of trans people.

HEALTH MINISTRIES AND HEALTH PROVIDERS WORKING ON HIV PROGRAMMES OR PROVIDING HIV RELATED SERVICE TO TRANS PEOPLE LIVING WITH HIV

Foster the visibility and empowerment of trans people living with HIV by resourcing networks that reflect the diversity of local trans communities.

HEALTH MINISTRIES AND HEALTH PROVIDERS WORKING ON HIV PROGRAMMES OR PROVIDING HIV RELATED SERVICES

Undertake mapping exercises of existing services and need, and create HIV resources and programmes tailored for the different populations in the trans community i.e trans sex workers, trans drug users, trans men.

HEALTH MINISTRIES AND HEALTH PROVIDERS WORKING WITH TRANS MEN	Develop HIV information and resources relevant to trans men's bodies, sexual behaviours and risks (including shared needle used for hormone injections) and to counter HIV-related myths that have developed amongst trans masculine communities.
HEALTH, FINANCE AND OTHER RELEVANT MINISTRIES AND DONORS	Contract CBOs to provide health and HIV services and support them through financial investment domestically and involving trans CBOs in National HIV/ AIDS programming.
HEALTH MINISTRIES AND HEALTH PROVIDERS	Partner with trans-led CBOs in the HIV response, not only in testing but also in treatment and care, and identify paid intern and volunteer opportunities for trans people.
HEALTH PROVIDERS AND CBOS	Develop mobile clinics and outreach strategies to ensure that trans people receive HIV and other healthcare as well as materials on the safe use of hormones.

05 Improve Trans People's Access to Gender-Affirming Care

HEALTH MINISTRIES, HEALTH PROFESSIONAL BODIES, AND HEALTH PROVIDERS	Ensure that trans people have access to quality, affordable hormones and information about their correct use and about the risks of non-approved hormones.
HEALTH MINISTRIES AND HEALTH PROVIDERS	Develop clear and flexible pathways for gender-affirming care, based on informed consent, enabling trans people to make decisions about their own healthcare.
GOVERNMENTS INCLUDING HEALTH MINISTRIES, HEALTH ACADEMICS, HEALTH PROFESSIONAL BODIES, AND HEALTH PROVIDERS	Address gaps in access to affordable gender-affirming care, including through public health insurance policies; by working collaboratively with medical schools, teaching hospitals and government hospitals; and by identifying opportunities for trans people to volunteer or intern in peer support roles.
GOVERNMENTS, INCLUDING HEALTH MINISTRIES	Ensure that gender-affirming healthcare is affordable for those with health insurance, and provide additional support for those who do not have any insurance to alleviate costs.
GOVERNMENTS, INCLUDING HEALTH MINISTRIES	Address the absence of affordable healthcare through implementation of universal health coverage, and introduce cost-saving schemes including for gender-affirming health services.
HEALTH MINISTRIES AND HEALTH PROFESSIONAL BODIES	Ensure all health services providing gender-affirming healthcare, including surgeries, align with international standards and evidence-based literature, and there are complaint mechanisms if they fail to meet these standards.

ENDNOTES

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- xiv. Trans people indicated the extent to which they agreed or disagreed with the following six statements, on a scale from 1 (strongly disagree) to 5 (strongly agree):
 1. Being trans or not identifying with my sex assigned at birth makes me feel special and unique.
 2. I am proud to be of different gender from my sex assigned at birth.
 3. If I choose not to disclose my gender identity, I am still proud of who I am.
 4. I am comfortable revealing to others my gender identity.
 5. I feel part of the community that identifies as trans or of different gender from their sex assigned at birth.
 6. I feel connected to this community.
- xv. The results are summarised and discussed by each country in turn, followed by a regional summary. All data presented reflect differences that are statistically significant using Chi-squared tests of proportions at $p < .05$, unless described as a trend, in which case there was a difference of more than five percentage points. However, the difference was not statistically significant (largely due to small sample sizes). Further analysis of the data is available from APTN, including a dashboard summary of statistically significant differences and indicative trends.
- xvi. We open with the mental health and healthcare section as this is the healthcare setting in which the Gender Minority Stress and Resilience framework is most commonly applied.
- xvii. For example, 5.9% of respondents who have experienced discrimination also experience no symptoms of depression.
- xviii. For example, 17.4% of respondents who delayed treatment due to cost also had no symptoms of anxiety.
- xix. For example, 14.5% of trans men experienced depression most of the time.
- xx. Lifetime diagnosis may be more likely to have links to current experiences for someone who is younger.
- xxi. For example, 29.4% of younger respondents had ever received counselling.

xxii. For example, 4.8% of those who experienced invasive questions had received counselling.

xxiii. For example, 4% of those who experienced assault felt depressed all the time.

xxiv. For example, 4.8% of those who experienced invasive questions had received counselling

xxv. For example, 45.6% of those who experienced invasive questions had thought of ending their life.

xxvi. As in the previous section, findings presented here are summarised and discussed by each country in turn, followed by a regional summary. All findings presented reflect differences, which are statistically significant using Chi-squared tests of proportions at $p < .05$, unless described as a trend. In that case, there was a difference of more than five percentage points but not statistically significant (largely due to small sample sizes).

xxvii. As a reminder, **gender minority stressors** were considered to be experiences of stigma and prejudice encountered previously in life (having been assaulted to the point of requiring medical treatment), during previous general health care encounters (having been refused treatment due to gender identity; having delayed medical treatment due to past experience of invasive questions; and having delayed medical treatment due to knowing there were no standards or guidance for transgender patients). The fifth stressor was related specifically to experiencing discrimination while accessing HIV services.

xxviii. For example, 70.8% of those who had been seriously assaulted had ever been tested for an STI.

xxix. For example, 99.8% of those associated with a CBO knew of STIs.

xxx. In June 2019, during the 1st Indonesian Symposium on PrEP organised by UNAIDS, a decision was made to pilot PrEP in four Indonesian cities with high levels of HIV prevalence, working in close collaboration with the Ministry of Health: https://www.unaids.org/en/resources/presscentre/featurestories/2019/july/20190718_indonesia-prep

xxxi. For example, 40.0% of those associated who were refused treatment have been tested for HIV.

xxxii. For example, 42.9% of those associated with a CBO who had been refused treatment thought that it was unlikely they would be diagnosed.

xxxiii. For example, 12.7% of those under 25 had a check-up in the last year

xxxiv. For example, 70.6% of those who had experienced discrimination in HIV services had also delayed treatment in the last six months due to fear of discrimination.

xxxv. NGOs (56.8%) were much more likely to be the place where Nepal trans people ever sought STI treatment, compared to 33.8% who went to NGOs/CBOs when they had fallen ill in the last six months. However, NGOs/ CBOs was still the most common response given, followed by 30.8% who went to government clinics if they fell ill.

xxxvi. For example, 47.8% of those who had delayed treatment due to distance had had a check-up in the last year.

xxxvii. For example, 74.1% of trans men had a check-up in the last five years.

xxxviii. For example, 20.0% of people low in pride had a check-up in the last year.

xxxix. For example, 39.2% of people who had delayed treatment due to invasive questions had a check-up in the last year.

xl. For example, 93.8% of people who had been previously refused treatment had also delayed treatment in the last six months due to fear of discrimination.

xli. For example, 9.4% of trans men had ever used hormones.

xlii. The *From Barriers to Bridges* conference report is available online at: <https://weareaptn.org/2018/12/13/6987/> and the subsequent Regional Mapping Report on Trans Health, Rights and Development in Asia can be downloaded from: <https://weareaptn.org/2020/02/19/regional-mapping-report-on-trans-health-rights-and-development-in-asia/>

xliii. For example, 72.7% of trans men had ever used hormones.

xliv. This section draws on qualitative findings from the FGDs for this research project and baseline data that APTN collected just prior to the *From Barriers to Bridges* conference held in September 2017, and subsequently published as the *Regional Mapping Report on Trans Health, Rights and Development in Asia*.

xlv. Some types of hormones used by waria to transition include PIL KB Andalan, Ciklopen (Injectable Birth Control), Pinokinin (Injectable Hormones), Exradiol, Duton, Diane 35, Aundrocure, Progynova, Estrojel. In addition to the injected hormones, warias also consume oral hormone pills.

xlvi. For example, 72.7% of trans men had ever used hormones.

xlvii. This section draws on qualitative findings from the FGDs for this research project and baseline data that APTN collected just prior to the *From Barriers to Bridges* conference held in September 2017, and subsequently published as the *Regional Mapping Report on Trans Health, Rights and Development in Asia*.

xlviii. This section draws on qualitative findings from the FGDs for this research project and baseline data that APTN collected just prior to the *From Barriers to Bridges* conference held in September 2017, and subsequently published as the

Regional Mapping Report on Trans Health, Rights and Development in Asia.

xlix. Article 37 of the 2005 Civil Code and Decree No. 88/2008/ND-CP.

l. Human Rights Watch, “Positive Step for Transgender Rights”, 30 November 2015: <https://www.hrw.org/news/2015/11/30/vietnam-positive-step-transgender-rights#:~:text=The%20law%20allows%20people%20who,Human%20Rights%20Watch%20said%20today>.

li. Civil Code No. 91/2015/QH13 of November 24, 2015. Article 36 highlights the right to re-determine gender identity of those who have “congenital defect” or require medical intervention to “identify clearly the gender.”

lii. Article 37 of the Civil Code 2015 states that those who have undergone sex-reassignment surgeries have the right and obligation to apply for change in their civil status. There has been no specific guidance on how the process will be carried out, and what evidence will need to be presented.

liii. This update was provided to the author in April 2020 in an interview with a trans activist in Vietnam.

liv. The AAAQ framework draws extensively on General Comment 14 from the United Nations Committee on Economic, Social and Cultural Rights. United Nations (2000). The right to the highest attainable standard of health: general comment 14, UN. E/C 12/2000/4.

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