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Towards Equitable Healthcare for All

LGBTQIA+ Human Rights Indicators for a Digital Community-Led Monitoring Tool

APCOM Foundation in collaboration with Shared Planet



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Abbreviations

AAAQ	–	Availability, Accessibility, Acceptability, and Quality
AIDS	–	Acquired immune deficiency syndrome
ART	–	Antiretroviral therapy
CLM	–	Community-led monitoring
CODE Strategies	–	Community-led Online and Digital Engagements as Strategies
CSO	–	Civil Society Organization
HCP	–	Health Care Provider
HIV	–	Human immunodeficiency virus
ICESCR	–	International Covenant on Economic, Social and Cultural Rights
IO	–	International organisation
KII	–	Key informant interview
LGBTQIA+	–	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, and others
NGO	–	Non-governmental organisation
OHCHR	–	Office of the High Commissioner for Human Rights
PrEP	–	Pre-exposure prophylaxis
PEP	–	Post-exposure prophylaxis for HIV
SOGIE	–	Sexual Orientation, Gender Identity, and Expression
SOGIESC	–	Sexual Orientation, Gender Identity, Gender Expression, and Sex Characteristics
SRHR	–	Sexual and Reproductive Health and Rights
STI	–	Sexually Transmitted Infection
The Global Fund	–	The Global Fund to Fight AIDS, Tuberculosis and Malaria
UN	–	United Nations
UNAIDS	–	Joint United Nations Programme on HIV/AIDS
UNDP	–	United Nations Development Programme
WHO	–	World Health Organization

1 Introduction

Health is a universal and fundamental human right, recognised in international documents and treaties such as the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights – many of which have been ratified by the six Asian countries that are the focus of this report, APCOM's Community-led Online and Digital Engagements as Strategies (CODE Strategies) Project countries, India, Indonesia, Nepal, the Philippines, Thailand, and Viet Nam). Yet, in practice, LGBTQIA+ individuals across these countries face structural barriers that obstruct their ability to access equitable, quality healthcare, including discrimination, criminalisation, and the absence of legal protections. These barriers also influence the social determinants of health, in turn driving health disparities both within LGBTQIA+ communities and relative to the general population.

Social determinants of health are recognised as the complex intersection of integrated, overlapping social and economic structures that determine health inequities.[1] For the LGBTQIA+ community, factors ranging from poverty and lack of housing and to more constrained access to education and exposure to violence all adversely impact health outcomes long before individuals interact with the health system. In India, for instance, trans people are systematically excluded from education and employment, such that many turn to sex work. Due in part to this, HIV prevalence for India's trans community is more than 26 times the national rate.[2]

This research takes a human rights-based approach to healthcare access for key population communities. This approach centres international human rights in healthcare advocacy and delivery, affirming the rights of key populations, who deserve the same protections and care as others. By empowering communities to know and assert their rights and holding states accountable for their legal obligations under international law, our approach seeks to ensure that policies and practices are grounded in universal, inalienable rights to dignity, equality, and non-discrimination.[3] This framing is deliberate. All six CODE countries are parties to the International Covenant on Economic, Social and Cultural Rights, which guarantees the right to the highest attainable standard of health, and these international legal obligations give communities a recognised basis for holding governments and health systems to account, even where national laws offer LGBTQIA+ people little or no protection.

This report explores the barriers that LGBTQIA+ people and other key populations, including sex workers and people who use or inject drugs (PWUD/PWID), face in upholding their right to the highest attainable standard of health in six countries: India, Indonesia, Nepal, the Philippines, Thailand, and Viet Nam. Firstly, exploring the established human rights frameworks related to LGBTQIA+ communities' access to healthcare through an analysis of international legal and policy frameworks. This is followed by summarising the theoretical explanations of disparities in LGBTQIA+ health outcomes and access, and consequently focusing on the barriers key population communities face in accessing healthcare along the patient journey. **This examination of barriers was used to set up a community-led**

monitoring (CLM) tool comprised of indicators that seek to monitor whether key population communities seeking healthcare can obtain acceptable, accessible and quality health services, as well as assess their experiences with social determinants of health.

As recognised by the World Bank, there is a need for more population-specific data on LGBTQIA+ health disparities.[4] The CLM tool developed through this research is a step towards addressing that, while also framing healthcare as a human right to which the LGBTQIA+ community is entitled. **Critically, our indicators, contextualised to each of the six countries, aim to empower key population communities and networks to take ownership of monitoring all human rights abuses in healthcare access and use the collected data for their services, programmes, and advocacy pathways.**

A summary of LGBTQIA+ rights across CODE countries

Some of the six countries have seen encouraging shifts in their legal and policy landscapes with respect to LGBTQIA+ rights. Legal recognition and protection play a major role in shaping health outcomes, as criminalisation and stigma can lead to discrimination by healthcare providers, fuelling distrust and discouraging LGBTQIA+ people from seeking the care they need. Illustrating these changing political dynamics, in January 2025, Thailand became the first Asian UN member state to pass a same-sex marriage law, backed by polling suggesting that a majority (60%) of Thai people supported legal recognition for same-sex marriage.[5] In the Muslim-majority countries of Malaysia and Indonesia, however, popular sentiment is strongly opposed to same-sex marriage (17% and 5% acceptance, respectively), mirroring wider cultural attitudes towards LGBTQIA+ individuals and issues, especially in regions like Aceh, where same-sex relations are criminalised under Sharia law.[6]

The state of transgender rights similarly varies across the CODE countries. India passed the Transgender Persons (Protection of Rights) Act in 2019,[7] though transgender activists in India have criticised the bill for putting forth less significant protections for trans people compared to cisgender people.[8] The ability to change gender markers on government-issued documents is also critical to protect the rights of transgender people to gender affirmation. In Thailand, there is no such legal affirmation. As recently as 2024, the Thai Parliament rejected a bill that would have allowed transgender people to change their titles on government-issued documents.[9] Though Indonesia does not have a specific law to regulate the right to modify gender markers on official documents, the Population Administration Law is often used by the transgender community to apply to change the gender marker on their papers. However, attempts at changing their gender marker are frequently denied by Indonesian judges on religious grounds.[10]

Terminology: LGBTQIA+ and SOGIESC

LGBTQIA+ stands for lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other related communities.

It is an umbrella term used to describe individuals whose identities do not align with traditional heterosexual and cisgender norms.

APCOM recognises that there is diversity across cultures and country contexts in using these and related terms.

Another relevant term used in this research is **SOGIESC**, which stands for sexual orientation, gender identity and expression, and sex characteristics – in turn referring to:

- **Sexual orientation**: 'Each person's capacity for profound emotional, affectional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender or more than one gender.'[11]
- **Gender identity**: 'Each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender, including dress, speech and mannerisms.'[12]
- **Gender expression**: 'Each person's presentation of the person's gender through physical appearance – including dress, hairstyles, accessories, cosmetics, and mannerisms, speech, behavioural patterns, names and personal references, may or may not conform to a person's gender identity.'[13]
- **Sex characteristics:** "Each person's physical features relating to sex, including genitalia and other sexual and reproductive anatomy, chromosomes, hormones, and secondary physical features emerging from puberty."[14]

While both terms are used to discuss issues related to LGBTQIA+ individuals, there is a distinction in their application. LGBTQIA+ is identity-based and commonly used in social and cultural discussions, whereas SOGIESC is primarily used in human rights and legal contexts to address discrimination affecting LGBTQIA+ individuals. We are basing our terminology on the Yogyakarta Principles.

2 Research Methodology

This research employed a mixed methodological approach, including secondary data collection through a desk-based evidence review, primary data collection in the form of key informant interviews (KIIs), and the creation of a specified indicator list for each of the six CODE countries. Our research methodology integrates qualitative in-depth interviews with diverse stakeholders, such as experts from international and community-led organisations, complemented by a detailed literature review. Both are essential in formulating comprehensive indicators.

The first phase of this research involved a thorough mapping and review of existing human rights frameworks and indicators, as well as their relevance to addressing the barriers to healthcare access for key population communities globally and across the six CODE countries. This phase also collected and analysed existing literature to explore the specific barriers to healthcare access faced by LGBTQIA+ individuals and other key populations, with the intention of laying a foundational list of human rights violations. A systematic scoping and analysis of peer-reviewed articles from journal databases was conducted, including Google Scholar, JSTOR, Scopus, and Web of Science, as well as white papers from non-governmental organisations (NGOs) and international organisations (IOs) released between 2010 and 2024.

Based on the desk-based review, the second phase comprised two sets of semi-structured KIIs from (a) experts from NGOs/IOs, including from the Joint United Nations Programme on HIV/AIDS (UNAIDS) and United Nations Development Programme (UNDP), and (b) **community-led organisations that are country partners for six CODE countries**. A full list of the stakeholders that the research team engaged with can be found in Annexure 1.

The research team conducted a comprehensive mapping of the relevant stakeholders within the LGBTQIA+ human rights space, especially those who focus on access to health services. Priority stakeholders were then identified for interviews based on input from the APCOM team. Five interviews were conducted to gain insights into: 1) the stakeholder's role and relevant LGBTQIA+ human rights programmes, and their understanding of health-related barriers; 2) how the stakeholder addresses data privacy and ethical data collection; and 3) the key knowledge gaps faced by the stakeholder and how the CLM toolkit could help.

Subsequently, six interviews were conducted with representatives from key population-led networks across the CODE countries. The purpose of these interviews was to gain a deeper understanding of 1) specific barriers faced by LGBTQIA+ individuals and other key populations in accessing healthcare across CODE countries; 2) country-level needs and challenges; and 3) urban-rural divides in healthcare access and solutions.

The third and final phase of the research, building on both the desk-based research and KIIs, involved creating an exhaustive list of human rights indicators that incorporated APCOM's existing CLM tool for HIV prevention. In addition to this exhaustive list, the research team developed tailored indicator lists for each of

the six CODE countries, grounded in established human rights frameworks that were adapted and refined to ensure contextual relevance across the target countries. This was circulated among the interviewees from the key population-led networks and updated based on feedback to ensure that the indicators represented each country's specific context.

3

Existing Human Rights Frameworks and Principles for LGBTQIA+ people in Healthcare Access and Provision

This section outlines key human rights provisions and instruments related to health. It serves as a foundation for the human rights-based approach we use to develop our framework of indicators.

International human rights treaties set out global standards and state obligations to address the direct and indirect barriers LGBTQIA+ communities face in accessing healthcare. While recognising that all human rights should be respected and fulfilled, this section focuses on (a) fundamental principles of human rights, including universality, equality, and non-discrimination; (b) the right to the highest attainable standard of health; (c) prohibition and prevention of discrimination; and (d) the prevention of torture and inhuman treatment. This chapter also delves into the Yogyakarta Principles specifically as they seek to apply SOGIESC-related considerations to human rights provisions.

Table 1: Human rights provisions most relevant to LGBTQIA+ individuals' access to healthcare. Source: prepared by the report authors.

HUMAN RIGHTS PROVISION	DESCRIPTION
Fundamental principles of human rights	**Article 1** of the **Universal Declaration of Human Rights** states that "*All human beings are born free and equal in dignity and rights.*"[15] This fundamental principle is applicable to all and constitute the basis for application of all other human rights frameworks. Since enshrined, the provision has been interpreted to include the elimination of all forms of discrimination based on SOGIESC. Subsequently, other treaty bodies, including the **Committee on Economic, Social, and Cultural Rights in the General Comment 20 and 22** upheld these principles.[16]
Right to the highest attainable standard of health	**Article 25.1** of the **Universal Declaration of Human Rights** states that '*Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.*"[17] The right to the highest attainable standard of health is applicable to all human beings. **Based on this understanding, this research acknowledges that continued barriers in LGBTQIA+ access to healthcare constitute a violation of human rights**. **Article 12** of the **International Covenant on Economic, Social, and Cultural Rights (ICESCR)**[18] integrates both physical and mental health into the interpretation of the right to the highest attainable standard of health. **The Committee on Economic, Social, and Cultural Rights** further clarified in its **General Comment No. 14 (2000)** that the right to health encompasses not only the right to be healthy, but also freedoms, like the right to control one's body, and entitlements, like the right to a system of health protection that provides equal opportunity to achieve the highest attainable health.[19] **General Comment No. 14** also acknowledges the need for non-discrimination and equal treatment on the basis of sexual orientation (p.6), but it adopts a binary "men and women" differentiation under its recommendations to States, thus excluding gender-diverse people (p.7). **General Commentary No. 22** of the **ICESCR (2016)** strengthens the right to sexual and reproductive health for LGBTQIA+ people.[20] Other relevant human rights treaties, including Convention of the Rights on the Child[21] or Persons with Disabilities[22] also recognise the right to highest attainable health. These articles are highly relevant for the application of other frameworks and lenses (such as disability and child rights) to LGBTQIA+ rights.

HUMAN RIGHTS PROVISION	DESCRIPTION
Prohibiting and preventing discrimination	**Article 2 and 7** of the **Universal Declaration of Human Rights** aim to prevent the experience of discrimination for all people in the form of social stigma, exclusion, or other forms of discrimination. This right, which can be observed in other human rights treaties such as the **International Covenant on Civil and Political Rights** as well as Article 2 of the **International Covenant on Economic, Social, and Cultural Rights** aim to establish a relationship between the right to highest attainable standard of health and the right to prohibiting and preventing discrimination.[23]
Preventing torture and cruel inhuman and degrading treatment and punishment	**Article 5** of the **Universal Declaration of Human Rights** states that "*No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.*"[24] This right is repeatedly used by UN human rights bodies and civil society to draw attention towards the maltreatment of LGBTQIA+ individuals, especially transgender and intersex individuals, in medical operations. An important aspect to fulfilling this right relates to the need for free consent to medical or scientific experimentation, which is highlighted in **Article 7** of the **International Covenant on Civil and Political Rights**.[25] Specific LGBTQIA+ experiences related to the infringement of this right, highlighted by UN agencies such as UNAIDS and OHCRC, include: (a) SOGIE change efforts (also known as so-called 'conversion therapies'); (b) forced and involuntary treatments like sterilisation and coerced gender reassignment interventions; and (c) medically unnecessary interventions performed on intersex children without informed consent.[26]

3.1 The Yogyakarta Principles

Adopted in 2006, the Yogyakarta Principles were developed to complement existing human rights frameworks by providing a clear and comprehensive application to the protection of rights related to SOGIESC. By consolidating general comments from the various international treaties outlined above, the Yogyakarta Principles establish an inclusive foundation to address discrimination and stigma related to healthcare access, availability, acceptability, and quality for the LGBTQIA+ communities. It does so by emphasising the fundamental rights of LGBTQIA+ communities and integrating specific healthcare provisions. It was expanded to the Y+10 Principles in 2017 to better account for gender expression and sex characteristics.[27] While widely accepted amongst human rights activists, the Principles have never been accepted at the UN and, therefore, are not legal instruments adopted by states.

Principle 17 of the **Yogyakarta Principles** stipulates that, ***"Everyone has the right to the highest attainable standard of physical and mental health, without discrimination on the basis of sexual orientation or gender identity."***[28] Importantly, the Principle sets out multiple obligations for States to (a) implement legal and administrative measures to ensure inclusive, non-discriminatory, access to healthcare, (b) ensure informed consent and provide comprehensive sexual and reproductive health and rights (SRHR), including gender-affirming care, and (c) implement educational programmes for health care providers (HCPs) to better recognise and understand LGBTQIA+ health needs. Under the Right to Sanitation (specifically **Articles 35.a and 35.d**) of the **Y+10 Principles**, the Principles call on States to **provide dignified public sanitation facilities, including at healthcare facilities**.[29] This provision is especially relevant for gender diverse people and the provision of gender-neutral sanitation facilities.

Principle 2 expands the State obligation to prohibit discrimination within the social determinants of health, stating that, *"Discrimination based on sexual orientation or gender identity may be, and commonly is, compounded by discrimination on other grounds including gender, race, age, religion, disability, health and economic status."* **Principle 10**[30] reaffirms the State obligation to prevent torture and cruel, inhuman, or degrading treatment or punishment, particularly for reasons relating to sexual orientation or gender identity. **Principle 18** outlines the right to protection from medical abuses, stating that, '*No person may be forced to undergo any form of medical or psychological treatment, procedure, testing, or be confined to a medical facility, based on sexual orientation or gender identity*.'[31] Finally, the Y+10 Principles add **the right to bodily and mental integrity under Principle 32**, which pertains to practices such as coerced gender reassignment interventions and SOGIE change efforts in the absence of free, prior, and informed consent.

3.2 AAAQ Framework

The **AAAQ (Availability, Accessibility, Acceptability, and Quality) Framework** mandates that all services, goods, and facilities must meet these **four essential criteria to uphold human rights in healthcare delivery**. Recommended by the World Health Organization (WHO) and the UN Human Rights Office (OHCRC), these four core components of the right to health are commonly used to collate and instrumentalise the long list of diverse human rights provisions. The table below summarises the four components of the AAAQ framework.

Table 2: The AAAQ Framework. Source: The Right to Health, Fact Sheet No. 31 (2010), Office of the United Nations High Commissioner for Human Rights and World Health Organization.

A Availability	A Accessibility
Healthcare facilities, goods, and services must be: • Functioning; • Publicly available; and • Available in sufficient quantity.	Healthcare facilities, goods, and services must be accessible: • Physically (location and infrastructure); • Financially; and • [accessible] in terms of the right to seek, receive, and impact health-related information.

A Acceptability

Healthcare facilities, goods, and services must:

- Respect medical ethics;
- Be culturally sensitive and appropriate; and
- Integrate SOGIESC-responsive approaches.

Q Quality of Services

Healthcare services must ensure:

- Well-trained trained health professionals;
- The use of scientifically approved and unexpired drugs and equipment;
- Adequate sanitation; and
- Safe drinking water.

Community-led monitoring (CLM) plays a crucial role in detecting human rights abuses throughout the patient journey, identifying service gaps, and advocating for necessary legislative, policy, and practical improvements in service delivery. Therefore, it is important to adopt a human rights-based approach to ensure the highest attainable standard of health across countries.

In this context, the AAAQ framework provides a structured mechanism to develop indicators operationalising human rights provisions related to LGBTQIA+ healthcare access. By applying this framework across the patient journey, it ensures that services are inclusive, non-discriminatory, and aligned with the needs of marginalised communities.

3.3 UNDP LGBT Inclusion Index

Initially published in 2019, the UNDP LGBTI Inclusion Index (hereafter "the Index") proposes a globally applicable set of indicators to measure the inclusion of LGBTQIA+ people in a comparative, standardised way. Developed through a collaborative process involving community members, researchers, governments, human rights advocates, and development institutions, the Index focuses on five interrelated dimensions, including health, which were identified as top priorities by stakeholders across more than 20 countries.[32]

While the Index is a valuable step forward, a closer analysis of the proposed health-related indicators reveals some limitations. Most notably, the indicators that are proposed under the health section do not fully capture the social determinants of health, which, as emphasised by the WHO, are essential for a holistic understanding of the health barriers and outcomes experienced by LGBTQIA+ people. The Index itself acknowledges this limitation: "Most dimensions of human life are so multi-faceted that one measure—or even two or three—could not adequately capture what is meant by 'health' or 'economic well-being.'"[33] (pg. 8). As such, many of the health indicators function as proxies, capturing only certain facets of the broader picture.

Currently, the Index primarily emphasises policy-level measures and the prevalence of disease or treatment access. While these are important for assessing structural barriers and disparities in healthcare outcomes, the indicators fail to address other crucial aspects, such as the acceptability and quality of care, patient-provider interactions, and the degree of safety and dignity experienced by LGBTQIA+ individuals within healthcare settings. These gaps are particularly evident in the absence of Tier 3 indicators, which rely on data generated through deeper collaboration with community-led organisations. Tier 3 indicators, while invaluable, are often more challenging to implement due to political sensitivities, resource constraints, or restrictive legal environments.

In 2022, the Index underwent a pilot phase in six countries, including the Dominican Republic, Georgia, Guyana, New Zealand, Pakistan, and Viet Nam, to assess its real-world applicability. In this initial phase, indicator selection was driven by data availability and feasibility, leading to an exclusive reliance on Tier 1 and 2 data sourced from aggregated government statistics.[34] While these provided a foundation, the process faced limitations: surveys were often conducted only in English and primarily reached urban, higher-income populations, underrepresenting rural and marginalised groups.

Looking ahead, the aspirations for Phase II are promising. There is a concerted effort to incorporate Tier 3 indicators, expand reach into rural areas, and strengthen the inclusion of key populations.[35] Despite its limitations, the Index represents a significant and commendable step in building global consensus on measuring inclusion. It lays essential groundwork for generating more nuanced, community-informed data and offers an important platform to advocate for more equitable, responsive, and inclusive health systems for LGBTQIA+ people worldwide. This research seeks to empower key population communities by providing them with CLM tools to collect, analyse, and advocate for themselves through granular data.

4 Root Causes of the Barriers related to Healthcare access of LGBTQIA+ Individuals

The literature on healthcare disparities among LGBTQIA+ communities highlights the complex interplay of social, political, and cultural factors that shape barriers to access and disproportionate health outcomes. **The following section provides an overview of the theoretical frameworks explaining how inequities in LGBTQIA+ healthcare outcomes and barriers are created and maintained**. However, a comprehensive analysis of the root causes of these barriers lies outside the scope of this research.

In summary, heteronormative and heterosexist biases within society are channelled through institutional settings to create both individual-level and institutional stigma, resulting in the victimisation of LGBTQIA+ individuals. Minority stress theory sheds light on the disproportionate physical and mental health implications of these interpersonal and structural discriminatory attitudes. Together, this lens of understanding highlights how these root causes impede the realisation of human rights for LGBTQIA+ peoples, whether by obstructing access to the healthcare system or the provision of specific services, or by preventing services from being acceptable and of good quality.

The figure below summarises the interplay between these factors. (Figure 1) Heterosexist and heteronormative disposition lead to stigma and discriminative behaviours towards LGBTQIA+ people lead to their victimisation. As a result, minority stress theory seeks to explain the physical and mental toll key population communities feel.

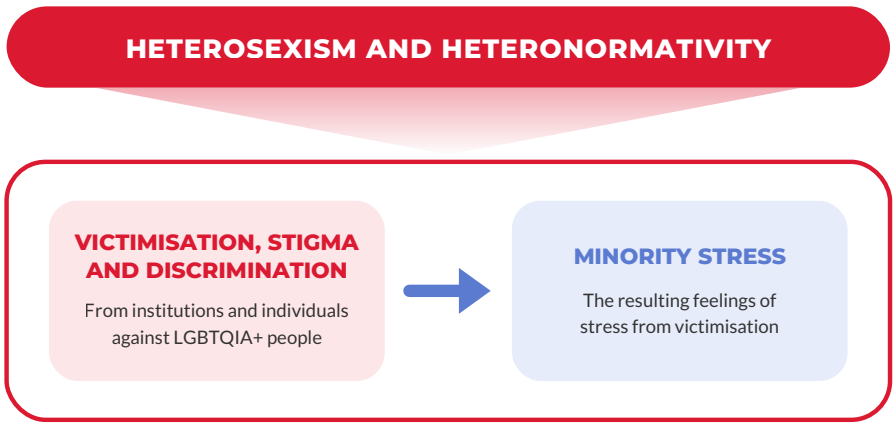

Figure 1: Relationship between the root causes of the barriers related to healthcare access of LGBTQIA+ people. Source: prepared by the report authors.

4.1 Heteronormativity and heterosexism

Many of the systemic barriers that LGBTQIA+ communities face in healthcare stem from deeply ingrained heteronormativity and heterosexist attitudes. These beliefs shape healthcare environments, policies, and interactions, often making healthcare settings unwelcoming, exclusionary, or outright discriminatory.

Heteronormativity refers to the set of deeply held beliefs that uphold heterosexuality as the norm. These beliefs promote a strict adherence to the male-female gender binary and enforce heteronormative roles. Relatedly, **heterosexism** constitutes a framework of adverse attitudes, beliefs, emotions, and behaviours that rely on a binary view of gender, privileging heterosexuality and heterosexual relationships.[36] To provide an example that distinguishes these interconnected concepts: a heteronormative practice within healthcare might include the absence of visual cues acknowledging non-heterosexual SOGIESC identities, such as in waiting room posters.[37] A heterosexist act in healthcare would include the active refusal by medical professionals to provide gynaecology services to transgender men due to the belief that these services are reserved for cisgender women.

Across CODE countries, and especially in countries such as Indonesia and Malaysia,[38] heterosexist and heteronormative attitudes are prevalent throughout the healthcare system. These attitudes are reflected in the limited inclusivity in consultations and the barriers in healthcare-related discussions, such as gynaecological needs for transgender patients.[39] The challenges are especially pronounced for intersex and transgender people, who face heightened exclusion due to the widespread normalisation of a binary understanding of sex and gender at birth.

4.2 Stigma, discrimination, and victimisation

Heteronormativity and heterosexism frequently result in discrimination and stigma against LGBTQIA+ communities, perpetuated by both institutions and individuals. Discrimination can manifest in various forms, such as the unequal availability of healthcare services, social stigma, harassment, violence, and limited legal protection or recourse – which will be outlined in the next section on barriers to healthcare access. These issues create an overall unwelcoming healthcare environment that deters LGBTQIA+ individuals from seeking necessary medical care.[40]

4.3 Minority Stress Theory

Minority stress theory is used to explain how violence, stigma, and discriminatory behaviours towards marginalised or minority groups result in disproportionately poorer physical and mental health outcomes within these communities.[41] The increased stress produced by both structural factors, such as criminalisation and pathologisation of LGBTQIA+ individuals, or interpersonal ones, like social

ostracisation and societal stigma surrounding sexually transmitted infections (STIs), **decreases the likelihood of health-seeking behaviour and trust in the healthcare system.**[42]

Double- or multiple-marginalised populations, such as LGBTQIA+ individuals who engage in sex work or use or inject drugs, experience multiple or compounded stresses.[43] As multiple-marginalised populations are pushed towards the fringes of society, they often experience living conditions and develop coping mechanisms that further exacerbate negative health experiences and outcomes. Minority stress theory is widely used to examine the health disparities and persistent barriers related to healthcare access amongst LGBTQIA+ youth.[44] The impact of religious institutions, for instance, has repeatedly been highlighted as a source of emotional distress for LGBTQIA+ youth, as religious institutions often exhibit antagonistic behaviours towards them. **The engagement in medically unsupported practices, like SOGIE change efforts that cause mental and physical distress amongst LGBTQIA+ youth, especially when the medical records related to patients' SOGIESC are shared by Healthcare Providers (HCPs).**

5

A Patient's Journey: Barriers Faced by LGBTQIA+ Individuals in Healthcare Access

This chapter explores the key barriers that LGBTQIA+ individuals face when accessing healthcare services. Using the AAAQ framework, this section presents how these healthcare barriers constitute human rights violations against LGBTQIA+ communities. While most academic research and grey literature structures barriers into individual and institutional factors, we use the **patient journey** as our analysis framework. This allows us to examine service availability, accessibility, acceptability, and quality to determine specific barriers faced at various points of engagement.

Based on the patient journey, the **pre-arrival** section focuses on the broader social determinants of health and the structural barriers preventing LGBTQIA+ individuals from accessing healthcare. This includes factors such as family and community dynamics, discriminatory policies and institutional designs, and information-related barriers. The second section considers the barriers that emerge **at the healthcare facility.** The section emphasises issues related to the basic infrastructure of the facilities, the availability of services, and interactions between other patients and HCPs. The final section examines **patient aftercare**, highlighting specific barriers LGBTQIA+ communities face in receiving continuous treatment for chronic medical conditions.

Table 3: The structure of this chapter, based on the patient journey.

1 Pre-arrival	2 At the healthcare facility	3 Aftercare
• Social determinants of health • Policy, legislative, and institutional environment • Information-related barriers	• Healthcare facility and basic physical infrastructure • Consultation process and relations with HCPs • Provision of services	• Continuous treatment

Disparities in health-related outcomes between LGBTQIA+ individuals and cisgender, heterosexual individuals are prevalent and well-documented. However, this chapter's main objective is to outline specific barriers to healthcare access based on LGBTQIA+ individuals' experiences, rather than detailing health disparities. Where there are clear disparities in health outcomes within LGBTQIA+ populations compared to the general population, for instance, in mental health, the literature review aims to highlight the barriers that may contribute to this disparity.

5.1 Pre-Arrival

This section explores the structural barriers that LGBTQIA+ individuals may face before accessing healthcare. This includes the social determinants of health linked to family and community dynamics, as well as political and institutional barriers, and information-related barriers.

5.1.1 Social Determinants of Health

The social determinants of health refer to the broad non-structural medical factors that may lead to both positive and negative outcomes – combined, they may account for up to 55% of health outcomes.[45] However, the root causes outlined above generally compromise the access of LGBTQIA+ individuals to healthcare or drive negative health outcomes.[46] A growing body of literature indicates that LGBTQIA+ individuals worldwide often encounter difficulties in obtaining employment opportunities, education, housing, and other essential services. These factors are likely to adversely affect their physical and mental health.[47] For instance, social and economic ostracisation of LGBTQIA+ individuals often result in lower income levels, which, in turn, limits access to the highest attainable standards of health, especially in the absence of universal health insurance, undermining full enjoyment of human rights.[48]

These barriers are created and sustained by entrenched **cultural norms** that can drive exclusion of LGBTQIA+ individuals from their families, communities, or society, as well as **structural factors** like local and national policies. Cultural and structural factors are often interlinked and hard to disentangle. The following section will explore the social determinants of health in relation to familial and social exclusion, and inequalities in income and social protection.

Family, community, and social exclusion

In some countries, LGBTQIA+ individuals experience open discrimination and exclusion from society. Public opposition to LGBTQIA+ individuals is a concerning and widespread trend worldwide. Some research attributes the backlash against LGBTQIA+ peoples and spaces to the increasingly visible national and international queer rights movements.[49] In Thailand, this public opposition prevents the adoption of measures to remedy the systematic marginalisation of LGBTQIA+ individuals,[50] further complicating access to and receipt of essential healthcare services.

Social exclusion often manifests in interactions with family members and peers. Discrimination and stigma from family and peers may take the form of **slurs, name-calling, misgendering, bullying, and harassment**.[51] This lack of acceptance and discriminatory behaviour can stem from religious views, cultural conservatism, and patriarchal traditions, and can also be based on caste. Such barriers are particularly pronounced in rural areas, which are often characterised by a higher level of religious conservatism. In India and Indonesia, it is common for families to pressure LGBTQIA+ individuals into marriage.[52] This pressure can undermine LBQ+

women's healthcare access, as **marriage often comes with restrictions on personal freedom and strict social expectations, leading to mental health issues, like depression**. Children may also face mistreatment or abuse from their families because of their SOGIESC, which can lead to greater vulnerability to physical and mental health issues in later life.[53] Moreover, youth who are shunned by their families or communities may be driven away from their homes, which places them at increased risk of homelessness or unstable housing, in turn driving negative health outcomes.[54]

Stigma and discrimination experienced by LGBTQIA+ individuals can impact access to healthcare in several ways. LGBTQIA+ individuals may feel forced to suppress their SOGIESC and avoid seeking **healthcare services** or **discussing their intimate relationships with their communities, who may channel them to seek healthcare services. This avoidance often stems from fear of reprisal or judgement**.[55] The fear of shame and social exclusion can disincentivise the uptake of specific health treatments. For example, LGBTQIA+ people may be reluctant to **test for HIV due to the potential implications of testing positive or being seen accessing HIV services, whether by their partners, family members, or community**.[56] In the Philippines and Indonesia, the growing stigma around monkeypox has made the LGBTQIA+ community more reluctant to reach out to healthcare providers.[57] The fear of shame is particularly pronounced among homeless or at-risk youth and sex workers and PWUD/PWID, who are often perceived as 'immoral or deserving of discrimination' by broader society.[58] As a result, LGBTQIA+ individuals, especially those who are doubly or multiply marginalised, may struggle to receive the healthcare they need.[59]

Reluctance to disclose SOGIESC to family members can compromise mental health and lead to unhealthy coping mechanisms. Pervasive discrimination often drives mental health issues, including **depression or suicidal thoughts**. These issues can increase **the likelihood of alcohol and drug use or self-harm, which further reduces the tendency to seek health care.** As addiction reduces the likelihood of seeking healthcare due to factors related to added shame and reduced motivation, it creates additional barriers. In some cases, social and familial stigma may lead to LGBTQIA+ individuals, especially youth, being forcibly referred to mental health professionals or even coerced into undergoing SOGIE change efforts (or the so-called *'conversion therapy'*), which can further compound mental stress.

Income and social protection

Experiences of stigma and discrimination against LGBTQIA+ individuals often lead to inequalities in access to housing or employment.[60] This inequality is compounded for double-marginalised individuals. For instance, sex workers tend to be depicted in the media and popular culture as **immoral and undeserving of healthcare, housing, or education, exacerbating their marginalisation**.[61] Yet, individuals, predominantly transgender individuals, tend to undertake sex work due to limited work and educational opportunities and as a means to support

themselves or their families. Sex work, especially unregulated, can drive poorer health outcomes, including **a higher risk of STIs that are left untreated due to fears of stigmatisation**.[62]

Systemic earning inequalities can compound the difficulties in accessing healthcare, particularly for **more expensive specialised services, such as gender-affirming care for the specific needs of transgender healthcare.**[63] In many contexts, especially where healthcare is privatised, LGBTQIA+ communities face limited or no access to insurance coverage, making healthcare services increasingly unaffordable or financially burdensome.[64] For instance, in Indonesia, LGBTQIA+ individuals often struggle to access to **health insurance** since it is based **on family-unit registration**, and many do not want to reveal their gender identity or sexual orientation to their family.[65] Equally, **LGBTQIA+ individuals may be prevented from covering their partners under life or health insurance plans due to existing laws** and may not be able to make healthcare decisions on behalf of their partners during emergency situations.[66] In Viet Nam, a lack of formal employment prevents some key populations from accessing employer-provided health insurance.[67] Without insurance, individuals are **often overcharged or forced to pay the higher costs of private health services**, especially if private services are more likely to be LGBTQIA+ friendly than public services.[68]

5.1.2 Policy, legislative, and institutional barriers

LGBTQIA+ individuals' access to healthcare can be obstructed by several political, legislative, and institutional barriers enforced by governments. In some countries, state practices are fundamentally discriminatory towards LGBTQIA+ groups and deliberately seek to undermine their fundamental human rights in accessing healthcare or other essential social services that determine health outcomes.

Policy and legislation

Although a majority of states worldwide (including CODE countries) have ratified international human rights treaties, codifying the right to the highest attainable standard of health, the full respect or fulfilment may be missing.[69] **In some societies, such as Malaysia and Indonesia, the right to the highest attainable standard of health is undermined by policies that criminalise same-sex relations and transgender gender expressions.**[70] In Malaysia, for example, *fatwas* (a formal interpretation of Islamic law by a qualified Islamic scholar) have been declared against LGBTQIA+ individuals, which impacts the right to live with dignity and the right to non-discrimination.[71]

In Indonesia, there are cases where **medical practitioners who provide gender-affirming care are criminalised**.[72] More generally, hostile policies towards PWUD and sex workers have compromised the uptake of HIV treatments due to the fear of reprisals, thereby worsening health outcomes.[73] According to UNDP, the criminalisation of sex work in some Southeast Asian countries has made male and transgender sex workers **reluctant to carry condoms or take HIV tests, since this can be used by law enforcement as evidence of engaging in sex work, which elevates the risk of contracting HIV and decreases the likelihood of receiving**

treatment.[74] In Viet Nam, the illegal status of sex workers can lead to detention or placement in rehabilitation centres.[75] Such legislation severely restricts access to healthcare and undermine basic human rights.

Even in societies where same-sex relations are not criminalised, the absence of anti-discrimination legislation can compromise healthcare access. Without **anti-discrimination legislation for LGBTQIA+ individuals, discrimination, marginalisation, harassment, and hate crimes can become more pervasive or normalised in society, limiting access to essential services, and increasing the likelihood of mental health issues among victims.**[76] For instance, in certain parts of Indonesia, there has been ongoing discrimination and violence against LGBTQIA+ people, including through extortion, harassment, and denial of basic rights.[77]

Another barrier to healthcare relates to the inability of transgender individuals to change their legal gender or prefix on official documentation due to anti-LGBT policies.[78] As noted by UNDP, the vast majority of transgender people in Asia and the Pacific are unable to obtain identity documents or gain formal recognition before the law.[79] This lack of recognition not only creates issues in attempting to access or register for health care, but may also lead to biased treatment within the healthcare system.[80]

Institutional

Discrimination may also be present within state institutions, which can affect health outcomes and healthcare access for minorities. Education systems may stigmatise LGBTQIA+ individuals, contributing to the propagation of discriminatory attitudes and practices within society.[81] These dynamics can be exacerbated by the media, which often propagates heteronormative conventions.[82] For instance, in Indonesia, the backlash against LGBTQIA+ campaigning has in part been driven by mainstream media outlets, which have also censored LGBTQIA+ content.[83]

Furthermore, legal systems may deliberately discriminate against or overlook the rights of LGBTQIA+ populations, particularly in countries where international human rights frameworks have not been fully implemented.[84] In countries that criminalise same-sex relations, legal services may not be available to LGBTQIA+ communities, resulting in a lack of "meaningful access to justice and judicial mechanisms."[85] Legal barriers are exacerbated for criminalised populations, such as sex workers.[86] This limited access to justice can make minorities, including the LGBTQIA+ community, **reluctant or even fearful of reporting breaches in their right to health, exacerbating the issue**.

Discrimination from individual state authorities

While national policies and legislation may discriminate against LGBTQIA+ individuals, there is also the risk of minorities being directly targeted by the authorities (other than healthcare practitioners) because of their SOGIESC. State authorities, intelligence services, and police forces have been known, particularly

in authoritarian contexts, to oppress or threaten individuals based on their assumed sexual orientation, resulting in harassment, violence and death threats.[87] In Thailand and Indonesia, police have carried out raids on private spaces and arrested individuals for engaging in same-sex activities.[88] These **abusive and discriminatory actions create a climate of fear, making vulnerable groups less likely to file formal complaints with law enforcement due to concerns about repercussions.**[89]

Discrimination from state authorities has also been observed in the categorisation of diverse sexual orientations and gender identities as **psychological or mental health problems**.[90] There have been several instances of this occurring in Indonesia. In 2016, the Director of Mental Health at the Indonesian Ministry of Health stated publicly that homosexuality is a "psychiatric condition."[91] This discriminatory rhetoric was later reinforced by the Indonesian Psychiatrists Association, which claimed that "people who are homosexual and bisexual are categorised as people with psychiatric problems."[92] Similar dynamics can be observed in Malaysia, where the country's mental health policies pathologise SOGIESC minorities.[93]

5.1.3 Information-Related Barriers

Barriers that prevent healthcare access may also arise from information-related challenges, such as a lack of awareness among LGBTQIA+ individuals of their rights or limited resources available related to safer sex practices and the importance of and ways to seek healthcare. These issues can result in the underutilisation of available healthcare support services, misconceptions about specific health risks, and a general reliance on informal networks or word-of-mouth for information on health issues, rather than seeking the available services for them.

Knowledge and resources

Societal discrimination against LGBTQIA+ individuals can lead to a lack of information about **safe sex practices and sexual health**. Young people are often unaware of or **misconceive modes of transmission of HIV, STIs, and lack knowledge of safe sex practices**.[94] India's National AIDS Control Organisation has also indicated that there is a higher prevalence of HIV a**mong transgender persons who cannot read or write, and consequently struggle to access credible sources of information on health and HIV transmission**.[95]

Many LGBTQIA+ individuals rely on informal sources of information for their medical care, including word of mouth or social media.[96] In countries, like Thailand, there are insufficient online resources for LGBTQIA+ youth to obtain accurate and reliable information on healthcare or health risks, despite efforts from CSOs to amplify online resources.[97] Likewise, in Viet Nam, the end to HIV education and testing in schools has forced youth to turn to other sources of information on sexual health.[98] **This means that youth rely on information from non-expert sources or content creators on largely unregulated social media and other online**

platforms. The reliance on social media can increase the risk of misinformation, particularly around specialised treatments and services, such as hormone therapy.

Lack of knowledge about rights

A lack of awareness of fundamental rights related to health is a key barrier to demand accessing healthcare and improving health outcomes for LGBTQIA+ individuals. **Young people in particular are often unaware of their rights related to healthcare**, which may be due to anti-LGBT discrimination within the education systems of some countries.[99] For instance, **many LGBTQIA+ youth in Thailand are unaware of their right to undergo an HIV test without parental consent, leading to lower demand for uptake of testing and preventative care.**[100] Moreover, India's National AIDS Control Organisation has reported that transgender persons who have experienced violence, including sexual violence, often lack knowledge of their **legal rights or the availability of legal aid programmes that can support them**.[101] These information-related barriers ultimately mean that vulnerable individuals may not be utilising available healthcare support services, ultimately compromising overall health outcomes.

5.2 At the Healthcare Facility

The literature highlights that LGBTQIA+ individuals encounter significant barriers when accessing healthcare services. These obstacles primarily arise from systemic discrimination, lack of inclusivity, and structural inequities present in healthcare facilities. These barriers manifest across various stages of healthcare provision, ranging from the physical infrastructure of facilities to interactions with healthcare providers.

Key population groups, who are often double- or multiple-marginalised subgroups within the LGBTQIA+ community, such as transgender individuals, sex workers, PWUD, and young people, often face compounded challenges due to intersecting forms of discrimination based on gender identity, sexual orientation, socioeconomic status, and age. These barriers not only hinder access to essential healthcare services, but also perpetuate cycles of exclusion and inequity, violating fundamental human rights, including the right to health, dignity, and non-discrimination.

5.2.1 Healthcare Facility and Basic Physical Infrastructure

The challenges related to mobility and physical infrastructure for LGBTQIA+ individuals not only limit access to healthcare, but can constitute significant human rights violations, as they deny individuals their fundamental rights to health, dignity, and non-discrimination. Accessibility of the healthcare facility in terms of physical distance and lack of acceptable and available facilities and registration processes create structural barriers for LGBTQIA+ individuals. These structural barriers highlight the need for healthcare facilities to adopt inclusive designs and policies that accommodate diverse identities and ensure equitable access to care.

Accessibility of the healthcare facility

The challenges related to mobility and physical infrastructure in healthcare settings disproportionately affect LGBTQIA+ individuals, especially those located in rural or remote areas. For example, in Thailand, the concentration of LGBTQIA+ friendly healthcare facilities in metropolitan areas highlights **a systemic urban bias in accessible healthcare provision.**[102] In Viet Nam, HIV and STI treatment is predominantly provided in urban centres, resulting in a rural-urban divide in service provision.[103] **This geographic disparity not only limits access for rural populations but also reinforces pre-existing socioeconomic inequalities, as individuals from lower-income backgrounds may lack the resources to travel long distances for high-quality care that meets their needs.**

For transgender individuals, who may require specialised services such as hormone therapy and gender-affirming care, this urban-centric model can create significant barriers to access. For instance, in India, there is only one clinic providing gender-affirming care in Delhi.[104] The financial and personal cost of travelling long distances to access essential treatments can heighten safety risks and exacerbate physical and mental health conditions.[105] Inequitable access violates the right to health, which mandates that healthcare must be accessible to all irrespective of geographic location. In addition, **long waiting lists for appointments and services for gender-affirming care, including treatments for gender dysphoria, demonstrate further violations of the human right to the highest attainable health**.

Hostile physical environment

Another barrier to accessibility and acceptability in healthcare facilities is the **gender-binary segregation commonly found in hospital physical spaces, including wards, waiting rooms and queues**. This segregation further marginalises transgender and gender-diverse individuals,[106] by alienating non-binary and transgender patients and denying them dignity. This also reflects the lack of institutional willingness to accommodate diverse gender identities, which can deter individuals from seeking care altogether and perpetuate cycles of health inequity.

A lack of medical privacy can further undermine health accessibility for LGBTQIA+ individuals and result in delays to care and support. **Healthcare facilities without dedicated private and safe consultation rooms to discuss sensitive issues for LGBTQIA+ individuals, such as STIs, can discourage individuals from seeking preventative or treatment services**. This lack of physical privacy can undermine trust in HCP, and discourage individuals from accessing care, increasing the risk of other health conditions.

The absence of inclusive representation of LGBTQIA+ individuals within healthcare settings, including in imagery, pamphlets, and public messaging, can reinforce feelings of exclusion and invisibility.[107] When facilities are not designed

to be inclusive and safe, they perpetuate systemic exclusion and signal a failure to recognise and validate diverse identities, deterring individuals from returning for follow-up consultations.

Registration process and interactions in the waiting room

During the registration process, assumptions of heterosexuality made by registration personnel and the lack of representation related to LGBTQIA+ identities can create an adverse environment for those seeking care. **The lack of inclusivity can make patients feel uncomfortable**, often preventing them from disclosing their SOGIESC.[108] These practices violate the right to non-discrimination and the right to health. **For transgender individuals, the absence of gender-concordant identity documents** further complicates access to healthcare. Many transgender people face **challenges when their official documents do not reflect their gender identity, leading to misgendering, denial of care or outright exclusion from services.**[109]

Financial barriers during the registration process also contribute to human rights complications by violating the principle of accessibility. **LGBTQIA+ individuals, particularly transgender persons, are often charged unusually high consultation fees due to their gender identity or sexual orientation.**[110] In some cases, Individuals are forced to **pay bribes to receive care**, or otherwise face being denied care outright, further exacerbating financial inequities and limiting access to essential services.[111]

Beyond the refusal due to absence of gender-concordant identity documents, **heteronormative registration forms that does not include representation related to SOGIESC expressions make patients uncomfortable and prevent them from disclosing their gender expression or identity.**[112] In addition, prolonged waiting times at the healthcare facility after registration – due to dedicated staff shortages, including nurses and medical doctors, especially for gender-affirming care – can also deter LGBTQIA+ individuals from seeking treatment. **Without appointments in the after-work hours or weekends, long waiting times at the healthcare facility disproportionately affect LGBTQIA+ people with lower financial means.**

For young LGBTQIA+ individuals, particularly those seeking HIV testing or gender-affirming care, the requirement for parental consent or accompaniment poses a significant barrier during the registration process. This can violate the right to health and privacy, as it prevents young people from accessing confidential healthcare services that are critical to their well-being. **Many hospitals still mandate parental involvement for minors, which can deter young people from accessing essential services due to fear of rejection, discrimination, or violence from their families.**[113]

Interactions among other patients during the registration process and in waiting rooms often involve overt or indirect discrimination. **LGBTQIA+ individuals, particularly transgender persons, frequently face overt discrimination, including name-calling, homophobic slurs, misgendering, bullying, and harassment.** Threats

of physical or sexual violence have also been reported, creating an unsafe and hostile environment.[114] **Indirect stigma, such as visible discomfort or stares from other patients, can further alienate LGBTQIA+ individuals and discourage them from seeking care**. These experiences can violate the right to dignity, safety, and freedom from discrimination.

The registration process can be a barrier to healthcare access due to discriminatory practices, lack of inclusivity, and systemic biases embedded in the healthcare system. Addressing these issues requires systemic reforms, including the introduction of inclusive registration forms, gender-concordant identity documents, anti-discrimination training for staff, and policies that protect the confidentiality and autonomy of the LGBTQIA+ people.

5.2.2 Consultation Process

The consultation process between LGBTQIA+ individuals and HCPs is characterised by power imbalances. These can result in the denial of care, coercion, and confidentiality breaches that constitute human rights violations. Such issues are especially salient due to a lack of training and inclusivity guidelines for HCPs on LGBTQIA+ health issues, and a lack of laws protecting confidentiality and informed consent for LGBTQIA+ individuals accessing healthcare.

Knowledge and attitudes of healthcare professionals

A critical barrier to acceptable healthcare is the **lack of knowledge and sensitivity among healthcare providers regarding specific health needs of the LGBTQIA+ community**. Many healthcare professionals lack adequate training on these issues, which can result in overt and indirect discrimination. Overt discrimination can include **care refusal, inadequate treatment, or hostility, particularly towards sex workers who face heightened stigma once/if their profession is disclosed**.[115] Indirect discrimination can manifest as microaggressions, including **the use of incorrect pronouns, invasive questions unrelated to the visit, or humiliating comments**, which are particularly prevalent for transgender individuals.[116] This can result in a hostile environment that deters care-seeking behaviour.

For PWUD, the fear of discrimination often prevents them from disclosing their drug use or sexual practices, leading to inadequate or inappropriate care.[117] Similarly, **the misplaced assumptions construed by secondary physical and mental HCPs about the connection between SOGIESC-related trauma, LGBTQIA+ identity, and substance use** when two of the experiences are disclosed can deter individuals from sharing critical information regarding their health needs.[118] **The lack of intervention by HCPs when other patients display discriminatory behaviour can further deter LGBTQIA+ individuals from sharing health information or even seeking care.**

The absence of formal training on LGBTQIA+ issues can also lead to harmful misconceptions, such as **conflating intersex and transgender identities**.[119] This lack of awareness can perpetuate an unsupportive environment where the specific healthcare needs of LGBTQIA+ individuals, including those related to addiction

and mental health, are overlooked.[120] **Additionally, the use of technical or inaccessible language by healthcare providers can further alienate LGBTQIA+ individuals, hindering their understanding of health risks and treatment options.**

Confidentiality, consent, and risk of coercion

The power imbalance between healthcare providers and individuals often results in confidentiality, informed consent, and autonomy violations. In the absence of protective laws and policies, LGBTQIA+ individuals, particularly transgender and intersex young people, are subjected to **unnecessary surgeries and hormone treatments without full informed consent**.[121] These practices, including sterilisations and so-called '*real-life tests*', are often performed before individuals can make informed decisions, violating their right to bodily autonomy and self-determination – therefore constituting torturous practices.[122]

Coercion into **SOGIE change efforts or alternative treatments, including religious or alternative types of medicine, including *allopathy, naturopathy, ayurveda, yoga, unani, siddha* or any other indigenous systems of health care can further exemplify these violations**.[123] The lack of standardised guidelines for gender-affirming care and **the unaffordability of supervised hormone replacement therapy often forces individuals to undertake unsupervised treatments, risking their health and safety**.[124] Additionally, invasive procedures, such as **per-vaginal and anal examinations**, are often conducted without active pursuit of consent, and LGBTQIA+ individuals, including transmasculine people, are sometimes subjected to observation by medical students without their permission.[125]

Confidentiality concerns also deter LGBTQIA+ individuals from accessing sexual health services or disclosing their sexual health concerns. **Inappropriate disclosure of confidential information by HCP, including sharing SOGIESC characteristics with patients' families, exacerbates these fears.**[126] For young LGBTQIA+ individuals, the lack of anonymous and confidential HIV testing and the adult-oriented design of healthcare services further marginalise them, discouraging them from seeking care.[127]

5.2.3 Provision of Services

There is extensive research to show that LGBTQIA+ individuals are at greater risk of certain health issues including STIs, HIV/AIDS, cancer, and mental health issues.[128] While this literature review does not focus on disparities in health outcomes, it is important to understand the relevant barriers that generate such disparities. The literature has shown how risks for LGBTQIA+ individuals from other health issues may be exacerbated by the presence of discrimination, inequalities in the provision of essential health services, and a lack of access to specialised care.

Lack of services

In countries where LGBTQIA+ individuals face discrimination or same-sex relations are criminalised, there is often an absence of health services or specialised care for LGBTQIA+ individuals. Certain services, such as gender-affirming care, hormone therapy or surgeries, may simply not be available in some

countries, as in Malaysia and India.[129] Gaps in provision may extend beyond treatments to a lack of medicines, services, and testing kits.[130] **In Nepal, most respondents to a survey mentioned insufficient mental health resources specifically targeting LGBTQIA+ needs.**[131]

AIDS responses in some countries are undermined by the unavailability of WHO-recommended HIV prevention and testing methods, including male and female condoms and lubricants, pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP), antiretroviral therapy (ART), and other medications.[132] There may also be a lack of adoption of early intervention and preventive approaches for certain health issues like HIV/AIDS.[133] Another barrier that LGBTQIA+ people face is the **over-reliance on HIV/AIDS testing as a response**. In the Philippines, for instance, services are inadequate for/who are tested positive for HIV, which compromises the mental and physical health of the community.

Mental health

As noted previously, LGBTQIA+ individuals face disproportionately higher rates of mental health issues, including depression, anxiety, self-harm, and suicidal thoughts, though the inequalities and mental health vulnerabilities of transgender and intersex people in particular are often **understudied or overlooked**.[134] These inequalities can also lead to other adverse health impacts, including higher rates of obesity, cardiovascular diseases and cancer.[135]

Inequalities in mental health are often linked to disparities in the mental health services and treatments available to LGBTQIA+ individuals.[136] Discrimination can result in LGBTQIA+ individuals being denied **access to specialised healthcare or mental health services**. These specialised services may also be severely **underfunded**, reducing their overall availability. For example, in Thailand, the government's mental health funding represents only 2.3% of total health spending and most of these funds are allocated to mental hospitals.[137] Furthermore,

Relatedly, where there is limited public availability, specialised mental health care may become very expensive or only available in private medical centres, which creates further barriers in accessibility for LGBTQIA+ individuals.[138] In the Philippines, while support systems for pre- and post-exposure to HIV/AIDS and other STIs are more common, only **a small proportion of psychosocial counsellors are trained to respond effectively to LGBTQIA+ community's needs of depression, anger, or other suicidal tendencies, problems with family, and self-acceptance**.[139]

Other healthcare services

Access to wider healthcare services may also be a challenge for LGBTQIA+ individuals in many countries. In terms of cancer treatment, for example, Harkins and Hoffman note that LGBTQIA+ individuals are less likely to be invited to and participate in cancer screening and early detection programmes, amplifying their vulnerability to certain types of cancer.[140] For instance, LGB women are at a

greater risk of cervical cancer, which has in part been attributed to a lower uptake of cervical cancer screening, a lack of knowledge of human papillomavirus (HPV) being a risk, or a lack of awareness of woman-to-woman HPV transmission.[141]

In the same vein, India's National AIDS Control Organisation highlights how, in many parts of India, there is **insufficient public communication on the risk of other diseases, including non-communicable diseases (such as cardiovascular and respiratory diseases, diabetes, and hypertension) for LGBTQIA+ individuals**.[142] This lack of knowledge and awareness of the risks results in lower participation in screening programmes and treatment uptake.

Nevertheless, where there is an uptake of treatment, such as cancer treatment, LGBTQIA+ people may face **delays in the provision of adequate care or simply receive lower quality care.**[143] This has been attributed in some contexts to the unavailability of specialised practitioners, such as vascular surgeons, proctologists and endocrinologists, and services, particularly for transgender individuals.[144] Barriers to access to specialised care may also be related to the cost or location of services.[145]

5.3 Aftercare

The above sections have analysed the numerous barriers that can exist ahead of and during healthcare for LGBTQIA+ individuals. Yet, it is crucial to recognise that such obstacles can continue to have a lasting impact on the lives of LGBTQIA+ patients after care has been administered. This can include ongoing physical and mental health effects linked to the type or manner of treatment, but also challenges in accessing ongoing care that may be required to treat a lifelong health condition.

5.3.1 Continuous Treatment

Legacies of treatment

The medical treatment that LGBTQIA+ individuals receive may have lasting impacts in later life. This is particularly the case where individuals have been provided sub-standard care because of discrimination from healthcare providers, have not been able to access the care they needed due to structural barriers, or **have been coerced into unnecessary medical interventions, among other factors**. European and Asian experiences among the older generations converge as the **Council of Europe reports how elderly intersex persons who were subjected to non-consensual medical interventions suffer the consequences of such treatments throughout their lives and, in many cases, face ongoing physical and emotional challenges as a result of non-consensual interventions.**[146] Such interventions, including surgeries or hormonal treatments, can result in scarring or other lingering physical effects, which may necessitate ongoing treatment or even further procedures to remedy.[147] This creates a situation where patients remain dependent on the healthcare system due to historical treatments. Moreover, LGBTQIA+ individuals may struggle to cope with the after-effects of care or be

unwilling to access support due to feelings of suspicion or mistrust as a result of having been lied to, or having had information withheld, by healthcare providers.[148]

Reliability of services and past experiences

The healthcare barriers LGBTQIA+ individuals face across the patient journey may persist throughout their lives and affect their likelihood of displaying health-seeking behaviours in the future. **A significant barrier to continuous treatment is the sporadic provision of services**. In Indonesia, CSOs in the LGBTQIA+ rights spaces help provide crucial mental and sexual health services in the absence of consistent public healthcare efforts. However, due to issues related to financial resources available, these may not be widely spread or inconsistently distributed.

The healthcare barriers LGBTQIA+ individuals face in some countries may persist throughout their lives and affect access to other types of healthcare in later life. As noted by Boehmer, LGBTQIA+ cancer patients **who live alone or lack informal support networks may struggle to access caregivers who can provide them with the necessary support throughout cancer treatments and beyond.**[149]

More broadly, societal discrimination increases the likelihood of older LGBTQIA+ individuals becoming isolated or even invisible, amplifying their challenges in accessing necessary care and their risk of suffering other health issues in later life.[150]

6 Development of the Indicator List

Based on rigorous desk-based research and consultations with experts, as well as inclusive co-creation with key population-led networks and community-led organisations that are implementers of the CODE project across six countries, this research proposes a list of indicators that are specifically tailored to highlight key aspects of human rights of LGBTQIA+ and other key populations related to health care access. In the next phase of the CODE Strategies project, these indicators will be used as part of the *KeyPop* app, developed by APCOM, as a digital CLM tool.

The overarching goal was to produce indicators supporting robust analysis and advocacy and reflecting key population communities' lived realities across the six CODE countries. To achieve this, the research developed a set of indicators using the AAAQ principles to translate human rights frameworks into evidence. To capture human rights abuses or violations at every stage of communities' interactions with the health care system in a structured manner, this phase replicates the 'patient journey' in categorising the indicators that encapsulate the social determinants of health and other institutional/informational barriers, interactions at the healthcare facility, and aftercare (see Table 4). Through this approach, this research aims to measure progress and identify areas for improvement at both the regional and country levels.

Table 4: Categories for the indicators.

1 Pre-arrival	2 At the healthcare facility	3 Aftercare
1.1. Social determinants of health	2.1. Facility and basic physical infrastructure	3.1. Continuous treatment
1.2. Policy, legislative, and institutional environment	2.2. Registration	
1.3. Information-related barriers	2.3. Consultation process and healthcare provider attitudes	
	2.4. Availability and provision of services	

This research subsequently facilitated further consultations with community-led and key population groups, ensuring the indicators accurately reflect each country's local context and needs. The ultimate aim has been to achieve a consensus on indicators that are appropriate, accessible, and meaningful for key population communities from various backgrounds. The process was grounded in the principle that indicators should not only align with international human rights standards, but also resonate with the actual experiences of the communities they are designed to serve. The resulting consolidated regional list of indicators is set out in full in Annexure 2. The country-specific versions, contextualised with each partner, are available only to CODE Strategies partners.

7 Conclusion

This report establishes human rights indicators for APCOM's mobile application, *KeyPop*, which is intended to serve as a CLM tool empowering LGBTQIA+ individuals and other key population communities across six CODE project countries, namely India, Indonesia, Nepal, the Philippines, Thailand, and Viet Nam.

The initial desk-based research indicates that LGBTQIA+ individuals and other key population communities across South and Southeast Asia encounter numerous complex and interrelated barriers when seeking healthcare, ranging from systemic discrimination and inadequate legal protections to their interactions with HCPs and the provision of services and treatment. These challenges have been further discussed, confirmed, and contextualised through deep engagement with experts and, most importantly, community-led organisations operating on the frontlines.

Addressing these challenges requires a holistic and intersectional approach that recognises the diverse experiences of LGBTQIA+ communities in a human rights-based framework. Therefore, this research expands APCOM's toolkit, currently focused on HIV service delivery, to include other human rights violations that LGBTQIA+ individuals experience in accessing healthcare. This is essential for understanding issues related to accessibility, availability, acceptability, and quality of services.

Furthermore, LGBTQIA+ individuals require targeted interventions that address both their physical and mental health needs, especially those who are most marginalised within the community and experience multiple, overlapping forms of discrimination. This demands not only systemic reform, but also meaningful collaboration among governments, HCPs, civil society, educators, and LGBTQIA+ advocates. Central to this effort is the generation of comprehensive, inclusive, and community-informed data.

It is in this vein that CLM becomes transformative. It is designed not only to document human rights violations, but also to equip communities with the tools to collect, analyse, and use their own data for advocacy. In doing so, it shifts the power to those most affected, enabling LGBTQIA+ communities to hold institutions accountable and push for rights-based change rooted in lived realities. When communities lead the process, data becomes more than a metric - it becomes a vehicle for empowerment, resistance, and long-term transformation.

"When communities lead the process, data becomes more than a metric – it becomes a vehicle for empowerment, resistance, and long-term transformation."

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Annexure 1: Stakeholders Interviewed

Key informant interviews were conducted between March and April 2025. To protect the confidentiality of participants, interviewees are identified by organisation only.

List of experts

CODE	ORGANISATION	TYPE OF INPUT
E1	UNDP Asia-Pacific	Interview
E2	UNAIDS Asia Pacific	Written submission
E3	The Trevor Project	Interview
E4	The Global Fund	Interview
E5	A multilateral development bank	Informal conversation

List of community-led organisation representatives

CODE	ORGANISATION	TYPE OF INPUT
C1	Blue Diamond Society – Nepal	Interview
C2	The Humsafar Trust/Aastha Parivaar – India	Interview
C3	GWL-INA – Indonesia	Interview
C4	Center for Applied Research on Men and Community Health (CARMAH) – Viet Nam	Interview
C5	HASH – The Philippines	Interview
C6	The APCOM Foundation – Thailand	Interview

Annexure 2: Community-Led Monitoring Indicator List

This annexure sets out the full list of **110 human rights indicators** developed for KeyPop, APCOM's digital community-led monitoring tool. The indicators follow the patient journey described in Chapter 5 and are grouped into the eight categories in Table 4. Each indicator is phrased as a statement that community members can agree or disagree with.

How to read the tables. Indicators shown with a lettered sub-code (for example, 1.1.2a) are follow-up questions that apply under the main indicator above them. The tick (✔) marks the 39 indicators carried over or adapted from APCOM's existing CLM tool for HIV prevention, and the key population column marks the 17 indicators addressed to a specific community. The source of each indicator is given beneath it.

This is the consolidated regional list. Country-specific versions, contextualised with partners in India, Indonesia, Nepal, the Philippines, Thailand and Viet Nam, are available only to CODE Strategies partners.

1. Pre-arrival

1.1 Social determinants of health

22 indicators

CODE	INDICATOR	KEY POPULATION	EXISTING TOOL
1.1.1	I am able to access safe and healthy working conditions that provide me with sufficient income. *OHCHR & WHO - Right to Health p.3*		
1.1.2	**I have access to healthcare insurance that covers all my medical needs.** *Healthcare for sex workers—access, barriers, and needs: An exploratory qualitative interview study p. 156-7*		
1.1.2a	↳ I have access to free, universal healthcare insurance. *Shared Planet stakeholder engagement*		
1.1.2b	↳ I am able to access private healthcare through my workplace. *Shared Planet stakeholder engagement*		
1.1.2c	↳ I am able to find affordable private healthcare insurance that I pay. *Shared Planet stakeholder engagement*		
1.1.3	I am able to access safe, nutritious, and affordable food. *OHCHR & WHO - Right to Health p.3*		
1.1.4	I am able to access safe drinking water and adequate sanitation. *OHCHR & WHO - Right to Health p.3*		
1.1.5	I am able to access safe and affordable housing. *OHCHR & WHO - Right to Health p.3*		

CODE	INDICATOR	KEY POPULATION	EXISTING TOOL
1.1.6	**My community is treated with respect by the general population.** *APCOM existing CLM tool for HIV prevention*		✔
1.1.6a	↳ The local community is respectful towards sex workers. *APCOM existing CLM tool for HIV prevention*	Sex workers	✔
1.1.6b	↳ The local community is respectful towards LGBTQIA+ community. *APCOM existing CLM tool for HIV prevention*		✔
1.1.6c	↳ The local community is respectful towards people who inject drugs. *APCOM existing CLM tool for HIV prevention*	People who use drugs	✔
1.1.6d	↳ The local community is respectful towards transgender persons. *APCOM existing CLM tool for HIV prevention*	Trans people	✔
1.1.6e	↳ The local community is respectful towards PLHIV community. *APCOM existing CLM tool for HIV prevention*	PLHIV	✔
1.1.7	**My community members do not face stigma and discrimination by the general population.** *APCOM existing CLM tool for HIV prevention*		✔
1.1.7a	↳ My community members do not face stigma and discrimination by the general population related to HIV/AIDS *Shared Planet stakeholder engagement*	PLHIV	
1.1.7b	↳ My community members do not face stigma and discrimination by the general population related to monkeypox *Shared Planet stakeholder engagement*		
1.1.8	I have the support I need from my natal family. *APCOM existing CLM tool for HIV prevention*		
1.1.9	My natal family refers to me with the correct pronouns. *Experiences of transgender persons in accessing routine healthcare services in India: Findings from a participatory qualitative study*		
1.1.10	I have the support I need from my community and/or kinship-based group. *Experiences of transgender persons in accessing routine healthcare services in India: Findings from a participatory qualitative study*		
1.1.11	I am able to access and participate in safe community spaces for LGBTQIA+ people that promote social support and healthy activities and behaviour. *Examining the social determinants of LGBT+ health and wellbeing p36*		
1.1.12	I do not feel threatened or coerced/abused by a romantic partner or a family member. *Shared Planet stakeholder engagement*		

1.2 Policy, legislative, and institutional barriers

7 indicators

CODE	INDICATOR	KEY POPULATION	EXISTING TOOL
1.2.1	I am able to change my gender identity on ID cards and other forms of identification and registration. *Thailand's Transgender Community Struggles To Find Health Care*	Trans people	

CODE	INDICATOR	KEY POPULATION	EXISTING TOOL
1.2.2	**I believe that there is an existing and well-enforced anti-discrimination law in my country that facilitates my right to access non-discriminatory healthcare services as a member of the LGBTQIA+ community.** *Advocating for Lesbian, Gay, Bisexual, and Transgender Youth Sexual and Reproductive Health and Rights in Central Asia*		
1.2.2a	↳ I do not believe that government actions, policy or attitudes put me in danger as a member of the LGBTQIA+ community. *Advocating for Lesbian, Gay, Bisexual, and Transgender Youth Sexual and Reproductive Health and Rights in Central Asia*		
1.2.2b	↳ I do not believe that government actions, policy or attitudes make sexual health and reproductive services less accessible. *Advocating for Lesbian, Gay, Bisexual, and Transgender Youth Sexual and Reproductive Health and Rights in Central Asia*		
1.2.2c	↳ I do not believe that I risk being criminalised for my drug use, and that instead it will be treated as a health issue. *Chemsex Toolkit For clinical services providers in the Asia-Pacific region*	People who use drugs	✔
1.2.2d	↳ I do not believe that I risk being criminalised for my SOGIESC characteristics. *Shared Planet stakeholder engagement*	Trans people	
1.2.3	I can seek healthcare services for sex□work□related needs without fear of criminal prosecution. *Shared Planet stakeholder engagement*	Sex workers	

1.3 Information-related barriers

4 indicators

CODE	INDICATOR	KEY POPULATION	EXISTING TOOL
1.3.1	I know that healthcare providers cannot force me to do anything that I do not want to do. *Trans COMPETENCY Community-Based Monitoring: Phase 2*		✔
1.3.2	I am aware of how to access my health insurance and what I am entitled to under my health insurance. *Healthcare for sex workers—access, barriers, and needs: An exploratory qualitative interview study p. 156-7*		
1.3.3	I can access accurate, respectful, and non-judgmental medical guidance and health-related information (including on the use of hormones) from healthcare providers, so I do not need to rely on informal sources like social media or peers. *Thailand's Transgender Community Struggles To Find Health Care*		
1.3.4	My ability to read, write, or understand health information is not a barrier to accessing or using healthcare services. *Health care needs and barriers to care among the transgender population: a study from western Rajasthan*		

2. At the healthcare facility

2.1 Facility and basic physical infrastructure

11 indicators

CODE	INDICATOR	KEY POPULATION	EXISTING TOOL
2.1.1	There is an LGBTQIA+ friendly hospital that is accessible to me - i.e. it is easy to commute to and there are no financial barriers for me to get there. *Thailand's Transgender Community Struggles To Find Health Care*		
2.1.2	The operating hours of the healthcare facility meet my needs. *Shared Planet stakeholder engagement*		
2.1.3	The facility was open during my last visit. *APCOM existing CLM tool for HIV prevention*		✔
2.1.4	**The facility was fully functional during my last visit.** *APCOM existing CLM tool for HIV prevention*		✔
2.1.4a	↳ There is basic cleanliness at the health facility. *APCOM existing CLM tool for HIV prevention*		✔
2.1.4b	↳ There is a usable toilet facility at the health facility. *APCOM existing CLM tool for HIV prevention*		✔
2.1.4c	↳ The healthcare facility has safe drinking water that I can access for free. *OHCHR & WHO - Right to Health p.4*		
2.1.5	When in-person healthcare visits are not necessary or possible, I am able to access online care and consultation with a healthcare professional. *Mental Healthcare Needs and Experiences of LGBT+ Individuals in Malaysia: Utility, Enablers, and Barriers*		
2.1.6	The spaces inside the hospitals (including wards, outpatient clinics, waiting rooms, washrooms, and queues in registration) are segregated in a gender neutral way. *Experiences of transgender persons in accessing routine healthcare services in India: Findings from a participatory qualitative study*	Trans people	
2.1.7	A separate private counselling room is available at the health facility. *APCOM existing CLM tool for HIV prevention*		✔
2.1.8	The leaflets and posters in the waiting room were appropriate and inclusive, e.g. they did not imply anything that was discriminatory to LGBTQIA+ people. *A Systematic Review of Sexual Minority Women's Experiences of Health Care in the UK*		

2.2 Registration

7 indicators

CODE	INDICATOR	KEY POPULATION	EXISTING TOOL
2.2.1	It is easy to register and use the healthcare services and there are no bureaucratic processes that prevent me from accessing healthcare. *Health Equity Matters CLM Tool*		✔

CODE	INDICATOR	KEY POPULATION	EXISTING TOOL
2.2.2	The intake forms included questions about my name, pronouns, gender identity, and sexual orientation, with options for open-ended responses, as well as pre-written response options beyond "male" and "female"; "straight", "lesbian", "gay", and "bisexual". *Experiences of and recommendations for LGBTQ+-affirming substance use services: an exploratory qualitative descriptive study with LGBTQ+ people who use opioids and other drugs*		
2.2.3	I was provided with the option to use a unique identity code (UIC) or an alternative in order to ensure my confidentiality. *Trans COMPETENCY Community-Based Monitoring: Phase 2*		✔
2.2.4	I have been informed of my rights as a patient and was asked to complete an informed consent form when I visit the clinic. *Trans COMPETENCY Community-Based Monitoring: Phase 2*		✔
2.2.5	**I felt safe in the public area of the health facility.** *APCOM existing CLM tool for HIV prevention*		✔
2.2.5a	↳ I did not feel discriminated against, stigmatised, harassed or verbally/physically abused by non-LGBTQIA+ patients or patients that did not share my sexual orientation or gender identity. *Experiences of transgender persons in accessing routine healthcare services in India: Findings from a participatory qualitative study*		
2.2.5b	↳ When I faced discrimination and/or stigma, the healthcare provider was willing to document and address this. *ITPC CLM Tool*		✔

2.3 Consultation process and healthcare provider attitudes

26 indicators

CODE	INDICATOR	KEY POPULATION	EXISTING TOOL
2.3.1	I have not worried that opening up to medical healthcare professionals about my gender or sexual identity could lead to repercussions such as job loss or discrimination. *Mental Healthcare Needs and Experiences of LGBT+ Individuals in Malaysia: Utility, Enablers, and Barriers*		
2.3.2	**I was not judged or discriminated against by healthcare providers due to my identity, background, substance use, or socio-economic status.** *Generalised by Shared Planet*		
2.3.2a	↳ I was not redirected to separate premises (e.g. waiting room, distinct department) by the facility staff as a result of my testing positive for HIV. *Stories of Stigma: Exploring Stigma and Discrimination Against Thai Transgender People While Accessing Health Care and in Other Settings*	PLHIV	✔
2.3.2b	↳ The healthcare practitioner provided me the drugs I needed in ways that are not visibly different than to anyone else, so that I do not risk stigmatisation or other repercussions because of the drugs that I need. *Shared Planet stakeholder engagement*		
2.3.3	Healthcare professionals ensure I am fully informed and give consent before any invasive procedure or examination, and that these are conducted in a safe and respectful manner. *A Systematic Review of the Health and Healthcare Inequalities for People with Intersex Variance*		

CODE	INDICATOR	KEY POPULATION	EXISTING TOOL
2.3.4	I feel safe and supported discussing substance use, including chemsex, with healthcare providers without judgment. *Chemsex Toolkit For clinical services providers in the Asia-Pacific region*	People who use drugs	
2.3.5	Healthcare professionals provide accurate information and referrals related to harm reduction, including safer use (safe injecting, wound care, and overdose) and mental health support. *Chemsex Toolkit For clinical services providers in the Asia-Pacific region*	People who use drugs	
2.3.6	Healthcare providers understand intersex variations and treat them with respect—not as disorders or abnormalities. *Chemsex Toolkit For clinical services providers in the Asia-Pacific region*	Intersex people	✔
2.3.7	Medical professionals do not recommend unnecessary non-emergency surgeries related to my intersex variance. *Chemsex Toolkit For clinical services providers in the Asia-Pacific region*	Intersex people	✔
2.3.8	I (and my family, if applicable) am offered support and information to understand and de-stigmatise intersex variance. *Chemsex Toolkit For clinical services providers in the Asia-Pacific region*	Intersex people	✔
2.3.9	The language used by the service provider is easy to understand and delivered in an appropriate and respectful manner. *Shared Planet stakeholder engagement*		
2.3.10	I feel that the healthcare practitioner listened to and could understand my concerns. *Trans COMPETENCY Community-Based Monitoring: Phase 2*		
2.3.11	The healthcare practitioner was patient in explaining to me the symptoms/processes that I came to consult on. *Trans COMPETENCY Community-Based Monitoring: Phase 2*		
2.3.12	I was comprehensively consulted about my health needs. *Shared Planet stakeholder engagement*		
2.3.13	If I am depressed or feeling anxious, I feel I can tell my healthcare provider. *ITPC CLM Tool*		
2.3.14	I feel more confident in making an informed decision about safer sex and reducing my risk after speaking to a healthcare provider. *UNAIDS*		
2.3.15	I do not believe that healthcare professionals would ask me to change my LGBTQIA+ identity through SOGI change efforts or so-called “conversion” therapy. *Mental Healthcare Needs and Experiences of LGBT+ Individuals in Malaysia: Utility, Enablers, and Barriers*		
2.3.16	I have not been asked invasive questions on my gender identity or sexual expression that are unrelated to the purpose of the visit. *Mental Healthcare Needs and Experiences of LGBT+ Individuals in Malaysia: Utility, Enablers, and Barriers*		
2.3.17	I am not worried that mental professionals may lack an understanding of LGBTQIA+ people. *Mental Healthcare Needs and Experiences of LGBT+ Individuals in Malaysia: Utility, Enablers, and Barriers*		

CODE	INDICATOR	KEY POPULATION	EXISTING TOOL
2.3.18	My LGBTQIA+ identity has not been viewed by healthcare professionals as a mental health issue or as the cause of a mental health issue. *Mental Healthcare Needs and Experiences of LGBT+ Individuals in Malaysia: Utility, Enablers, and Barriers*		
2.3.19	I believe that my healthcare professional's moral, religious or cultural beliefs do not lead to discrimination against me within a healthcare setting. *Examining the social determinants of LGBT+ health and wellbeing p29*		
2.3.20	I feel comfortable talking to a healthcare or mental health professional about drug or alcohol use and other coping mechanisms including disordered eating. *Examining the social determinants of LGBT+ health and wellbeing p29*		
2.3.21	I can ask my counsellor for introduction to legal services if I need it. *Shared Planet stakeholder engagement*		
2.3.22	I can discuss my concerns related to intimate partner violence with my healthcare provider. *Trans COMPETENCY Community-Based Monitoring: Phase 2*		✔
2.3.23	I have been informed by my healthcare provider during the consultation of which cancers I am at higher risk of developing due to my gender or sexual identity and of the importance of screening for cancer (i.e. breast, prostate, anal or vaginal). *Shared Planet stakeholder engagement*		
2.3.24	I did not feel uncomfortable, unsafe, or in pain when my private/breast/chest/genital area was examined. *Trans COMPETENCY Community-Based Monitoring: Phase 2*		✔

2.4 Availability and provision of services

27 indicators

CODE	INDICATOR	KEY POPULATION	EXISTING TOOL
2.4.1	All staff members that I needed (doctor, counsellor, community liaison person, etc.) were available at the time of my visit. *APCOM existing CLM tool for HIV prevention*		✔
2.4.2	When I require medical or mental health treatment, I am able to receive it in a timely manner (e.g. in terms of waiting times). *Mental Healthcare Needs and Experiences of LGBT+ Individuals in Malaysia: Utility, Enablers, and Barriers*		
2.4.3	I am able to access integrated sexual health and substance use services, that include HIV prevention. *Health Equity Matters CLM Tool*		
2.4.4	My ability to seek and receive accessible health-related information does not impair my right to have personal health data treated confidentially. *OHCHR & WHO - Right to Health p.4*		
2.4.5	**I sought STI-related services at the healthcare facility.** *Generalised by Shared Planet*		
2.4.5a	↳ The pre-test STI counselling was helpful. *UNAIDS*		

CODE	INDICATOR	KEY POPULATION	EXISTING TOOL
2.4.5b	↳ My counsellor has suggested I invite my intimate partner for an STI test. *UNAIDS*		
2.4.5c	↳ I was given a prescription when I tested positive for an STI. *UNAIDS*		
2.4.5d	↳ I am able to access Hepatitis B and C vaccinations at the health facility. *Health Equity Matters CLM Tool*		
2.4.6	**I sought HIV/AIDS-related services at the healthcare facility.** *Generalised by Shared Planet*		
2.4.6a	↳ PrEP was available at the healthcare facility. *APCOM existing CLM tool for HIV prevention*		✔
2.4.6b	↳ PEP was available at the healthcare facility. *APCOM existing CLM tool for HIV prevention*		✔
2.4.6c	↳ HIV screening test was available at the healthcare facility. *Shared Planet stakeholder engagement*		
2.4.6d	↳ OST was available at the health facility. *APCOM existing CLM tool for HIV prevention*		✔
2.4.6e	↳ OST was provided to me at the time of my visit. *APCOM existing CLM tool for HIV prevention*		✔
2.4.6f	↳ Viral load tests were available at the health facility. *APCOM existing CLM tool for HIV prevention*		✔
2.4.6g	↳ The results of the viral load tests are communicated with me in a timely manner. *Shared Planet stakeholder engagement*		
2.4.6h	↳ CD4 reagents and kits and ART medicine were available at the health facility. *APCOM existing CLM tool for HIV prevention*	PLHIV	✔
2.4.7	HIV/AIDS educational and IEC materials were displayed at the facility. *APCOM existing CLM tool for HIV prevention*		✔
2.4.8	Sufficient and high quality condoms (male and female) were available at the health facility without rationing. *Edited from APCOM's existing toolkit*		✔
2.4.9	Sufficient and high quality lubricant (male and female) was available at the health facility without rationing. *Edited from APCOM's existing toolkit*		✔
2.4.10	**I have sought mental health services at the healthcare facility.** *Generalised by Shared Planet*		
2.4.10a	↳ I am able to access mental healthcare services that are sensitive to my particular needs. *Healthcare for sex workers—access, barriers, and needs: An exploratory qualitative interview study p.158*		

CODE	INDICATOR	KEY POPULATION	EXISTING TOOL
2.4.10b	↳ I am able to access mental healthcare in the format that I prefer (e.g. via Zoom, over the phone, in person). *A Systematic Review of the Health and Healthcare Inequalities for People with Intersex Variance*		
2.4.11	Needles and syringes were available at the health facility. *APCOM existing CLM tool for HIV prevention*		✔
2.4.12	Needles and syringes were provided to me at the time of my visit. *APCOM existing CLM tool for HIV prevention*		✔
2.4.13	Reproductive health services (family planning, contraception etc.) were available at the health facility. *Shared Planet stakeholder engagement*		

3. Aftercare

3.1 Continuous treatment

6 indicators

CODE	INDICATOR	KEY POPULATION	EXISTING TOOL
3.1.1	I am able to receive consistent mental and medical health treatment, i.e. I do not have to meet with a different doctor or counsellor each time with varying assessments. *Mental Healthcare Needs and Experiences of LGBT+ Individuals in Malaysia: Utility, Enablers, and Barriers*		
3.1.2	There are feedback options for me to inform the health facility about my care at the facility e.g. a suggestion box, client satisfaction monitoring, etc. *Health Equity Matters CLM Tool*		✔
3.1.3	I was offered the option for follow-up counselling via telephone, email, or other media. *Trans COMPETENCY Community-Based Monitoring: Phase 2*		✔
3.1.4	I am encouraged to return for regular check-ups and demonstrate reactive responses to notifications or symptoms. *Shared Planet stakeholder engagement*		
3.1.5	The facility provided effective patient follow-up care, including phone calls, emails, etc. *Shared Planet stakeholder engagement*		
3.1.6	I feel that I have the access to a support system during the healing or post-treatment process. *Shared Planet stakeholder engagement*		

Notes

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51. Paschen-Wolff et al., 2024.
52. APCOM, 2020.
53. UNDP, 2015a; Fongkaew et al., 2021; Gaur et al., 2023; Ahuja et al., 2024; Harkins and Hoffman, 2024; Joshi, 2024.
54. Gaur et al., 2023.
55. Bachman and Gooch, 2018.
56. Human Rights Watch, 2018; Beattie et al., 2021; Fongkaew et al., 2021; Chakrapani et al., 2023).
57. KII with UNDP and GWL-INA.
58. Gaur et al., 2023.
59. Mladenovic et al., 2024
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62. Gibson et al., 2016; Newman et al., 2021.
63. Wolter and Hegarty, 2022; Joshi, 2024.
64. Ahuja et al., 2024; Council of Europe, 2024.
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98. KII with CARMAH.
99. Newman et al., 2021.
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103. KII with HASH.
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We are united in advocating for issues around HIV and those that advance the rights, health and well being of people of diverse sexual orientation, gender identity, gender expression and sex characteristics.

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APCOM Secretariat | 48 Soi Udomsuk 13, Bangna, Bangkok 10260, Thailand
+66 2399 1145 / +66 2399 1146
www.apcom.org | apcom@apcom.org

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