

Trans COMPETENCY Community-Based Monitoring

Key findings from the multi-country pilot
implementation of the **APTN Trans COMP CBM Tool**



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Partners



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EXECUTIVE SUMMARY

Asia Pacific Transgender Network (APTN) is a trans-led regional organisation that engages with a range of partners across Asia and the Pacific to support, organise, and advocate for fundamental human rights including gender identity; access to justice and legal protections; and comprehensive gender-affirming healthcare and policies, for trans and gender diverse people.

APTN works with in-country trans-led and trans-inclusive community groups / organisations in Southeast Asia, South Asia, the Pacific, and East Asia.

This document is a report on the key findings from the pilot implementation of the Trans COMP CBM Tool in 7 countries, the very first community-based monitoring tool solely developed and led by trans people focusing on trans health in the region.



Foreward

In keeping with the phrase, “Nothing About Us, Without Us”, APTN wholly advocates for the usefulness and validity of trans-led community based monitoring. Transgender people, as those with the direct and lived experiences with oppression, particularly within the healthcare sector, are essential to addressing the issues within this system, not just as patients or research subjects, but as research-leads involved in improving transgender healthcare.

In 2020, APTN began the development of our Trans COMP CBM Tool, designed by and for transgender community members, to assess and monitor service provision and trans-cultural and clinical competency of healthcare providers in our region. In 2021, we piloted this first-of-its-kind tool in **Bangkok, Vientiane, Kathmandu Valley, Metro Manila, Colombo, Port Moresby** and **Ulaanbaatar**. Through this process we collected baseline data on the availability, accessibility, acceptability, and quality of healthcare services currently available, while also strengthening the skills of the trans community in community based participatory research practice.

While the results of the pilot are unsurprising to those of us within the trans community, such as the experiences of stigma and discrimination and misconstructions about transgender people’s personal

lives and bodies, it is essential that we understand the gaps, and share these findings to push for improvements.

Despite the immense challenges presented by COVID-19 that delayed and required replanning the research process, such as clinic closures and increased wait times, movement restrictions, and our own team members dealing with COVID-19, we are proud to officially share the findings of APTN’s Trans COMP Community Based Monitoring pilot. This report is a culmination of over two years of work in the making, almost 50 trans people’s involvement from seven trans-led and trans-inclusive organisations in seven countries and three sub-regions.

I am particularly grateful to our Project Coordinator, Emily Rowe, and our Project Partners, Focal Points, and Data Gatherers for their buy-in, excitement, and engagement in this project in such a

challenging time. We are also grateful to our donors, stakeholders, and advisors without whom this project would not have been possible.

The importance of this Community Based Monitoring is not limited to the baseline data collected; rather it exemplifies our community’s ability to actively participate in the improvement of trans healthcare through evidence-building, advocacy, and sensitization of health care providers.

We hope that this pilot of the Trans COMP CBM Tool is just the beginning, and that it can be applied as a tool for policy, programmatic change, and community empowerment to remove barriers faced by transgender people.



Joe Wong
Executive Director



ACKNOWLEDGEMENTS

APTN would like to acknowledge the extraordinary dedication and level of commitment demonstrated by the Focal Points in each country.

APTN would like to acknowledge: **Wijeratne Arachchige Imasha Perera** from FPA Sri Lanka, **Jonathon Wala Lady Gaga** from Hetura Papua New Guinea, **Anoulack Somphong** from CHIAS (Community Health and Inclusion) Laos, **Eda Catabas** from LakanBini Advocates Pilipinas Inc. from Phillipines, **Purevtsogt Bayanmunkh** from Youth for Health Mongolia, **Umesh Shrestha** from Blue Diamond Society Nepal, and **Akekrin Kerdsoon** from the Foundation of Transgender Alliance for Human Rights Thailand. APTN also greatly appreciates the hard work of all the **Data Gatherers** in each study site.

APTN would further like to acknowledge the valued participation of **partners** and **trans representatives** that provided insight and feedback on the development of the tools during inception. APTN would like to thank **Yanyan** from Victoria-The LoveYourself Philippines, **Dr Angel Arroyo-Sergio** from Lily-The LoveYourself Philippines, **Dr Loyd Norella** from Save The Children Philippines, **AR Arcon** from Pioneer FTM Philippines, **Jemma Samitpol** from Institute of HIV Research

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APTN would also like to extend sincere thanks to the **donors** and all the **country stakeholders** and **service providers** for their cooperation and collaboration during the development of the tools and the pilot implementation. The Trans COMP CBM implementation was supported by the EpiC Project "Meeting Targets and Maintaining Epidemic Control" through the Key Population Investment Funds (KPIF) managed by Family Health

International (FHI 360); and the Sustainability of HIV Services for Key Populations in Asia Program (SKPA) funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), managed by the Australian Federation of AIDS Organizations (AFAO).

Special thanks to **Joe Wong**, **Cole Young**, **Raine Cortes**, **Eric Nadir** and **Jas Pham** from APTN for ongoing support and guidance.

This report was prepared by **Dr Emily Rowe**, with technical assistance provided by **Mohamad Shahrani bin Mohamad Tamrin** during piloting process.

LIST OF TERMINOLOGIES

GENDER IDENTITY

A person's deeply felt internal and individual experience of their gender, seeing themselves as male, female, a blend of both or neither. Gender identity can be the same as, or different from, a person's sex assigned at birth.

GENDER EXPRESSION

A person's presentation of their gender through physical appearance – including dress, hairstyles, accessories, cosmetics – and mannerisms, speech, behavioural patterns, names, and personal references. Gender expression may or may not conform to a person's gender identity.

TRANS MAN

This term is used to describe someone who identifies as a man or a boy, who was assigned female at birth.

TRANS WOMAN

This term is used to describe someone who identifies as a woman or a girl, and who was assigned male at birth.

GENDER DIVERSE

This term is used to describe people who do not conform to their society or culture's expectations for males and females. Being transgender can be one way of being gender diverse, but not all gender diverse people identify as being transgender and vice versa.

TRANSGENDER PERSON/TRANS PERSON

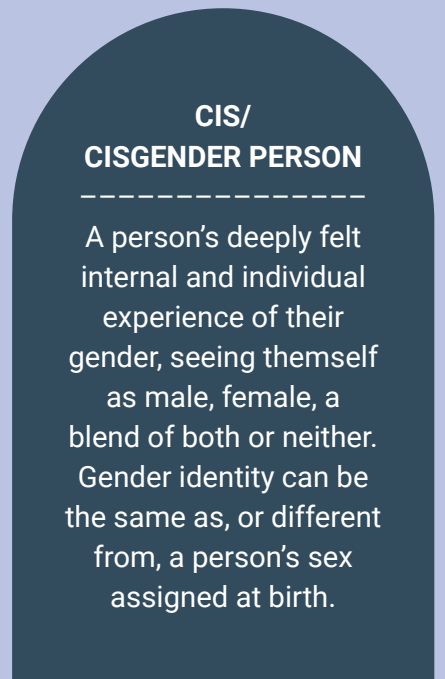
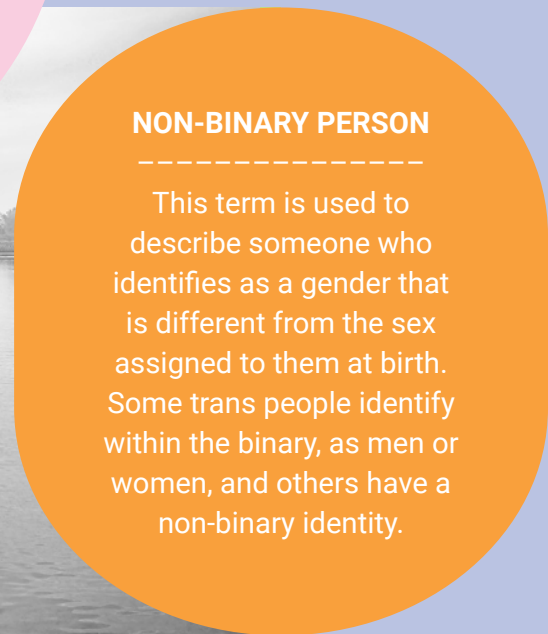
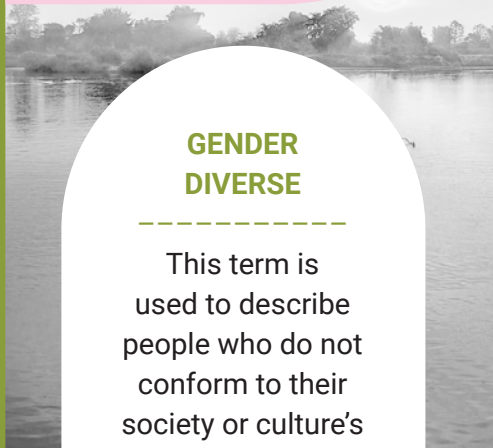
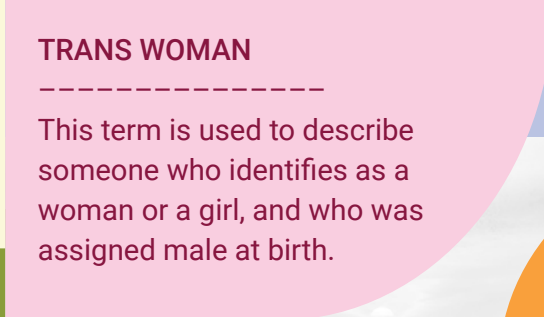
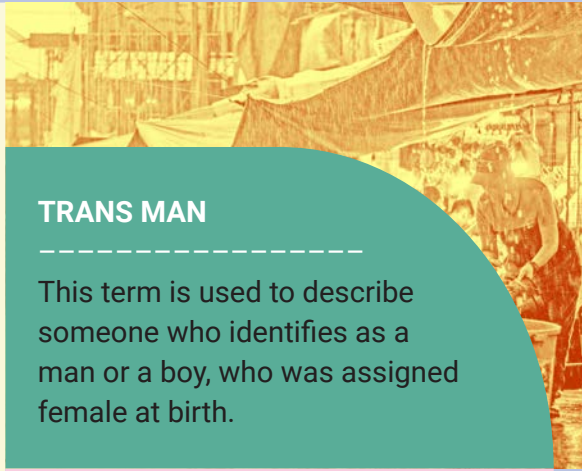
This term is used to describe someone who identifies as a gender that is different from the sex assigned to them at birth. Some trans people identify within the binary, as men or women, and others have a non-binary identity.

NON-BINARY PERSON

This term is used to describe someone who identifies as a gender that is different from the sex assigned to them at birth. Some trans people identify within the binary, as men or women, and others have a non-binary identity.

CIS/ CISGENDER PERSON

A person's deeply felt internal and individual experience of their gender, seeing themselves as male, female, a blend of both or neither. Gender identity can be the same as, or different from, a person's sex assigned at birth.



Languages across the world, including in this region, do not always distinguish between the terms sex, gender, gender identity and/or sexual identity. For example, some culturally specific, including indigenous, terms may describe a person's gender identity, gender expression and/or sexual attraction.

In Asia and the Pacific, there is a long history of culturally specific and non-pejorative terms for diverse gender identities or expressions.

Sex characteristics refer to the chromosomal, gonadal, and anatomical features of a person. Some are primary characteristics (for example, reproductive organs, genitalia, chromosomes, and hormones). Some are secondary characteristics (such as muscle mass, hair distribution or breast development).



Intersex is an umbrella term used to describe people born with physical sex characteristics that do not fit medical and social norms for male or female bodies. Intersex people's bodily diversity is innate, though may not be apparent at birth. Unless a trans person is also intersex, the physical changes they experience are not innate, and require gender-affirming hormones or surgeries.

GENDER-AFFIRMING HEALTHCARE

This refers to any form of healthcare that trans and gender diverse people receive to align their body with their gender.



BACKGROUND

Transgender people have very specific health care needs that should never be limited solely to sexual and reproductive health service provision. Transgender people may face a constellation of social and health-related issues and legal barriers that impact upon their well-being and ability to attain and lead full and productive lives.

Particularly in the Asia-Pacific region, these concerns are sometimes compounded by the fact that they have less access to health care responding to their needs, but also due to limited education and employment opportunities, housing challenges, familial discord, lack of health insurance coverage, or anticipated stigma and discrimination from healthcare providers.

Transgender people experience substantial health disparities and obstacles to accessing appropriate health care services. These disparities can diminish opportunities for achieving the highest possible health status and can result in poor health outcomes. Existing socioeconomic determinants of health can further legally, socially, and economically marginalise transgender people. Transgender people are also disproportionately affected by systemic forms

of violence, problematic substance use and attendant mental health concerns.

This evident disparity is the result of a variety of factors. However, physician and healthcare provider behaviour and attitude and negative experiences in healthcare settings are regularly cited as reasons why transgender individuals fail to seek and lack access to appropriate medical care.

It is important to remember though that the paucity of available, quality healthcare services for transgender people is not always owing to a lack of providers, or an unwillingness of providers to holistically serve the community, but oftentimes due to the fact that many providers have yet to be capacitated in transgender healthcare service provision.

This is where the community can come in- transgender



people can play a critical role in educating and sensitizing healthcare workers in how to provide appropriate, quality care. A core part of this dynamic is community-based and community-led monitoring.

The Trans COMP CBM Tool is the very first community-based monitoring tool developed by and for transgender people in the Asia Pacific region, and wherein transgender people were primary actors throughout the pilot implementation: from study team recruitment, service provider liaising, data gathering, data gatherer technical support and guidance, data analysis and within the dissemination process.

COMMUNITY-BASED MONITORING TOOLS



Community-based, informed and led monitoring can help community members and health care providers understand the **AAAAQ (Availability, Accessibility, Acceptability, Affordability, and Quality)** of a service being offered.

Community-based monitoring (CBM) affords tools and frameworks developed by a specific community that encourage users of a facility to assess and score the service they access.

Results from community-based monitoring can help facilitate collective agreement and action with the eventual goal of improving service delivery and capacitation of providers.

It can facilitate community engagement with health care providers and positively impact upon service quality, efficiency, and accountability. This is achieved by providing space for these two groups to engage in a participatory dialogue that is action-based and accountability-focused.

Although the end result is sometimes the same, community-based monitoring is different to other more traditional, provider (or donor, or government) led forms of monitoring. When developed and implemented correctly, community-based monitoring can:

(I) Ensure a greater sense of connection between providers and users of service provision through engagement during the data gathering and dissemination process, linking trans service users directly to providers in formal albeit safe and open platforms.

(II) To foster greater ownership through the prioritisation of trans people as tool developers, as study leads, as data gatherers, in data analysis through to dissemination.

(III) Help to better establish more meaningful partnerships between trans representatives at the national and regional level, and further between trans representatives and service providers, country partners, donors and stakeholders.



There are added benefits and value to carrying out community-based monitoring. CBM activities can help providers capitalise on service users' experience of services and become motivated to address identified shortcomings and improve service scope and quality. CBM is also beneficial for community members, as only they know what is best for their community, and what kind of service provision is preferential.

Community-based monitoring can not only help communities keep track of service provision and providers, but also help foster ownership and buy-in among the community. Individuals are naturally more likely to engage with services that respond to and reflect their needs, and where they feel the provider will be accountable when faced with service provision discrepancies and failings. Users can provide insight and helpful feedback for providers and guide them towards implementing corrective measures that address (and plan for) issues that arise. Further, data obtained via a CBM activity is also generally more nuanced.

TRANS COMPETENT SERVICES

Trans-competent health services ensure clear and easy pathways for accessing all types of healthcare, including HIV, gender-affirming, mental health, and general healthcare, regardless of one's background. Trans-competent care refers to healthcare that demonstrates both trans cultural competency and technical, clinical competency.



TRANS CULTURAL COMPETENCY

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.



TRANS CLINICAL COMPETENCY

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

There are a number of factors, and actors, that can help ensure rights-based trans-competent healthcare provision. In resource poor settings, coordination between providers is important and can fill service gaps, and a referral network or directory of trans-friendly and competent providers that goes beyond

healthcare to include social care, legal aid, and ancillary services can further support transgender people's health needs. Alternative methods

for information dissemination such as online counselling, and flexible provider opening hours, as well as peer-led services, are also part and parcel for providing comprehensive care¹.

Trans-competent services extend beyond primary healthcare provision and should reflect the multifarious needs of the community- and that includes non-binary people, trans women, and trans men². Transgender people access care in different ways and should not be homogenised. For example, in order to meet their gender affirming care needs, some people access services and hormones directly from

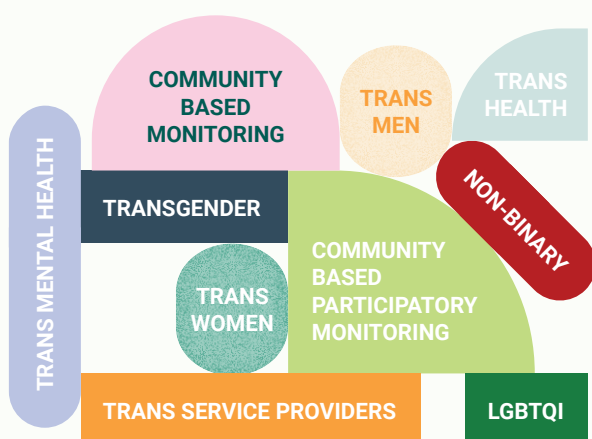
peers, pharmacists or over the internet and self-administer which can lead to poor health outcomes. Others access gender-affirming (however often costly) care from private physicians, or HIV/STI testing and treatment services from public clinics, specialist clinics, hospitals, donor-run non-government organizations, and sexual and reproductive health centres. In the global north, there has been great progress towards achieving universal access to trans-competent health care and coverage, but in the Asia-Pacific region there is still much room for growth.

THE GENESIS OF THE TRANS COMP CBM TOOL

In order to ensure that the Trans COMP CBM Tool resonated with the needs of the transgender community (in the broadest sense, in the best practice global sense) extensive Desk Review was conducted to scope the kinds of materials currently available and gain an understanding of what works/ what wouldn't work (particularly in lower middle-income countries in the Asia Pacific region).

Desk review was conducted by perusing materials already stored along with review of documents provided by APTN. These were collated. Online search was then conducted using key words/terms such as:

APTN also connected with a leading advocate for transgender health in Australia and participated in an online training on contemporary trends/approaches to quality trans health provision, with a particular focus on mental health and social support. Core websites such as WPATH were also explored. From these a list of indicators was brought together.



In addition, as part of this process, APTN consulted with a number of strategic partners in the Philippines, Nepal, Papua New Guinea, Myanmar, Indonesia and Thailand³ at the country level and their feedback informed the tools and particular requests were incorporated where possible.

¹ <https://www.who.int/gender-equity-rights/knowledge/AAAQ.pdf?ua=1>

² Health Policy Project, Asia Pacific Transgender Network, United Nations Development Programme. 2015. Blueprint for the Provision of Comprehensive Care for Trans People and Trans Communities. Washington, DC: Futures Group, Health Policy Project.

Community consultation was framed around the following questions:

1

What monitoring tools are currently used by you at your organization to monitor AAAAQ (availability, accessibility, acceptability, quality (and affordability) of trans competent HIV and Health Services? Who made these tools?

2

What have you found to be useful monitoring tools that have helped you effectively assess the AAAAQ of HIV and Trans Healthcare services accessed by your program beneficiaries and peers?

3

What have you found unhelpful or challenging when conducting monitoring activities?

4

What would you like to see in a community-based monitoring tool apart from measuring AAAAQ?

5

What indicators do you think we should include? Particularly with regards to AAAAQ?

6

How do you foresee community-based monitoring tools will be used? In what form or medium? Should it only be done through physical monitoring or online? Should it be done anonymously?

7

What indicators do you think we should include? Particularly with regards to AAAAQ?

Findings from the interviews were woven into the tool and helped provide local, community context.

3 Participating partners included: TheLoveYourself (PH), Save the Children (PH), Pioneer FTM (PH), Institute of HIV Research and Innovation-Tangerine Clinic (TH), SWING (TH), Myanmar MSM and TG Network (MY), GWL-INA (INDO), Jaringan Transgender Indonesia (INDO), Blue Diamond Society (NEPAL), Save the Children (NEPAL), Nepal Human Rights Commission (NEPAL), UNAIDS (PNG), Hetura NCD LGBT Group / KP Partnership Network Advocacy Consortium (PNG), Burnet Institute (PNG)



THE TRANS COMP CBM TOOL

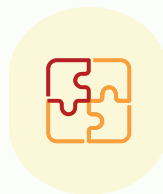
To document the lived experiences of trans men and trans women in the region and feed into existing monitoring efforts, APTN has developed a number of tools for the perusal of the community. The Trans COMP CBM Tool is designed to capture quality of HIV-related care and provide a means to track trans-competent and gender affirming health care in countries in the Asia-Pacific region, including access to and availability of hormones, sexual and reproductive health services and barriers to health care.

The Trans COMP CBM Tool is a living document, and it is hoped that future iterations will be developed by communities, that these iterations respond to the adapting needs of transgender people as service provision improves and progresses both at the regional and the global level. APTN has developed

the Trans COMP CBM Tool and coinciding Module and virtual tutorial. The Trans COMP CBM Tool is designed for transgender community members and service users to assess and monitor service provision.

The **Trans COMP CBM Tool** consist of four separate parts, for two separate audiences:

FOR TRANS COMMUNITY MEMBERS

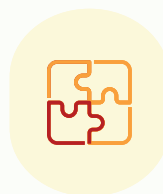


**TRANS
COMP CBM
SCORECARD**

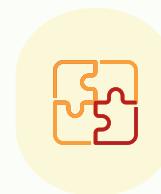


**TRANS COMP
CBM EXCEL
SPREADSHEET**

FOR SERVICE PROVIDERS



**TRANS COMP
PROVIDER
CHECKLIST**



**TRANS COMP
PROVIDER
ACTION PLAN**

This Trans COMP CBM Tool is designed for transgender community members to assess and monitor service provision.

The Trans COMP CBM Scorecard is a list of indicators. There are 6 broad themes to be monitored: Clinic Experience, Provider Experience, Health Services (+HIV Prevention, Testing and Treatment, +STI Diagnostics, Testing and Treatment, Gender Affirming Care, Mental Health and Harm Reduction), and Post-Service Reflection.

The following page details how the Scorecard can be used in a number of ways:

A) To monitor experience accessing a Comprehensive Package (HIV services, STI services and Gender Affirming Care)

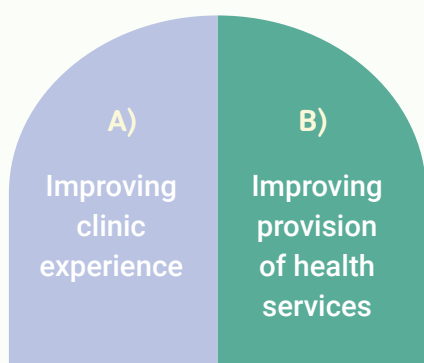
B) To monitor a singular experience accessing an Individual Package (HIV services, or STI services)

C) To monitor a Combination Package (HIV services + STI services)

For each relevant indicator, the Data Gatherer then rates their experience. The format of the Scorecard is illustrated below:

NO.	SECTION A: CLINIC EXPERIENCE	NOT APPLICABLE	STRONGLY DISAGREE	DISAGREE	UNDECIDED	AGREE	STRONGLY AGREE
A1	I found the clinic location with no problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A2	It was easy to find out about these services and make an appointment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A3	The clinic signage and materials are welcoming, accessible, informative, and inclusive	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A4	The operating hours of the clinic meet my needs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A5	The staff including the receptionist asked and called me my preferred name and pronouns/salutations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A6	I was able to put my preferred name and pronouns/salutations and gender identity on the clinic's check-in form	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A7	I was provided with the option to use a unique identity code (UIC), in order to ensure my confidentiality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A8	I have been informed of my rights as a patient	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A9	I am asked to complete an informed consent form when I visit the clinic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A10	I felt safe in the public area of the health facility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A11	The facilities at the clinic were clean	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A12	I was able to use the toilet that I was comfortable going to	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A13	The wait time at the health facility is reasonable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The **Trans COMP Provider Checklist Tool** is designed for use by Service Providers (illustrated on the right). The objectives of this tool are to **assess and take stock of the enabling factors and progress** of the clinic/organization towards becoming trans-competent. The Tool is divided into two parts:



NO.	INDICATOR	YES	NO
1	Our clinic/organization conducts an annual needs assessment to ensure we are meeting the needs of the trans community	<input type="radio"/>	<input type="radio"/>
2	Our clinic has easily available information both online and offline for patients to learn about our clinic and make appointments with ease	<input type="radio"/>	<input type="radio"/>
3	Our clinic has trans-inclusive health materials available at the clinic, including signage, brochures, and pamphlets	<input type="radio"/>	<input type="radio"/>
4	Our staff including the receptionist, doctors, and nurses ask each patient their preferred name/promouns and use this name when addressing the patient	<input type="radio"/>	<input type="radio"/>
5	Our clinic uses a unique identity code (UIC) to ensure confidentiality	<input type="radio"/>	<input type="radio"/>



This activity can be conducted **quarterly**, or as needed, and be updated with additional checklist items when required. Service providers should **map out solutions** wherever possible to mitigate issues raised or identified in the Trans COMP CBM Tool. This is a critical step as **feedback MUST be actioned and responded to**. According to the urgency of the issue, this can be identified as **Immediate** (must be addressed directly/at the soonest), **Intermediate** (to be included in organization/clinic 3-6 month plan) or **Long Term** (6 months +). The findings of the Trans COMP CBM Tool should be disseminated to health service providers to capacitate these on how to improve their services, as well as reflect upon their shortcomings and successes.

The **Service Provider Mapping Tool** (Refer to Annex) and virtual tutorial are supplementary tools for the CBM implementation process and are designed to help guide the Focal Point and Data Gatherers in identifying sites for data gathering. This Mapping Exercise was conducted to see what services are available for trans people in their country context before commencing data gathering and which ones are free or incur out of pocket costs- this is identified by **red** when costs incurred, **orange** if subsidised and **green** if free of charge. If information on the service is not available, this is left blank. This Mapping Tool can be regularly updated to be a

database of services for trans people in the country context and can also be adapted to suit other population needs.

Before commencing Data Gathering and after completion of the Service Provider Mapping Tool the Focal Points with the assistance of the country partners informed each of the Service Providers about

the Data Gathering plans, and processes involved. The purpose of this was not necessarily to obtain permission from providers, but more to inform them of the proposed activity, to gain stakeholder buy-in and commitment for further engagement with APTN in order to improve service provision for trans people in the region.

"THE FINDINGS OF THE TRANS COMP CBM TOOL SHOULD BE DISSEMINATED TO HEALTH SERVICE PROVIDERS TO CAPACITATE ON HOW TO IMPROVE THEIR SERVICES, AS WELL AS REFLECT UPON THEIR SHORTCOMINGS AND SUCCESSSES."

TRANS COMP CBM TOOL PILOT AIM

At the beginning of May 2021, APTN commenced the implementation of the APTN Trans COMP CBM Tool Pilot in 7 partner countries:

SRI LANKA • MONGOLIA • THAILAND • NEPAL
PAPUA NEW GUINEA • PHILIPPINES • LAO PDR

The Tools were translated into Sinhala, Mongolian, Thai, Nepali, Tok Pisin, Tagalog, and Laotian, and APTN engaged Focal Points and Data Gatherers in each country to coordinate the piloting of the Tools at the local level.

THE OBJECTIVES OF THE TRANS COMP CBM TOOL PILOT WERE:

✓ To assess the applicability and usefulness of the Trans COMP CBM Tool in measuring the trans-competency of selected services

✓ To capacitate both trans men and women in community based participatory monitoring and research

✓ To provide insight for Service Providers on potential opportunities for advancing towards becoming trans-competent

✓ To elicit stakeholder buy-in and commitment in prioritising the health of trans people in the region



STUDY TEAM

In each country context, a recruited Focal Point was engaged to be study lead and data gathering coordinator in their study site.

As a community-based participatory research activity, the Focal Points were representatives from the trans community, from a variety of diverse backgrounds, and were identified by partner organisations as competent and knowledgeable community representatives. The Focal Points recruited carefully selected Data Gatherers with guidance from partner organisations

and were responsible for management of the Data Gatherers (a minimum of 4 per country site) and ensuring data quality assurance and timely submission of deliverables. Focal Points were provided with stipend as compensation for their contribution, and Data Gatherers were allocated a fee for each scorecard completed and reimbursed for any out-of-pocket costs incurred during service access.

TRANS COMP CBM TOOL PILOT FRAMEWORK

The Trans COMP CBM Tool pilot was conducted in stages. To commence the activity, the CBM Project Coordinator and country trans Focal Points conducted an internal health service mapping per country, with inputs coming from the country partners, using the APTN developed Service Provider Mapping Tool.

The Tool is supported by a video tutorial and available in Qcode, printable and excel spreadsheet version. This exercise is to identify the different healthcare facilities/providers where the communities will administer the Trans COMP CBM Scorecard. As this was a pilot activity with a small sample size, the selection of healthcare facilities/providers was limited to urban/metro city in each country:

Bangkok (Thailand), **Vientiane** (Lao PDR), **Kathmandu** (Nepal), **Metro Manila** (Philippines), **Colombo** (Sri Lanka), **Port Moresby** (PNG) and **Ulaanbaatar** (Mongolia). Further iterations and roll-out of the tools should incorporate provinces outside of the selected sites for the pilot.

APTN selected Data Gatherers who identify as trans feminine or trans masculine and where possible to ensure that they represent a sub-group, such as trans youth, trans sex worker, trans PLHIV, trans with disability, trans who use drugs, among others. In each country site 4 Data Gatherers were recruited, however, in some

cases due to competing issues, a number were replaced. For example, in the context of the Philippines due to the impact of Super Typhoon Rai, the contracted trans masculine Data Gatherer was unable to continue in the data gathering process. In the context of Mongolia, sudden changes in outside work commitments prevented the trans feminine Data Gatherer from further participating.

The Data Gatherers were responsible for attending and accessing a variety of services documented by Focal Points in the mapping activity. Sites selected included those frequented by trans people as well as those identified by the country partners. Virtual training facilitated by APTN at the country level using video tutorial and translated tools was carried out.

Over two to three months, the Trans COMP CBM Data Gatherers in each country implemented their data gathering plans for the Trans COMP

CBM Scorecard. During the data gathering process, they were supervised and coordinated by the country trans Focal Points. Focal Points assigned the Data Gatherers sites to visit and progress tracked using the Trans COMP CBM Data Gatherers Tracking Sheet. Each of Trans COMP CBM Tool Pilot Data Gatherers attended a healthcare facility/provider and accessed/experienced an actual health service, paid for it (if there was a related cost), and then

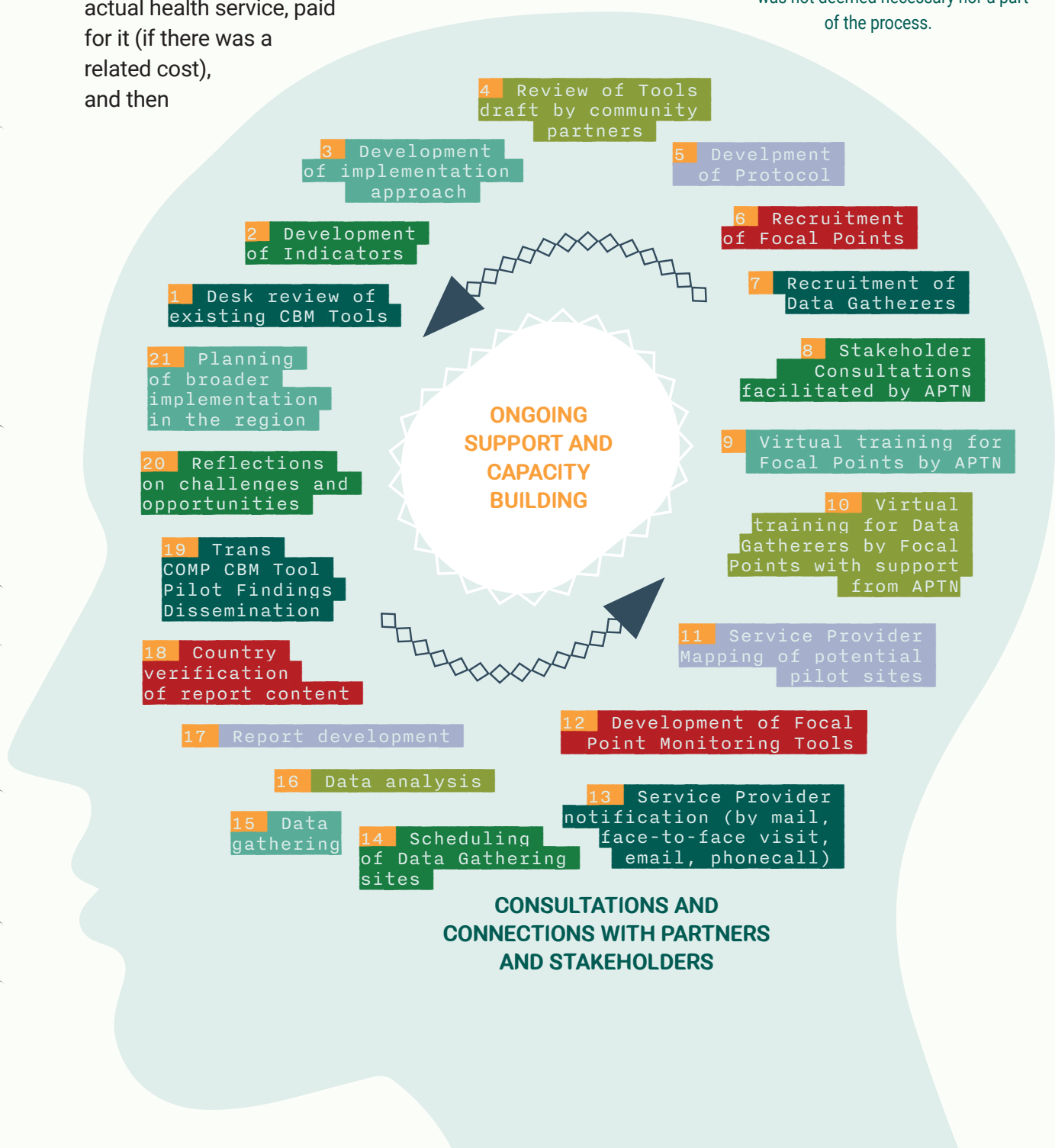
accomplished the Trans COMP CBM Tool Scorecard and submitted to the Focal Point for data entry and analysis.

In total, there were 21 steps in the Trans COMP CBM Tool pilot process. Throughout the process there was ongoing and consistent support and capacity building at the internal level with the Focal Points and Data Gatherers,

with reporting back and inclusion and consultations as well as fostering connection and buy-in from partners and stakeholders.

This is a visual depiction of the steps involved in the pilot⁴.

⁴ As this study was a community based participatory research activity, and the study leads themselves were the subjects directly accessing the services with no intermediary party or researchers, in this instance Ethics Clearance submission was not deemed necessary nor a part of the process.



DATA ANALYSIS

Country folders were established by the Project Coordinator for data analysis. Data on the service provider accessed was de-identified, however made available to the Service Provider upon request.

As data sample size was relatively small and in order for raw primary information gathered in the Trans COMP CBM Tool Scorecards to be processed into meaningful and verifiable data, data was analysed using excel spreadsheet software and based upon the findings, the Service Provider was

allocated a classification (see below). The purpose of the classification was not to illustrate the shortcomings of the service accessed, rather to assist the provider in identifying gaps towards becoming trans competent and highlight key areas for future training and capacity building activities.



CLASSIFICATION: GOLD

Trans COMP Gold Class
76-100 points

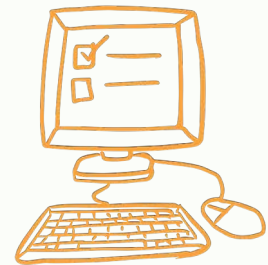
- All points above are covered
- Clinic met all my gender affirming care needs
- Broader health concerns were discussed and my information needs met
- Referral to legal aid, harm reduction, and cancer check services is offered as requested
- Information on safe binding, tucking, and silicone use is offered as requested



CLASSIFICATION: SILVER

Trans COMP Silver Class
61-75 points

- All points above are covered
- PEP, PreP is offered
- STI, HIV testing, and treatment are free. Information is tailored to the trans community
- The staff asked me my preferred pronoun and called me by this
- There were trans staff available
- Comprehensive referral to appropriate services is offered
- Confidentiality in this facility is protected
- Informed consent is required and clients are provided a UIC



CLASSIFICATION: BRONZE

Trans COMP Bronze Class
0-60 points

- Clinic is clean, accessible, affordable, and offers timely services suitable to community needs
- All primary care needs are met
- Clinic provided the basic SRH services and commodities require including condoms and lubricant
- Staff were friendly and courteous
- There was information about SRH available

OBSERVER BIAS

APTN acknowledges that without mitigation, due to the subjective nature of the study, observer bias was a possibility. Observer bias (also called experimenter bias or research bias) is the tendency to see what we expect to see, or what we want to see.

"APTN PUT IN PLACE CERTAIN PARAMETERS AND FRAMEWORKS TO ALLAY PREJUDICE AND HELP PROVIDE A CORRECTIVE LENS TO DECREASE BIAS POTENTIAL."

When a researcher studies a certain group, they usually come to an experiment with prior knowledge and subjective feelings about the group being studied. In other words, they come to the table with conscious or unconscious prejudices.

Before and throughout the Trans COMP CBM Pilot tool process, APTN has considered carefully the issue of Observer Bias. APTN put in place certain parameters and frameworks to allay prejudice and help provide a corrective lens to decrease bias potential such as providing the observer with clear observable criteria or well-designed observational rubric (such as the Scorecard), through training (sensitisation on the meaning of observer bias and how to be cognizant of it during data gathering work), as well as with intelligent study planning and careful Data Gatherer screening and recruitment. These methods are often used in community led and/or qualitative studies, such as community based participatory research or participatory action research, and there is extensive literature discussing these (observer bias is in itself a field of inquiry).

In anticipation of this, for the purposes of this study observer bias was reduced or eliminated by:



ENSURING THAT OBSERVERS WERE WELL TRAINED



SCREENING OBSERVERS FOR POTENTIAL BIASES



HAVING CLEAR RULES AND PROCEDURES IN PLACE FOR THE EXPERIMENT



MAKING SURE BEHAVIOURS ARE CLEARLY DEFINED, AND STUDY TEAM MONITORED



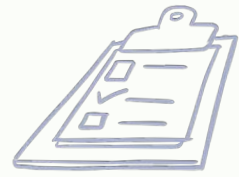
SETTING A TIME FRAME FOR COLLECTING DATA

In addition, while these concerns are valid, what needs to be emphasized is that the main objective of the 'pilot' was to assess the applicability of these previously designed Tools while at the same time gathering some core indicative data. Although as much as possible the Pilot has attempted rigour, this was by no means a scientifically robust research activity nor study.



RISKS AND MITIGATION

In the development of the Study design, APTN anticipated a number of potential risks and implemented mitigation measures to address these.



In the development of the Study design, APTN anticipated a number of potential risks and implemented mitigation measures to address these.

During the data gathering process, any challenges/ issues experienced by the trans CBM Data Gatherers were reported to the country trans Focal Points who coordinated with the CBM Project Coordinator. Fortunately, during the pilot there were no serious complaints or issues raised, however, where needed psycho-social support was provided during daily contact with focal points and APTN, and during weekly regional monitoring calls. During such calls, focal points provided mutual peer support and guidance.

In cases that the trans CBM Data Gatherers experienced discrimination during the health visit and data gathering, APTN set-up a complaints and response mechanism

to deal with such incidents (fortunately there were no serious complaints). APTN closely monitored the COVID19 situation in each site and ensured that all activities aligned with government protocols. COVID19 and attendant restrictions on movement of people unquestionably impacted upon pilot implementation⁵.

In order to ensure both the safety of Data Gatherers and that the good governance upheld by APTN remained intact, Data Gatherers were also invited to sign a Disclaimer and APTN Code of Conduct.

"DURING THE DATA GATHERING PROCESS, ANY CHALLENGES/ ISSUES EXPERIENCED BY THE TRANS CBM DATA GATHERERS WERE REPORTED TO THE COUNTRY TRANS FOCAL POINTS WHO COORDINATED WITH THE CBM PROJECT COORDINATOR."

⁵ APTN has documented the process within an Evaluation Report on the Trans COMP CBM Tool Pilot which is available upon request.

TRANS COMP CBM TOOL PILOT

REGIONAL FINDINGS

It is important to remember that by no means was this a robust research activity, however standard academic rigor was applied throughout. The process of this community-based monitoring activity was just as critical (if not more so) than actual raw data collated. The Trans COMP CBM Tool Pilot had many unintended or previously unimagined outcomes.



Community based monitoring has immense value in that it not only can provide insight into the kinds of information important to the community itself aside that of externally applied indicators, but also ensure community ownership over the data collected and processes involved.



Throughout each stage of the Pilot trans people were the study leads, study designers and study data collectors. In the Trans COMP CBM Tool pilot community members were also involved in ensuring accuracy of data collected and in analysis. This is incredibly important and the role of CBM in improving service provision should never be underestimated.



Throughout the process, the Focal Points fostered maintained strong relationships with their peers in the other study sites and provided mutual guidance and support.

Capacity building was not only a feature during initial training but throughout the process including that with regards to project management- not only from APTN to the entire study team but also bilateral capacity building between the Focal Points in one country to another, and also from the Focal Point to the Data Gatherers, and horizontally

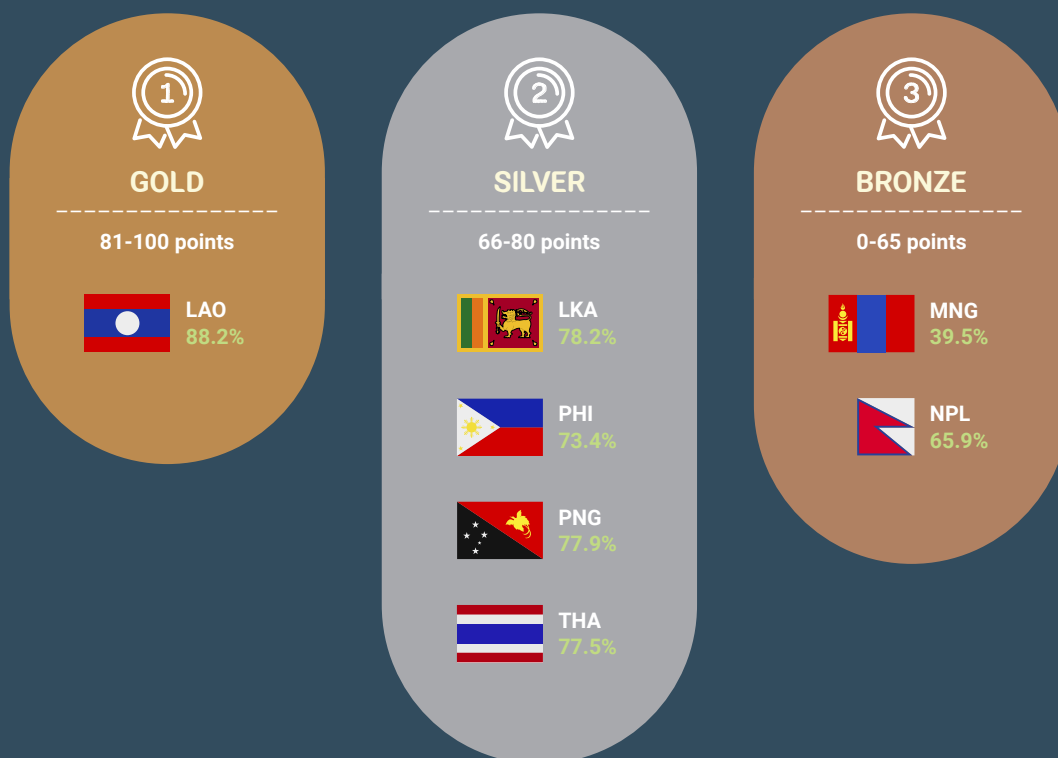
among the Data Gatherers themselves. Each actor in the Trans COMP CBM Tool Pilot demonstrated adaptability especially in the face of COVID19 and attendant obstacles and challenges. This CBM activity helped to contribute to community strengthening at both the country and regional level, and also provided an opportunity

for a 7-country collaboration. Collaboration with country partners and the trans community was also further developed and it is hoped this collaboration continues.

The purpose of the Trans COMP CBM Tool Pilot was not to identify failings of service providers and facilities, but rather to gain insight into

opportunities for capacity building and avenues for further becoming trans-competent in care provision. Key findings were identified by assessment of the scorings from within the Trans COMP CBM Tool Scorecard as well as qualitative thematic analysis of comments provided in the respective feedback sections.

Data were analysed from all country data sets in order to provide a country score, based on the coding system developed:



Broadly speaking, a number of key issues were identified in the analysis of all country Scorecards, on issues of safety and well-being and provision of gender affirming care, which pose as both challenges and opportunities for service providers and stakeholders at the regional and country context.

From information gathered in the scorecards it was evident that there is a serious paucity of gender affirming care facilities, and

lack of integration (however potential) for incorporation of services into general healthcare facilities. Trans masculine people, trans youth and trans people living with disabilities are particularly underserved, as are those seeking harm reduction services. COVID19 restrictions inevitably exacerbated these existing deficiencies in services.



"TRANS MASCULINE PEOPLE, TRANS YOUTH AND TRANS PEOPLE LIVING WITH DISABILITIES ARE PARTICULARLY UNDERSERVED, AS ARE THOSE SEEKING HARM REDUCTION SERVICES."



SAFETY AND WELL-BEING

For trans feminine and trans masculine people, being in a possibly hostile or transphobic public environment in which their appearance or actions are different from the dominant majority can be a cause of distress and impact upon mental health and overall well-being.

This can also impact negatively on health seeking behaviours and willingness to seek healthcare. Review of regional data indicated that a number of data gatherers expressed concern about their personal welfare, and felt 'exposed', or unsafe when presenting at certain facilities. This feeling of insecurity should not be underestimated as this acts as a barrier and deterrent from accessing services and achieving the highest possible health outcomes, however, also issues that can be mitigated throughout capacity building and sensitization.

"REVIEW OF REGIONAL DATA INDICATED THAT A NUMBER OF DATA GATHERERS EXPRESSED CONCERN ABOUT THEIR PERSONAL WELFARE, AND FELT 'EXPOSED', OR UNSAFE WHEN PRESENTING AT CERTAIN FACILITIES."

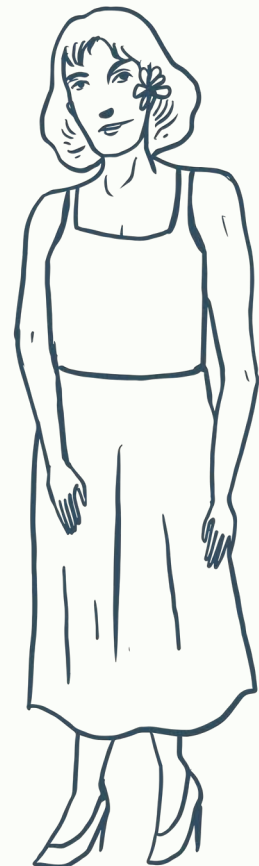
Positively, in Laos and Nepal Data Gatherers reported feeling safe and supported by healthcare providers, however

Data Gatherers in Mongolia and Papua New Guinea reported feelings of concern, if not fear, while waiting near the facility and being in public spaces:

"I felt intimidated and shy accessing this place" Mongolia Data Gatherer

"The location of the clinic is not safe and didn't feel comfortable" Papua New Guinea Data Gatherer

"The clinic is very far from the bus stop and its very scary for transgenders to wait outside too. I was not comfortable with that" Papua New Guinea Data Gatherer



These feelings of insecurity and anxiety were particularly highlighted in both trans feminine and trans masculine Data Gatherer's reflections upon use of public washrooms in facilities visited and wherein they reported feeling extremely vulnerable and distressed. This was reported by Data Gatherers in Nepal, but most especially in Sri Lanka:

"The place wasn't clean and due to the fact I was a trans man, I had difficulties to use the washroom because in order to use it we had to stand" Nepal Data Gatherer

"When I asked permission to go to the female washroom, the attendants looked at me ridiculously. So I did not use the washroom" Sri Lanka Data Gatherer

"My physical appearance has changed as a male. So I can use the male washroom without any consideration. But it will be difficult if my appearance has not changed as a male" Sri Lanka Data Gatherer

"I was not allowed to go to the toilet which suited my identity. I was given a male toilet" Sri Lanka Data Gatherer

GENDER AFFIRMING HEALTHCARE

In the region many trans people procure hormones outside the formal medical sector, with no monitoring before or after commencing hormone therapy or provision of further information about overall trans health.



There is an identified need for further collaboration and capacity building in trans health for all levels of healthcare providers. Existing services for trans feminine people are unaffordable and hard to access - there were no reported service catering to the health needs of trans masculine people. The service provider was able to answer most of their questions, however counselling was

hurried and the Data Gatherers often felt their information needs not met (especially with regards to gender affirming care and trans health). Positively, in some sites service providers were adequately informed about hormone therapy, although need for improvement was identified. A number of Data Gatherers reported a positive consultation with their healthcare providers:

"The doctor who saw me was friendly and polite, he explained to me in simple terms that I understood clearly" Papua New Guinea Data Gatherer

"The doctor was very careful and good with providing information on hormones" Nepal Data Gatherer

However, data Gatherers in a number of sites indicated that they felt that their information needs were not met particularly regarding trans health, and that counselling was rushed, leaving them feeling dissatisfied:

A lack of informed consent was also a serious concern, as demonstrated in Scorecard indicators analysis on the issue:

"Only short time for me to talk to them, I felt I needed more time"
Laos Data Gatherer



13.5% strongly disagreed that the healthcare provider explained that confidentiality would be guaranteed regardless of gender identity and health status.

"I did not understand when they were explaining to me"
Mongolia Data Gatherer



31.7% stated that they were informed of their rights as a patient.

This is an identified opportunity for capacity building:

"The service care provider was friendly though I noticed that lot of the staff didn't have good knowledge on hormones"
Nepal Data Gatherer



30.8% stated that the doctor sought consent before proceeding to do any examinations/ screenings.

"I'd come back to this place, but also believe they should have done more research on trans health care"
Nepal Data Gatherer



Only 43.8% agreed that the provider is not permitted to force them to undergo any procedure/examination/test without consent.

"As a trans woman, I feel most of my questions were not answered properly"
Papua New Guinea Data Gatherer



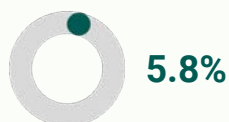
However, only 18.8% strongly agreed that felt uncomfortable/ unsafe when private/ breast/



chest/ genital area was examined, indicating just the opposite. As reflected in the thoughts of a Nepali Data Gatherer:



Further training on specific gender affirming care and sensitisation was also a recommendation, as reflected in key finding of indicators connected to gender affirming care.



Out of all Data Gatherers that accessed gender affirming care services only 5.8% strongly agreed that the doctor explained the necessary steps they had to take before starting gender affirming hormone therapy (GAHT) (medical history examinations, liver function test, hormone count).



9.2% agreed that the doctor explained the health implications of taking hormones on fertility and

suggested options based on needs.



Only 8.7% were informed of drug interaction risks.



Only 7.3% stated that the doctor explained the potential health risks of tucking/ binding for extended periods.



Just under 5% agreed that the healthcare worker would be able to provide guidance on safety and risks or was able to offer referrals on top/bottom surgery options if requested.

"OUT OF ALL DATA GATHERERS THAT ACCESSED GENDER AFFIRMING CARE SERVICES ONLY 5.8% STRONGLY AGREED THAT THE DOCTOR EXPLAINED THE NECESSARY STEPS THEY HAD TO TAKE BEFORE STARTING GENDER AFFIRMING HORMONE THERAPY."



Further, only 4.8% agreed that they felt comfortable in

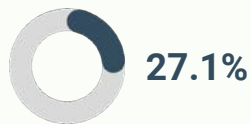
discussing side effects of hormones (eg. menstrual issues, decreased/ increased libido) with their provider.



STIGMA AND DISCRIMINATION

Many trans people face discrimination in general healthcare settings, and this is compounded when a trans person's gender identity or expression does not match their gender marker or their bodily diversity or identification documents.

Misgendering was recorded across all sites, and the request to be addressed by a preferred pronoun at times ignored or proactively dismissed (whether or not this was intentional to cause discomfort is unclear).



Only 27.1% of Data Gatherers strongly agreed that ancillary staff at the facility addressed them appropriately.



35.6% said that the healthcare provider or clinician asked and called by preferred name and pronoun/salutation.

"This is a big hospital. The main reception staff misgendered me but the front desk personnel called me with my preferred pronouns/salutations" Papua New Guinea Data Gatherer

"I was not allowed to use my preferred name at their facility" Philippines Data Gatherer

"I wrote my preferred name in the signup form but staff asked me to change it to my name assigned at birth" Philippines Data Gatherer

"The counsellor repeatedly called me "Sir"" Philippines Data Gatherer

"They opened a file when we are register in Gender clinic on our birth name. Publicly call us on that name" Sri Lanka Data Gatherer

"Even after I changed my ID, still they are using my previous name" Sri Lanka Data Gatherer

"The attendants and nurses at the clinic called me by my legal) name. It was a big inconvenience to me as my identity card name not been changed yet" Sri Lanka Data Gatherer

"The pronouns and the names they use for us is not much comfortable. They hardly call us by our preferred name" Sri Lanka Data Gatherer

Such stigma and discrimination (felt or perceived) and misconceptions about trans people's personal lives and bodies was evident when healthcare provider (and support staff, for example, reception) posed unnecessary questions or raised inappropriate or irrelevant lines of inquiry outside the parameters of the actual reason for consulting with the provider.



41.3% of Data Gatherers said that the language used by the service provider was easy to understand and delivered in a respectful manner.

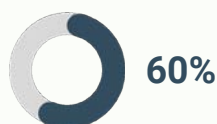


Only 29% strongly agreed that after the clinic consultation, they felt reassured and more confident in making informed health decisions. This was reported by Data Gatherers in almost all study sites:

"I felt quite uncomfortable after all the questions that doctor asked which wasn't the reason I went there, so I wouldn't go back to this place nor recommend my peers to go there"
Mongolia Data Gatherer

"The clinician didn't ask me a lot about why I am there and also didn't feel comfortable in there"
Papua New Guinea Data Gatherer

"Even though I was there for my STI treatment but the doctor asked me different questions which wasn't related to the test which made me uncomfortable"
Nepal Data Gatherer



More than 60% of Data Gatherers said that they felt 'judged' because of their gender identity. This was reported to have occurred not only during interactions with the clinician but also ancillary staff:

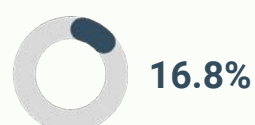
"The nurses, including the doctor, talked about my personal life and even my job and ridiculed me. They often asked me unnecessary questions"
Sri Lanka Data Gatherer

"In the clinic staff looked at me from time to time- I think they were talking about me and made me feel ashamed"
Sri Lanka Data Gatherer

"I wouldn't come back at this place, the way the registration officer treated me was inhuman"
Nepal Data Gatherer

The misconception that all trans women are sex workers was also reported by one Data Gatherer in Nepal:

"Doctors had a negative attitude towards trans women. He considered all trans women who visits there are sex workers"
Nepal Data Gatherer

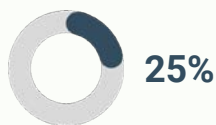


Only 16.8% of Data Gatherers who engaged in sex work said they felt comfortable sharing this information with the provider.

In Sri Lanka the issue of societal stigmatisation based on class and cultural and religious identity was raised:

They judge us from our social status and treat us differently. They give priority to the people who speak English and from higher social class"
Sri Lanka Data Gatherer

"I was disrespected for my religion (Muslim) Sri Lanka Data Gatherer



Overall, less than 25% of Data Gatherers agreed that their mental health had improved after the engagement with the provider at the facility.



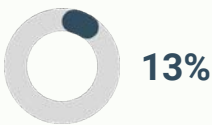
Just 42.5% said that they would unquestionably return to access services at the facility they monitored.

Data Gatherers in general appreciated the efforts of service providers in the facilities they visited, however, in the 7 study sites an overwhelming absence of knowledgeable and trans-competent service providers remains a formidable barrier to equitable healthcare for trans people in the region.

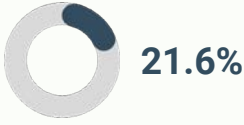
Access and referral to complementary services that may resonate with the diverse health and well-being needs of trans people was also an identified gap.



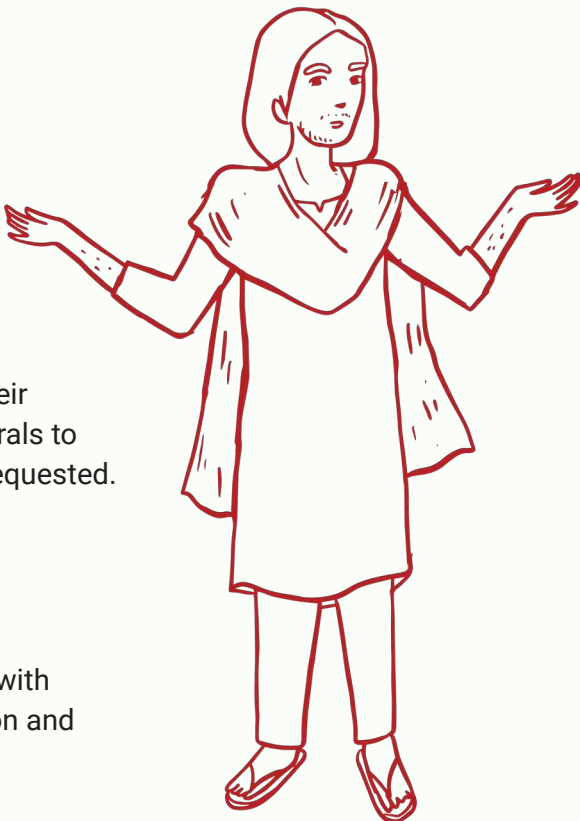
Only 10.1% stated that they received information about substance use and harm reduction.



13% were undecided whether or not their provider would be able to provide referrals to SGBV support services or legal aid if requested.



Trans youth are severely underserved, with only 21.6% stating that their information and healthcare needs were met.



COUNTRY CHAPTER LAOS



In Laos existing disparities in reproductive and sexual health service coverage and access especially those that are trans-friendly or trans-competent are influenced by a number of factors, including, physical distance to a provider and geography/terrain, education and literacy levels and socio-economic status, ethno-linguistic challenges, and traditional heteronormative socio-sexual mores and beliefs⁶.



VIENTIANE

There is a paucity of disaggregated data on HIV and trans people in Lao PDR (trans feminine people are categorised as ‘men who have sex with men’ although there is advocacy to address this), and an absence of services for gender diverse and trans people⁷. Although HIV testing and treatment

is available for free, seeking testing and treatment for STIs is hampered by high costs, long waiting times, and stigmatising attitudes of health care providers⁸. Compared to neighbouring countries, Lao PDR has a low HIV prevalence however increasing rates in other sexually transmitted diseases

such as syphilis, and chlamydia, indicate a possible shift in socio-sexual risk behaviours.⁹ Due to limited access of services, trans people from ethnic minorities are particularly vulnerable¹⁰.

Trans people in land-locked Laos live in a relatively tolerant society, identified by the community accepted terms of kathoey for trans feminine and tom for trans masculine¹¹ however there are challenges to being trans in Lao society and societal stigma and discrimination towards trans people persists.



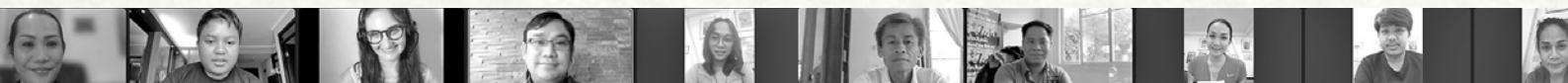
Trans people in Laos are politically disenfranchised and have limited employment and education opportunities^{12,13}.



Socio-cultural and religious beliefs and norms are connected to trans people experiencing stigma, discrimination and marginalisation.



The Constitution of Lao PDR, Article 35, states that "Lao citizens are all equal before the law irrespective of their gender, social status, education, belief and ethnic group", however in reality this is not the case.¹⁴



Although there are no specific laws or legislation which criminalise being trans, there are also very few mechanisms that protect or fully recognize gender diverse or trans people. As a result, there are also no procedures or measures in place to address and report discrimination, harassment or violence based on a person's sexual identity and/or gender expression, especially from healthcare providers.

Gender affirming healthcare is not discussed in law in Lao PDR; it is neither legal nor illegal and no law exists. Any services available are sparse. Hormones are available for trans feminine people, however services tailoring to the gender affirming care needs of trans masculine people are non-existent.

If financially able, many trans people seek gender affirming care services in Thailand¹⁵ but for those in the poorer quintile or in rural settings more often than use of illegal or unregulated hormone injections is commonplace.¹⁶

Trans competency training on the needs of trans feminine people has been conducted for service providers.¹⁷ Nevertheless, reported challenges such as fear of "outing" themselves as key population members; the potential for harassment, stigma and discrimination by healthcare providers; and concern that their status may not be held in confidence act as barriers for many trans masculine and trans feminine people for accessing services¹⁸.

88.2% OVERALL FINDINGS FROM THE TRANS COMPETENCY SCALE IN VIENTIANE WERE RELATIVELY POSITIVE

Overall findings from the Trans COMP CBM Tool pilot in Vientiane were relatively positive (88.2% on the trans competency scale). From information gathered in the scorecards it was evident that there is a serious paucity of gender affirming care facilities, and lack of integration (however potential) of services into general healthcare facilities.



With regards to misgendering, positively 76.7% said that they were able to use their preferred name and pronoun at the service they accessed.



56.7% said that they felt their needs were addressed as trans youth.

Data Gatherers explained that there was a lack of appropriate washroom facilities they felt comfortable using, and overall they felt under supported or in a number of incidences not handled or serviced with respect. Stigma and discrimination towards trans people continues to be a concern, as does patient

confidentiality. The service provider was able to answer most of their questions, however, counselling was rushed and the Data Gatherers often felt their information needs not met (especially with regards to gender affirming care and trans health). Medication, particularly for treatment of STIs was not affordable. There was also an identified need for access to a peer support person.



Only 26.75% felt that they received adequate information about blood borne viruses or risks with needle sharing.



Only 6.7% stated that they could seek assistance from the healthcare provider about mental health concerns.

Unquestionably, COVID19 also severely impacted service provision and accessibility at services visited during the data gathering process.

6 USAID, Laos Health Strategy: 2019-2023, USAID. <http://ghpro.dexisonline.com/reports-publications>

7 USAID, Laos Health Strategy: 2019-2023, USAID. <http://ghpro.dexisonline.com/reports-publications>

8 Phrasisombath et al., 2021, Risks, benefits and survival strategies-views from female sex workers in Savannakhet, Laos, BMC Public Health 2012, 12:1004

9 Vongdala, C. Undated. Laos Health System Review: Health Systems in Transition, National Cancer Center Korea

10 <https://journals.sagepub.com/doi/abs/10.1258/ijsa.2012.011416?journalCode=stda>

11 APTN consultations with Trans COMP CBM Tool Pilot Focal Point for Laos

12 <https://coupleofmen.com/18963-gay-in-laos-current-situation-lgbtq-community/>

13 <https://www.equaldex.com/region/laos>

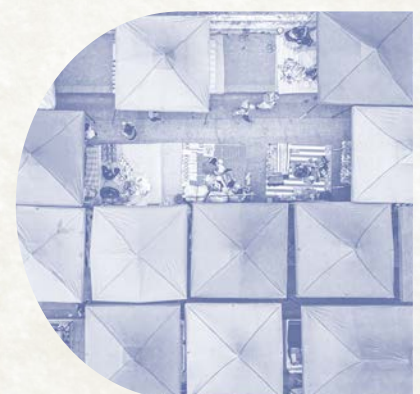
14 https://www.apcom.org/wp-content/uploads/2020/12/2020-11-26_Report_APCOM_Financelnc_LaoPDR_Rev_2-withLogos.pdf

15 <https://www.42d.org/2020/12/07/the-state-of-lgbtqi-peoples-economic-inclusion-lao-pdr/>

16 https://www.apcom.org/wp-content/uploads/2020/12/2020-11-26_Report_APCOM_Financelnc_LaoPDR_Rev_2-withLogos.pdf

17 <https://weareaptn.org/resource/regional-mapping-report-on-trans-health-rights-and-development-in-asia/>

18 <https://www.usaid.gov/global-health/health-areas/hiv-and-aids/information-center/success-stories/success-laos-hiv-testing-friendly-faces>



COUNTRY CHAPTER MONGOLIA



Mongolia hosts one of the region's lowest HIV epidemics¹⁹. HIV in Mongolia increased from 100 cases in 2001 to 650 in 2020 growing at an average annual rate of 14.57%. There is very limited data on transmission rates of trans people in Mongolia²⁰.



As with other countries in the region, trans masculine, trans feminine and gender diverse people in Mongolia experience widespread and institutionalised prejudice. Conservative traditional and heteronormative norms that support binary roles, narratives and values contribute to this stigmatisation.

Discrimination in the education sector and limited employment opportunities are also a challenge. Young trans people are particularly vulnerable²¹ and age-related barriers to access to sexual and reproductive health services persist.²²

Although there exists a Criminal Code addressing

'hate crimes' with the protected grounds including gender identity and expression, arbitrary detentions and physical abuse by law enforcement authorities or ultra-nationalist groups continue to be recorded.²³

Trans people are neither criminalised or prosecuted under Mongolian law²⁴ and an amendment made in June 2009 to Article 20(1) of the *Civil Registration Law* (Улсын бүртгэлийн ерөнхий хууль) allows transgender people to change their legal gender on birth certificates or citizen identification cards, after undergoing gender affirmation surgery²⁵.



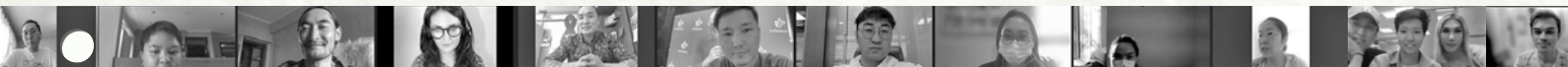
Mongolia's Health Law (1998) stipulates that every citizen has the right to equitable, non-discriminative healthcare, however trans people continue to be marginalised.



Negative and unsupportive healthcare provider attitudes and poor quality of health services remain as obstacles for trans and gender diverse people²⁶.



Both trans masculine and trans feminine people face particular challenges with a lack of hormone therapy, gender affirmation surgery or psychological services. Additionally, none of these services are covered by social insurance²⁷. There were no reported service catering to the health needs of trans masculine people and a lack of harm reduction services.



Discrimination and negative attitudes towards trans people are pervasive at all levels of Mongolia's health system. The Trans COMP CBM Tool pilot in Ulaan Baatar has been instrumental into gaining further insight into the lived experiences of trans people accessing health-care services at the local level.



63.3%

Data gathered included, in addition to a severe paucity of affordable health services for trans people and a lack of informed consent and counselling, an identified overall lack of services for people with disabilities who are trans or trans youth- 63.3% said that their needs were not met.

39.5%

OVERALL FINDINGS FROM THE TRANS COMPETENCY SCALE IN ULAANBAATAR WERE VERY LOW



50%

In Mongolia, Data Gatherers felt discriminated against and intimidated by staff and 50% of Data Gatherers said they were misgendered, and felt disempowered.

There is an identified need for further collaboration and capacity building in trans health for all levels of healthcare providers, with the overall rating for trans competency in Ulaan Baatar very low (39.5% on the trans competency scale).



43.3%

43.3% said that they felt that their confidentiality would not be guaranteed.



40%

40% of Data Gatherers felt that their mental health declined after visiting the facility.

19 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7731272/>

20 <https://knoema.com/data/mongolia+hiv>

21 http://www.news.cn/english/asiapacific/2021-12/01/c_1310345587.htm

22 <https://www.aidsdatahub.org/sites/default/files/resource/2020-aids-data-book-mongolia.pdf>

23 <https://www.apcom.org/msm-country-snapshot-series-mongolia/>

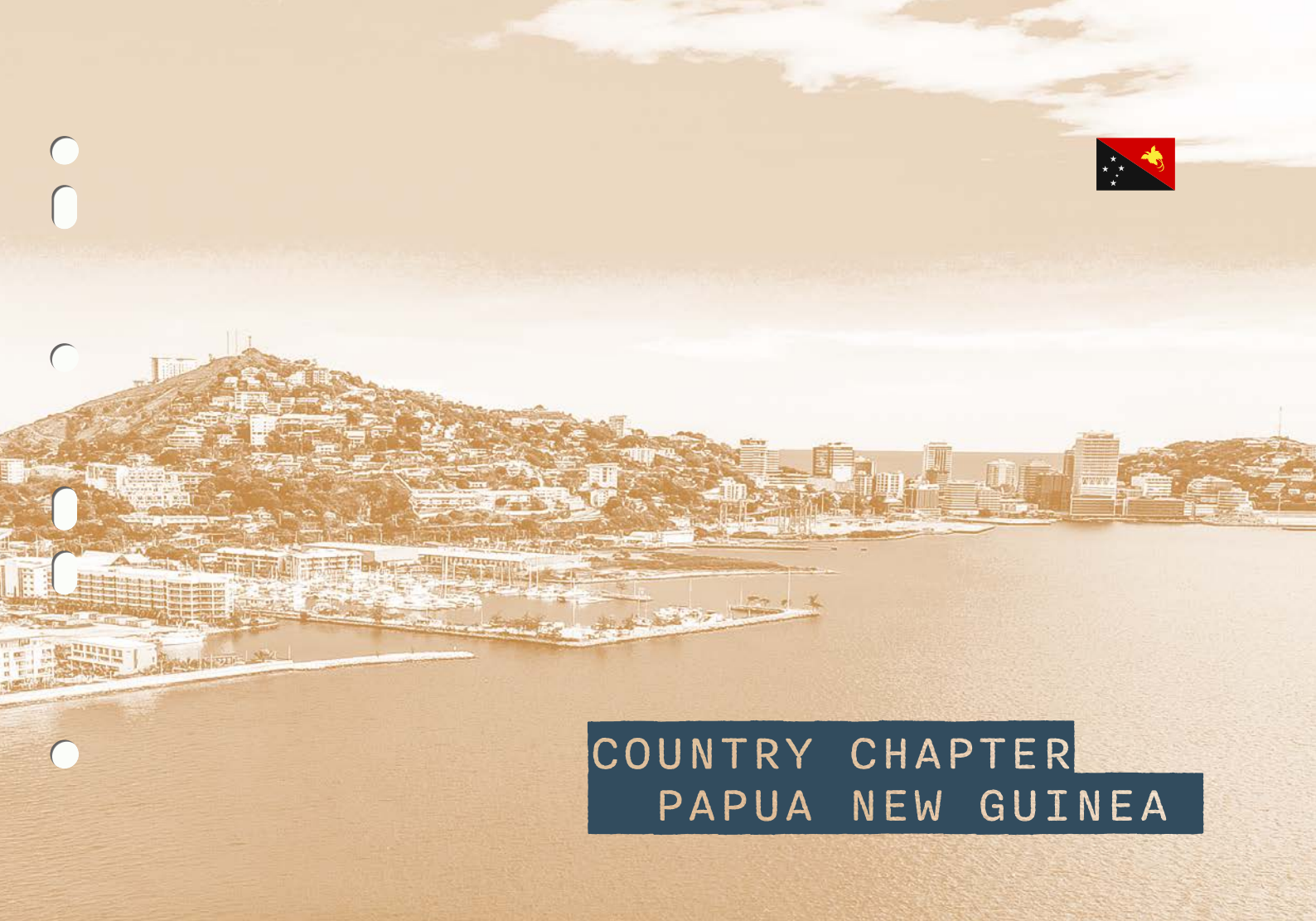
24 <https://www.aidsdatahub.org/sites/default/files/resource/2020-aids-data-book-mongolia.pdf>

25 <https://www.legalinfo.mn/law/details/11634>

26 <https://www.refworld.org/pdfid/54ed84be4.pdf>

27 Consultations with Trans COMP CBM Tool Pilot Mongolia Focal Point





COUNTRY CHAPTER PAPUA NEW GUINEA

Papua New Guinea has one of the highest rates of HIV infection in the Pacific Islands²⁸. The condition wherein in Papua New Guinea both sex work and same sex relations are criminalised significantly increases the risks of violence and exposure to HIV for transgender communities²⁹.



Criminalisation of trans people³⁰ leads to unconfirmed reports of violence and discrimination against trans masculine and trans feminine people, and trans people are extremely vulnerable to societal stigmatisation³¹.

outlaws any sex "against the order of nature," which has been interpreted to apply to consensual same-sex acts, and is punishable by up to 14 years imprisonment.³²

exclusion, severe lack of employment opportunities and avenues for further education.³³

The criminal code in Papua New Guinea is punitive and

This has ramifications for trans people and gender diverse people in Papua New Guinea who face social

Although the Sambia people of the Eastern Highlands province in Papua New Guinea recognise a traditional third gender: *kwolu-aatmwol* (a portmanteau meaning *male thing transforming into female thing*), there is a strong cultural attitude portraying trans people as 'both pathological and perverse'³⁴ and this perspective is reflected in interactions with healthcare providers and other power brokers.



Gender affirming healthcare is not discussed in law in Papua New Guinea; it is neither legal nor illegal.



For trans women, diagnosis not always required for hormone treatment, however, hormones are illegal, with many accessing from abroad or procured from the informal economy.



Trans people can access general healthcare, HIV services, sexual and reproductive healthcare, and there is inclusion in National HIV Strategy, trans-specific HIV data, trans-specific HIV programs as well as trans health research³⁵. Nevertheless, there is serious paucity of services (health or otherwise) that align with the diverse needs trans people in Papua New Guinea.



Data Gathering in Papua New Guinea had unique challenges including government enforced curfews and in order to mitigate possibly unsafe travel to and from home in the National Capital District/Port Moresby, limited moments for Data Gathering.

Although overall trans competency score was relatively high (77.9% on the trans competency scale), evidence indicates that trans people in Port Moresby face severe challenges in accessing appropriate and quality health care services, including HIV services.



Data gathered showed that there was a lack of opportunity to use preferred pronouns and names on the service provider administration forms- only 16.7% were provided with this opportunity.

77.9%

OVERALL FINDINGS FROM THE TRANS COMPETENCY SCALE IN PORT MORESBY WERE RELATIVELY HIGH



43.3%

Services accessed were also deemed unaffordable- 43.3% of the Data Gatherers considered the service to be too costly for them.

The safety of trans people waiting at or near the clinic was a serious concern- Data Gatherers reported a lack of privacy- feeling 'exposed' or nervous.



20%

20% responded that they felt uncomfortable being examined by the healthcare provider.

There was an overwhelming lack of knowledge on trans health- which is an identified opportunity. Attitude of

service providers varied- some friendly, some were not.

Although there was relatively sufficient provision of HIV and other sexual health services, there was an identified need for peer-led service provision and a need for capacity building of service providers, including training to address stigma and discrimination towards trans people, including trans people who are engaged in sex work.

28 <https://www.usaid.gov/pacific-islands/global-health>

29 <https://rainbowpng.wordpress.com/2016/10/23/group-hetura-ncd/>

30 <https://www.aidsdatahub.org/sites/default/files/resource/png-country-card-aug2021.pdf>

31 <https://www.humandignitytrust.org/country-profile/papua-new-guinea/>

32 <https://www.refworld.org/topic,50ffbce4c9,50ffbce4fc,5a61ee3ea,0,,PNG.html>

33 <https://www.equaldex.com/region/papua-new-guinea>

34 <https://www.refugeelgalaidinformation.org/papua-new-guinea-lgbti-resources>

35 <https://weareaptn.org/resource/regional-mapping-report-on-trans-health-rights-and-development-in-asia/>



COUNTRY CHAPTER PHILIPPINES



Although the Philippines has arguably one of the most comprehensive HIV responses in the region, it is also unfortunately home to one of the fastest growing HIV epidemics globally. Recent IHBSS indicated that there was an alarming 203% increase in new HIV infections from 2010 to 2018.

MANILA



Coverage is also high among trans women in the Philippines, with 80% of trans women being reached by HIV prevention programs, and 74% of trans women have received an HIV test and know their results.³⁶

Despite an extremely punitive drug approach, drug use is reportedly high among trans women in the Philippines, and

this syndemic can facilitate HIV transmission among the community, in the behavioural forms of 'party and play' and CHEMSEX, however there are a lack of appropriate harm reduction services for them³⁷. In the Philippines, generally speaking, there is an enabling environment wherein trans people are acknowledged and provided with safe spaces to express their gender identity

and sexual orientation. There is also adequate social space for other expressions of 'queerness' and both trans feminine and trans masculine people are represented in most sectors, most especially in urban centres and among the middle/upper middle class.

The overall strategic framework of the “Philippine Development Plan 2017-2022”³⁸ is a set of strategies into three pillars such as: 1) “*Malasakit*” - enhancing the social fabric; 2) “*Pagbabago*” - inequality-reducing transformation; and 3) “*Patuloy sa Pag-unlad*” - increasing growth potential³⁹. These frameworks are philosophically supportive of the meaningful involvement of all peoples, including trans and non-binary people.



Another mechanism that supports the involvement of trans and gender diverse people is Republic Act 11166, otherwise known as the Philippines AIDS Law. “Republic Act 11166” is defined as “An Act Strengthening the Philippine Comprehensive Policy on Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) Prevention, Treatment,

Care, and Support, and, Reconstituting the Philippine National Aids Council (PNAC), Repealing for the Purpose Republic Act No. 8504.” This Act stipulates the meaningful involvement of PLHIV from all backgrounds in programme design and in principle guarantees ongoing access to comprehensive and high quality, non-discriminative services⁴⁰. The Republic Act 10354

(RPRH Law) also ascertains the sexual and reproductive health rights of all, however, as protective mechanisms these laws are arguably weak as they do not explicitly outline SOGIESC related stigma and discrimination or acknowledge the rights of youth which in most instances require parental consent for access to health services including gender affirming care.⁴¹



Gender affirming care is available in the capital and a number of other urban centres, however, there are regions in the island nation that have yet to be reached by basic health services and stigma and discrimination towards trans people continues to be an issue.⁴²



Included in the carte du jour of services for trans people are the provision of estrogen, and hormones are freely available without prescription for trans women, however trans men require a prescription for testosterone.

One notable NGO, Love Yourself, runs the Victoria Clinic, which was established to meet the gap and provide trans-specific services including hormone support. Other gender affirming care services include the integration of gender sensitive HIV services into CBOs, surgeries, access to PrEP, trans-specific data, trans-competency trainings and trans health research⁴³.

Findings from the roll out of the Trans COMP CBM Tool Pilot in the NCR, Philippines will hopefully better inform advocates and stakeholders about the needs of trans feminine and trans masculine people in the archipelago.

73.4%

OVERALL FINDINGS FROM THE TRANS COMPETENCY SCALE IN PHILIPPINES WERE RELATIVELY HIGH

Although the trans-competency score of the Philippines was relatively high (73.4% on the trans competency scale), issues were identified during data analysis.

Reported incidences of 'misgendering', particularly by facility support staff and oftentimes an inappropriate line of questioning was a concern.



20% said that they were not given the choice to use their preferred name or pronoun.



33.3% noted that there was a lack of informed consent and explanation of their rights as a patient or client.



There was also a reported lack of services that were disability friendly- 20% of data gatherers recorded this in their scorecards. Data gatherers recorded the fact some service providers lacked comprehensive knowledge of gender affirming care and

there was an identified need for gender sensitivity training.



Only 30% said that their information needs were met.

In addition, there was an absence of in-depth discussion on GAHT (including the risks of self-medication), a lack of pre-HIV test counselling and lack of STI counselling and information on PreP and harm reduction provided (although a need identified). There were also some incidences of reportedly poor attitudes of clinicians providing the service.



Only 46.7% said that their mental well-being improved after a visit to the facility.



Nearly 67% intimated that there was no judgement towards them related to their gender identity.

36 Save The Children, 2020 Grant Name: "Accelerating Community Engagement and Response on HIV and AIDS Prevention" (ACER Project)

37 Harm Reduction International 2020 Summing it up: building evidence to inform advocacy for harm reduction funding in Asia, London

38 National Economic and Development Authority (NEDA). "Philippine Development Plan 2017-2022.", pp.47-49 and 138-147.

39 PHILIPPINE HEALTH SECTOR- HIV STRATEGIC PLAN 2020-2022 Department of Health Disease Prevention and Control Bureau Final Draft, 15 March 2020

40 https://www.ship.ph/wp-content/uploads/2019/07/Final-HRR-of-RA11166_-July10.pdf

41 Del Rosario, D. 2019 Impermeable: Assessing Evidence-Based Policymaking in Sexual and Reproductive Health in the Philippines, International Institute of Social Studies

42 PNAC 2016 6th AIDS Medium Term Plan: 2017-2022 Synergizing the Philippine HIV& AIDS Response, Manila

43 <https://weareaptn.org/resource/regional-mapping-report-on-trans-health-rights-and-development-in-asia/>



COUNTRY CHAPTER NEPAL



The HIV epidemic in Nepal is concentrated, with approximately 60% of infections occurring in key populations and over 50% of these are to be found also in the Kathmandu Valley and along the highway districts bordering India⁴⁴.



There is an estimated 5.0% HIV prevalence in trans feminine people. As the majority trans feminine people reside in relatively urban areas in the Kathmandu valley, it is reasonable to assume owing to the complex geographical Nepalese terrain that those in remote and isolated areas may not have access to HIV services such as testing and treatment and are not documented.⁴⁵

The government of Nepal has rolled out comprehensive HIV services that are inclusive of trans people, however, as in neighbouring countries fear of stigma and discrimination act as a deterrent for accessing services.⁴⁶

Due to arguably heteronormative cultural principles, many trans feminine people particularly young trans people avoid

accessing community-specific services or eschew HIV testing and treatment services⁴⁷. There are very limited services for trans masculine people.

Nepal has made some progress in terms of acknowledgement of the rights of trans and non-binary people, through a Supreme Court ruling in 2007, which promoted “the abolishment of discriminatory laws against sexual and gender minorities, same-sex marriage, and the official recognition of the third gender”⁴⁸.



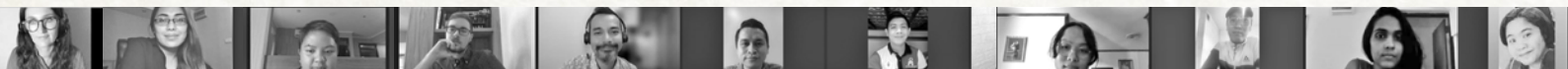
The more recent constitution of 2015 also works to ensure the rights of sexual and gender minorities. However, the implementation of the third gender, same-sex marriages, and prevention of discrimination in private and public settings are still subject to controversy⁴⁹. This

has meant that many trans people have low literacy, limited access to a variety of employment opportunities and are significantly disenfranchised. Further, it should be noted that transgender communities continue to face challenges such as limited awareness

in society about sexual and gender minorities, lack of data and statistics, ongoing social stigma, discrimination, and violence, limited employment opportunities, and exclusion from governance processes such as parliament, national planning commission, and other government positions⁵⁰.



These forms of national recognition have however helped paved the way for the implementation of a variety of gender affirming care services, such as the availability of regulated and prescribed hormones, access to PrEP, trans-specific programs, inclusion in the National HIV Strategy, trans-specific HIV data and trans-health research.



For trans women, the only hormones available are birth control pills from the pharmacy, which are affordable. Testosterone for trans men is not available in Nepal, so it is expensive and unaffordable. The majority of services available are limited to Kathmandu Valley, and those in rural or remote settings are very underserved⁵¹.

The quantitative and qualitative information collected in the Trans COMP CBM Tool Pilot in the Nepalese capital will no doubt contribute to further understanding of the needs of trans people in the country and insight into the ways in which service provision could be improved.

Highlighted findings include an overall lack of services for trans people with disabilities, a lack of appropriate bathroom facilities for trans people, particularly trans masculine people which causes discomfort and embarrassment.



Positively, 60.7% said that were provided the option to use their preferred pronouns.

65.9%

OVERALL FINDINGS FROM THE TRANS COMPETENCY SCALE IN NEPAL WERE AVERAGE



Only 50% said they felt safe in the public area of the facility.



About 53% said that they felt judged because of their gender identity.

Further findings include the high out of pocket costs for gender affirming care, a lack of informed consent, inappropriate, or unnecessary line of questioning on sexual health and risk.



Only 53.3% said that the language used by the provider was delivered in a respectful way and that their concerns were adequately addressed.

There was no information on PrEP provided and very limited information on harm reduction and pre-STI testing counselling. Nevertheless, data gathered indicated that service providers were adequately informed about hormone therapy, although need for improvement was identified.

Staff were trans friendly and non-discriminative at majority of sites visited, however several displayed misconceptions that all trans women are sex workers- this is an important finding.

Nepal's overall trans competency average was 65.9% and most of the data gatherers said that they would return to the facility they accessed.



44 Deuba, K. et al 2020 Effectiveness of interventions for changing HIV related risk behaviours among key populations in low-income setting: A Meta- Analysis, 2001–2016 Scientific Reports 2020) 10:2197 | <https://doi.org/10.1038/s41598-020-58767-0>

45 Poudel, et. al 2019 Mapping and Size Estimation of Key Populations on HIV Surveillance in Nepal, J-GMC-N | Volume 12 | Issue 01 | January-June 2019

46 Government of Nepal 2019 Factsheet 2019, Ministry of Health and Population National Centre for AIDS and STD Control Teku, Kathmandu

47 Deuba, K. et al 2020 Effectiveness of interventions for changing HIV related risk behaviours among key populations in low-income setting: A Meta- Analysis, 2001–2016 Scientific Reports 2020) 10:2197 | <https://doi.org/10.1038/s41598-020-58767-0>

48 Storm et al. 2020 Prevalence of HIV, syphilis, and assessment of the social and structural determinants of sexual risk behaviour and health service utilisation among MSM and transgender women in Terai highway districts of Nepal: findings based on an integrated biological and behavioural surveillance survey using respondent driven sampling BMC Infectious Diseases (2020) 20:402

49 Storm et al. 2020 Prevalence of HIV, syphilis, and assessment of the social and structural determinants of sexual risk behaviour and health service utilisation among MSM and transgender women in Terai highway districts of Nepal: findings based on an integrated biological and behavioural surveillance survey using respondent driven sampling BMC Infectious Diseases (2020) 20:402

50 <https://weareaptn.org/resource/from-barriers-to-bridges-full-meeting-report/>

51 <https://weareaptn.org/resource/regional-mapping-report-on-trans-health-rights-and-development-in-asia/>

COUNTRY CHAPTER SRI LANKA



In Sri Lanka, a country of pervasive hegemonic heterosexuality and heteronormativity, cisgender non-heteronormative, gender diverse and trans people most especially those from socio-culturally and economically disadvantaged backgrounds experience multi-faceted and systemic discrimination, stigma and marginalisation at all levels of society, including from healthcare providers.⁵²



COLOMBO ●

Transgender people in Sri Lanka are also disproportionality affected by sanctioned forms of transphobia, violence, problematic substance use and attendant mental health concerns, all of which have been exacerbated by the

COVID19 pandemic⁵³. The 2018 Integrated Biological and Behavioural Surveillance population estimate for trans women was reportedly low at 22,913⁵⁴ and there is a paucity of accurate data on trans masculine and other gender diverse people in Sri Lanka,

which unquestionably impacts negatively upon HIV service coverage and domestic investment into healthcare for trans people.

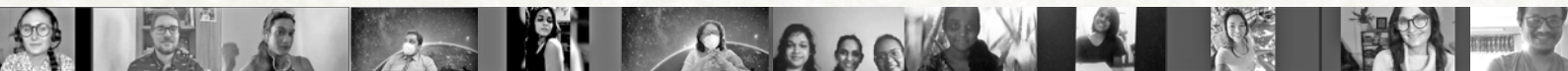
Although gender affirming healthcare is legal and regulated, hormones for both trans feminine and trans masculine people are available, prescribed and monitored by medical professionals, and trans competency trainings for healthcare practitioners have been carried out⁵⁵.



Transgender people in Sri Lanka continue to experience substantial health disparities and obstacles to accessing appropriate and quality health care services, including HIV services.



A number of key issues were identified from analysis of the Trans COMP CBM Tool Pilot data gathering process, namely: a lack of clean washroom facilities and long waiting times and inability to use washroom of choice which was a cause of embarrassment and unease.



At several of the services there were frequent incidences of misgendering, for example, staff and healthcare provider did not use preferred pronoun, or call by chosen name.



30% stated that they were misgendered.

There were also reported incidences of being made to feel shame or discomfort during their site visits.

Confidentiality on personal information sharing was also an issue- staff asked inappropriate or unnecessary questions- including in the non-private waiting rooms and public spaces. Further, some recorded in the scorecards that the staff were discriminative based on the persons religious identity and social status.

There was also evident discrimination between individuals that had undergone surgery as opposed to those in transition/pre-surgery.

78.0%

OVERALL FINDINGS FROM THE TRANS COMPETENCY SCALE IN SRI LANKA WERE RELATIVELY HIGH

At a number of services there was a lack of knowledge about the broad range of gender affirming care services.



46% said that the doctor or healthcare provider was well informed about correct hormone therapy application.



Findings indicated that 40% stated that they did not explain the health risks of binding or tucking for extended periods. This is an identified opportunity for learning.



26.7% said there was a lack of option for follow up counselling.



Positively, 80% said they felt listened to by the doctor about their health concerns and that the doctor was patient.

Overall, Sri Lanka ranked very high, with an average of 78%.



60% of the data gatherers stated that their mental health had improved after visiting the sites.



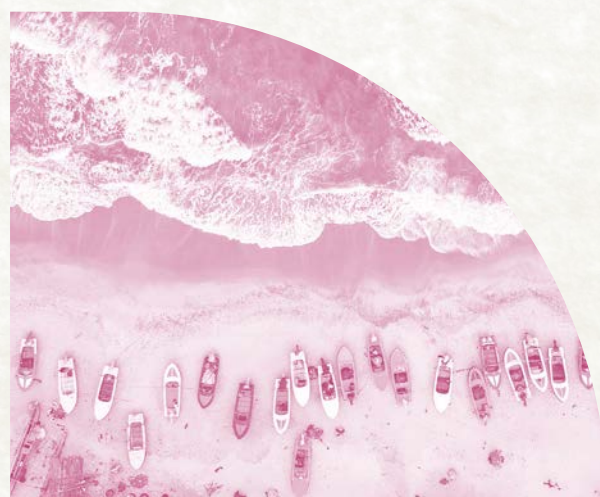
74% said that they would return to the site again.

52 <https://weareaptn.org/resource/conversion-therapy-practices-against-transgender-persons-in-india-indonesia-malaysia-and-sri-lanka/>

53 <https://weareaptn.org/resource/trans-resilience-report-stories-of-hope/>

54 https://www.aidscontrol.gov.lk/images/pdfs/publications/research_documents/IBBS-REPORT-PDF.pdf

55 <https://weareaptn.org/resource/regional-mapping-report-on-trans-health-rights-and-development-in-asia/>





COUNTRY CHAPTER THAILAND

Although comparatively Thai culture is more supportive of trans, gender diverse and non-binary people, stigma and discrimination especially from healthcare providers still continue. Philosophies around filial piety are strong in Thailand which impacts upon the ability of many trans people particularly in rural settings to express their gender identity⁵⁶.



Trans masculine and trans feminine people in Thailand continue to face substantial barriers to employment and further education.

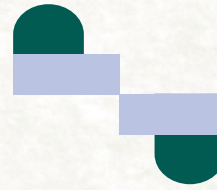
The overarching goal of the Thai national health program is "to equally entitle all Thai citizens to quality

*health care according to their needs, regardless of their socioeconomic status", however hostility and prejudice towards trans and gender diverse people persists.*⁵⁷

Thailand's laws and policies do not explicitly

address SOGIESC related discrimination on the basis of sexual orientation or gender identity.⁵⁸

Even though Thailand's Constitution and numerous ratified human rights resolutions and conventions prohibit discrimination against trans people, including the *Gender Equality Act B.E. 2558* was passed on 13 March 2015 and came into force on 9 September 2015⁵⁹, specific laws that refer to sexual orientation and gender identity do not exist⁶⁰



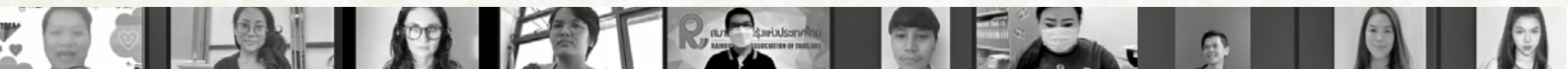
Notably, Thailand has one of the highest HIV prevalence in Asia, and an estimated 11% among transgender people.⁶¹



Thailand also has one of the most successful and comprehensive responses within the region⁶².



There are numerous facilities that offer gender affirming care, many of which are community run and led. These include HIV services in CBOs, hormones prescribed and monitored by doctor, surgeries available, access to PreP for trans people, inclusion in National HIV Strategy, trans-specific HIV programs and the availability of trans-specific HIV data. However, some service available are unregulated nor monitored.



Many trans people procure HRT that is cheap, not monitored and not prescribed. Although forms of physical augmentation surgeries for gender-affirmation are possible, legal, and advanced in Thailand, current law does not allow transgender individuals to change their gender identity on legal documents.

The attitude of some health care providers who are prejudiced against trans persons also represents a barrier to health and well-being. Many trans masculine and trans feminine while seeking health care services have faced discrimination which includes, but is not limited to, unequal standards of health care given to trans persons, the disclosure of sensitive and private health information, the refusal of treatment, and referring transgender persons in hospital wards in opposition to their preferred gender identity⁶³.

The Trans COMP CBM Tool pilot in Bangkok unearthed a number of key findings. These include: a lack of services for people with disabilities, however positively services were available for the deaf and hearing impaired. Trans healthcare services in Thailand are not fully covered by universal health coverage schemes or mechanisms. In the services assessed in the Bangkok roll out, although a broad range of services are available, some costs incurred made many unaffordable.

77.5% OVERALL FINDINGS FROM THE TRANS COMPETENCY SCALE IN BANGKOK WERE RELATIVELY HIGH



In the Bangkok context, 63.3% stated the clinic hours suited their needs.



43.3% stated that the receptionist asked and used preferred pronouns/name.



73.3% of Data Gatherers said they felt comfortable in asking the provider for more information about their healthcare.



Stigma and discrimination (felt or perceived) and misconceptions about trans peoples personal lives and bodies was evident as only 26.7% felt comfortable telling the healthcare provider that they engaged in sex work.

Positively, most providers had effective referral systems put in place, however there was a lack of harm reduction services or information, including avenues to address concerns

regarding substance use. There was also a reported lack of comprehensive pre-HIV and pre-STI counselling. Overall, comparatively, service providers in Bangkok received a trans competency rating of 77.5%, particularly those that focus on gender affirming care.



17% stated that there was a lack of information about the risks of self-medication.



20% said that the healthcare provider did not effectively explain drug contraindications, for example, between ART and hormones.



In Bangkok 57% of data gatherers said they would return to the clinic to access services.



Over 50% said they felt more confident and that their mental health improved after a visit and did not feel judged because of their ability, religion, ethnicity, occupation,

HIV status or socio-economic background.

Data Gatherers in general appreciated the efforts of service providers in the facilities they visited, however, further capacitation of service providers in Thailand remains critical.

56 <https://www.refworld.org/pdfid/54ed82784.pdf>

57 International Labour Office, 2016, Universal Health-care Coverage Scheme: Thailand, ILO.

58 ARROW, 2014, Country Profile on Universal Access to Sexual and Reproductive Rights: Thailand, ARROW.

59 <http://www.ratchakittha.soc.go.th/DATA/PDF/2558/A/018/17.PDF>

60 UNDP, 2014, Being LGBT in Asia: Thailand Country Report. Bangkok. USAID.

61 https://www.avert.org/professionals/hiv-around-world/asia-pacific/thailand#footnote29_zrdafo

62 Bristol, N. 2008, Mechai Viravaidya: Thailand's Condom King [https://www.thelancet.com/article/S0140-6736\(08\)60091-4/fulltext](https://www.thelancet.com/article/S0140-6736(08)60091-4/fulltext)

63 UNDP, 2014, Being LGBT in Asia: Thailand Country Report. Bangkok. USAID.



RECOMMENDATIONS

Despite challenges in the pilot process, including that from COVID19 and limitations in data set sizes, through analysis of the Trans COMP CBM Tool Scorecards, a number of opportunities have been identified to address existing disparities and improve provision of care for transgender people as a basic human right in the region.



It is critical to note that under Agenda 2030, CEDAW and other international conventions, persons affected by violence and discrimination based on sexual orientation and gender identity must be prioritised through policies and practice around rights-based sexual and reproductive health care.

In addition, governments have a duty to capacitate the health system so that persons affected by violence and discrimination based on sexual orientation and gender identity can receive care that meets their physical and mental health needs and rights. Where technical help is needed to formulate policies addressing these barriers and unmet needs, collaborating with CBOs who have been providing such services to their communities must be sought.

Further, governments should be aware of the

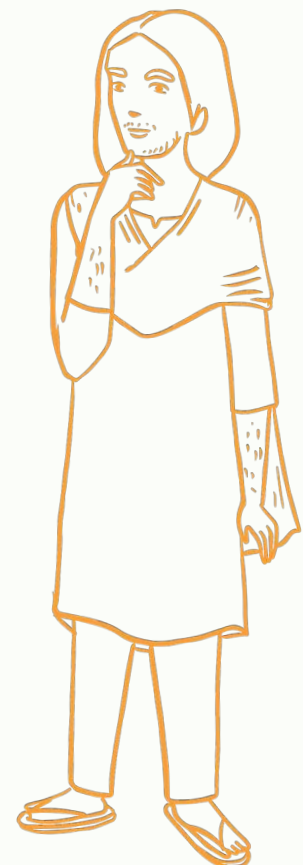
General comment 14 of the Committee on Economic, Social and Cultural rights⁶⁴ Article 12 which states that *each individual (regardless of gender identity) has the right to the highest attainable standard of health including availability, accessibility, acceptability (must be respectful of medical ethics and culturally appropriate), affordability, and quality of healthcare.*

In order to achieve affordable, equitable, quality healthcare for all, it is critical that healthcare providers are engaged and sensitised in the importance of the provision of rights-based gender affirming care, regardless of whether or not gender affirming healthcare interventions fall within the parameters of their field of work.

Gender affirming care services include, but are not limited to, hormone therapy, surgical interventions, facial hair removal, interventions

for the modification of speech and communication, and behavioural/aesthetic adaptations such as genital tucking or packing, or chest binding.

Each of these interventions can have unintended negative implications, however with guidance and support from the provider, it can be mitigated.



⁶⁴ <https://www.ohchr.org/en/resources/educators/human-rights-education-training/e-general-comment-no-14-right-highest-attainable-standard-health-article-12-2000>

In order to become trans-competent, specific recommendations include:

A

Most medications used in gender-affirming hormone therapy are commonly used substances with which most prescribers are already familiar, however it is important that providers are educated in the potential risks related to hormone intake for both trans masculine and trans feminine people.

Healthcare providers should be aware of the possible pharmaceutical contraindications between feminizing or masculinizing hormone therapy (oral, topical or injectable) and other kinds of medication, for example anti-retroviral therapy, beta-blockers or heart medicine, HCV treatment, opioid substitution therapy, tuberculosis treatment, anti-depressants or mood stabilisers, antibiotics, insulin, PrEP, PEP and illicit substances or even heavy alcohol consumption.

B

Hormone levels should also be monitored to ensure that therapy intake levels are adequate, sustained or require titration. Further it is recommended that prior to therapy initiation transgender patients be counselled on the possible effects of transition on their fertility.

Providers should also be aware of the effect of taking hormone therapy at different ages and periods of life, taking into consideration also general health of the patient (for example migraines, diabetes mellitus or high blood pressure), and family health history (for example, osteoporosis, cancer or cardiovascular conditions) and include these in consultations with the patient.

C

Cancer screening (breast, ovarian, cervical, testicular, prostate) or referrals to cancer screening providers should also be promoted.

D

Healthcare providers should also become cognisant of possible health ramifications of binding for extended periods of time which can result in breast pain, local skin irritation or fungal infections and tucking which can cause urinary trauma or infections or testicular pain.

E

Peers should be engaged at all levels of management and service provision at the facility, as senior staff, peer navigators or peer counsellors as well as support personnel.

F

Healthcare provider attitude and language can impede or facilitate access to care and attainment of highest standards of health and well-being for transgender people. It is therefore critical that providers approach their clients without stigma or judgment, editorializing or pathologization. Consent should always be elicited, and confidentiality guaranteed.

Providers should be educated in SOGIESC and become aware of basic terminology used by the trans community in their socio-cultural context. Trans-cultural sensitivity and awareness should begin with reception or front office staff, and other staff that are points of contact for transgender patients. To prevent misgendering, ancillary staff and healthcare providers should make efforts to inquire about and adopt appropriate pronouns and conjugations and name of choice of patient. If a staff member is unsure, it is recommended that they ask the patient for clarification. SOPs addressing these issues should also be developed, in consultation with trans community representatives.

G

As identified in the Scorecards, for many, access to washroom facilities congruent with their gender identity proved challenging. It is recommended that each facility provide a gender-neutral bathroom, or access to a bathroom that reflects their gender identity.

H

Many transgender people in the Asia Pacific region face inexorable hardship as a consequence of stigma, discrimination, and marginalisation. Transgender people often experience socio-economic precarity and live in poverty or familial discord, have limited employment and education opportunities and are frequently victims of sexual, gender-based or intimate partner violence. All of these realities can result in poor mental health outcomes and diminish overall feeling of well-being.

As mental health is vital to positive physical outcomes, transgender people therefore have the right to be referred to and receive mental healthcare support and services from providers who demonstrate trans-cultural sensitivity and competency. Providers should also be capable of providing referrals to legal aid or harm reduction services if requested. Policies and programmes should be put in place that explicitly address the mental health care needs of trans and gender diverse people, including mechanisms to mitigate depression and anxiety, suicidal ideation and problematic substance use.

I

Trans youth and transgender people with disabilities should also be assured unfettered access to healthcare that resonate with their specific needs.

In addition, the further capacity building of service providers using the *Towards Transformative Healthcare: Asia Pacific Trans Health and Rights Module* can help to address existing disparities by equipping primary care providers and health systems with the tools and knowledge to fulfill the health care and social needs of their transgender and gender nonconforming patients.

Uptake of the *Service Provider Checklist and Action Plan* and further implementation of the Trans COMP CBM Tool at other geographic sites would also contribute to efforts to improve service provision for transgender people in the region. It is further recommended that implicated governments as signatories be held **accountable to their commitments within the SDGs (and beyond)**, explicitly that addressing SOGIESC and health as basic human rights⁶⁵, including but not limited to:

Indicator 3.3.1: *Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations;*

Indicator 3.4.2: *Suicide mortality rate;*

Indicator 3.5.1: *Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders;*

Indicator 3.5.2: *Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol;*

Indicator 3.7.1: *Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods, including lesbian and bisexual women, and trans persons;*

Indicator 3.7.2: *Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women and trans men in that age group, particularly among LBT and GNC young individuals;*

Indicator 3.8.1: *Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases*

and service capacity and access, among the general and the most disadvantaged population); and

Indicator 3.8.2: *Proportion of population with large household expenditures on health as a share of total household expenditure or income.*

At the **stakeholder level**, it is advised that the Trans COMP CBM Tool be embedded into existing national level monitoring mechanisms. In addition, ongoing **collaboration and meaningful engagement** of transgender people of all backgrounds in national healthcare program design, **health strategic plan development** with implicated stakeholders and policy makers, including in conversations regarding health budget advocacy for **investment** into gender affirming care service provision (for both trans feminine and trans masculine people) is highly recommended.

⁶⁵ <https://sdgs.un.org/goals/goal3>

FURTHER READING

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