

Trans COMPETENCY Community-Based Monitoring. Phase 2

CAMBODIA • INDIA • INDONESIA



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



Trans **COMPETENCY** Community -Based Monitoring: **Phase 2**

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





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

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CONTENTS PAGE

5	Acknowledgements
6	Introduction
8	What are the Trans COMP CBM Tools?
11	Trans COMP CBM Tool: Phase 2
13	Trans COMP CBM Tool Framework
14	Desk Review of Existing CBM Tools Development of Indicators
18	Development of Implementation Approach Review of Tools by Community Partners
20	Development of Protocol
22	Recruitment of Focal Points
23	Meet the Trans COMP CBM Pilot 2 Team
24	Recruitment of Data Gatherers Stakeholder Consultations
25	Virtual Training for Focal Points Virtual Training for Data Gatherers
26	Service Provider Mapping
27	Development of Focal Point Monitoring Tool
28	Service Provider Notification Scheduling of Data Gathering Sites
29	Data Gathering
30	Trans COMP CBM Tool: Phase 2 Findings
32	Country Chapter: Cambodia
39	Country Chapter: India
45	Country Chapter: Indonesia
50	Discussions and Recommendations
52	Further Reading



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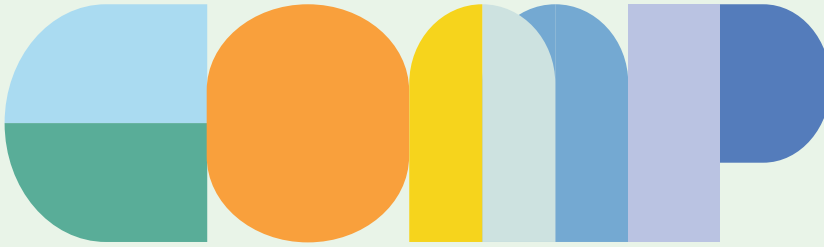
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Introduction

Transgender people have very specific health care needs that should not only be reduced to sexual and reproductive health service provision. Transgender people may face a constellation of social and health-related issues that impact upon their well-being and ability to live full and productive lives.



Particularly in the Asia-Pacific region, these concerns are sometimes compounded by the fact that they have less access to health care responding to their needs, but also due to limited employment opportunities, housing, lack of insurance coverage, or fear of stigma and discrimination from healthcare providers. Transgender people experience substantial health disparities and obstacles to accessing appropriate health care services. These disparities can diminish opportunities for achieving the highest possible health status and can result in poor health outcomes. Existing socioeconomic determinants of health can further legally, socially, and economically marginalise transgender people. Transgender people are also disproportionately affected by systemic forms

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

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

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

can come in- transgender people can play a critical role in educating healthcare workers in how to provide appropriate, quality healthcare. One part of this process is community-based monitoring (CBM).

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

Community-based, informed and led monitoring can help community members and health care providers understand the AAAAQ (Availability, Accessibility,

Acceptability, Affordability, and Quality) of a service being provided. Community-based monitoring gives tools and frameworks developed by a specific community that encourages users of a facility to assess and score the service they access. Results from community-based monitoring can help facilitate collective agreement and action with the eventual goal of improving service delivery. It can facilitate community engagement with health care providers and positively impact upon service quality, efficiency, and accountability. This is achieved by providing space for these two groups to engage in a participatory dialogue that is action-based and accountability-focused.

Although the end result is sometimes the same, community-based monitoring is different to other more traditional, provider (or donor, or government) led forms



of monitoring. When developed and implemented correctly community-based monitoring can help:

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

2 Foster greater ownership through the prioritisation of trans people as tool developers, as study leads, as data gatherers, in data analysis through to dissemination.

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

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

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

WHAT ARE THE TRANS COMP CBM TOOLS?

In order to capture the lived experiences of trans men and trans women in the region and feed into existing monitoring efforts, APTN developed a number of tools for the perusal of the community.

The Trans COMP CBM Tool is designed to capture quality of HIV-related and provide a means to track trans-competent and gender affirming health care in countries in the Asia-Pacific region, including access to and availability of hormones, sexual and reproductive health services and barriers to health care.

The Trans COMP CBM Tool is a living document,

and it is hoped that future iterations will be developed by communities, that these iterations respond to the adapting needs of transgender people as service provision improves and progresses both at the regional and the global level.

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

FOR TRANS COMMUNITY MEMBERS



TRANS COMP CBM SCORECARD



TRANS COMP CBM EXCEL SPREADSHEET

FOR SERVICE PROVIDERS



TRANS COMP PROVIDER CHECKLIST



TRANS COMP PROVIDER ACTION PLAN

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

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

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

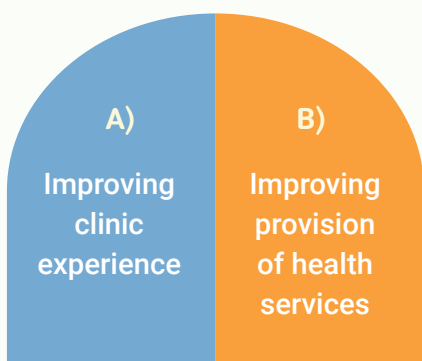
B) To monitor a singular experience accessing an Individual Package (HIV services, or STI services)

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

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

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

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



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



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

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

for trans people in the country context and can also be adapted to suit other population needs. Before commencing Data Gathering and after completion of the Service Provider Mapping Tool the Focal Points with the assistance of the country partners informed

each of the Service Providers about the Data Gathering plans, and processes involved. The purpose of this was not necessarily to obtain permission from providers, but more to let them know of the planned pilot.

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

TRANS COMP CBM TOOL : PHASE 2

Beginning May 2021, APTN began the implementation of the APTN Trans COMP CBM Tool Pilot Phase 1 in 7 partner countries:

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

Initially there were plans to incorporate Myanmar, however due to the coup and civil unrest this was unfortunately deemed unfeasible. This decision to exclude Yangon as study site was informed by community consultation with Myanmar country partners, and considerations of study team safety and well-being.

For Phase 1 the Tools were translated into Sinhala, Mongolian, Thai, Nepali, Tok Pisin, Tagalog, and Laotian, and APTN engaged Focal Points and Data Gatherers in each country to coordinate the piloting of the Tools at the local level. Pilot was completed at the end of 2021, with dissemination activities carried out early 2022.



At the end of 2022 APTN implemented **Trans COMP CBM Tool Phase 2** in another 3 countries, these were India, Indonesia, and Cambodia, collaborating with local partners in 2 separate sites in each country. The reasoning for selection of more than 1 site per country was in order to capture information and experiences from

transgender people in diverse socio-economic and cultural contexts. Sites chosen were Bali and Jakarta in Indonesia, Battambang and Banteay Meanchey in Cambodia and New Delhi and Uttar Pradesh in India. After some consideration, partners chosen were Men’s Health Social Services in Cambodia, Jaringan Transgender Indonesia for India and Basera Samajik Sansthan

for India. Tools were translated in Khmer, Bahasa Indonesia and Hindi, respectively.

Trans COMP CBM Tool Phase 2 replicated the model and framework of Phase 1, nevertheless challenges and attendant mitigating strategies were entirely indigenous to the Phase 2 country sites.

THE OBJECTIVES OF THE TRANS COMP CBM TOOL PILOT WERE:

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

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

✓ To capture primary data on the trans-competency of selected services at the country level, including the affordability, availability, accessibility and quality

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

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



This report documents the unique process and approach of the Trans COMP CBM Tool Phase 2, as well as captures the findings from the Trans COMP CBM Tool Phase 2 study in the region, and assessment of the challenges and enabling factors of each step of the roll out in the region.

Support documentation and relevant materials are accessible for internal review and perusal here: [Trans COMP CBM Tool Phase 2.](#)¹



¹ https://drive.google.com/drive/folders/1Ri7UZGPrOc-owluzepv6m47gs21xp3D0?usp=share_link

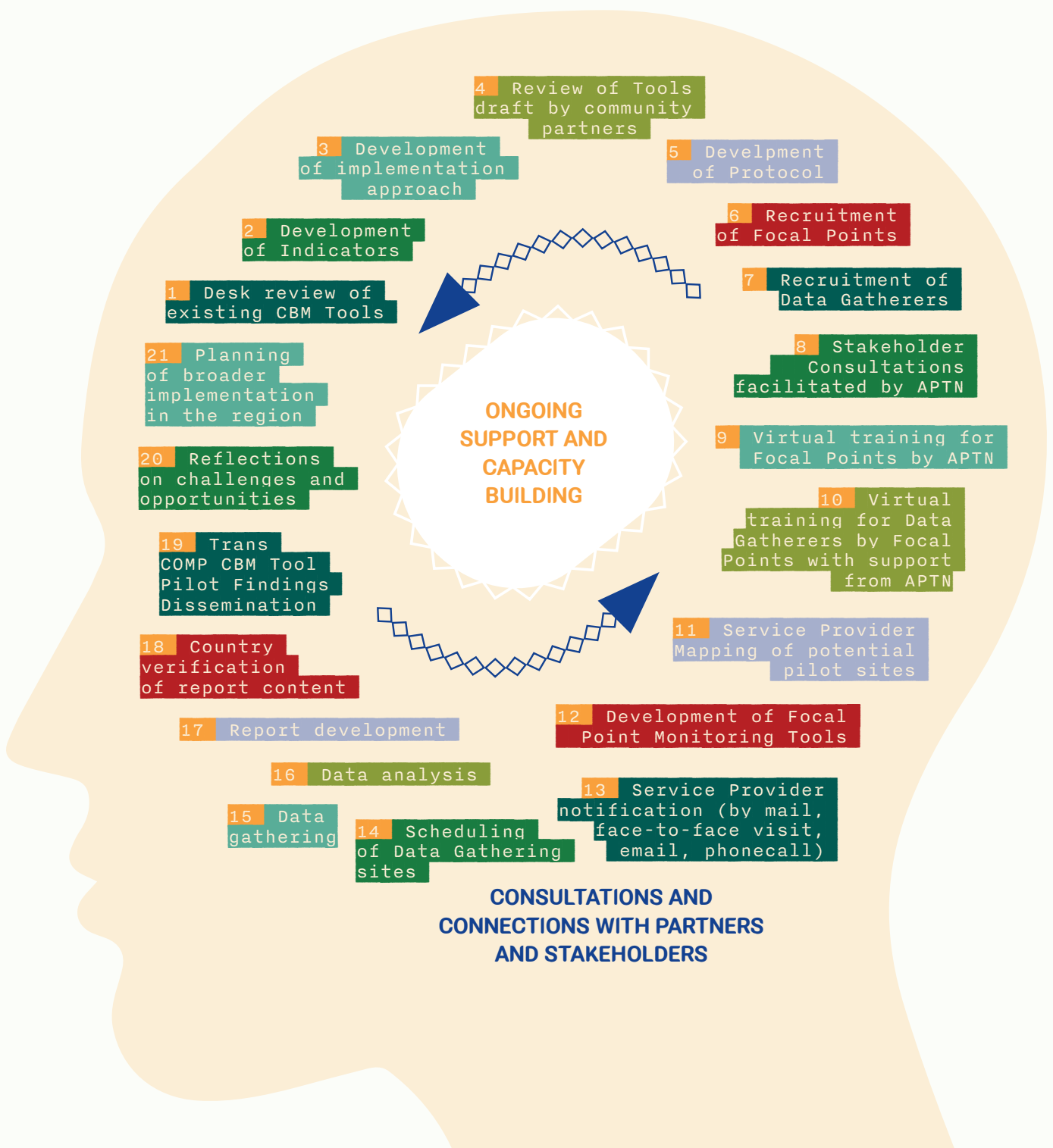
TRANS COMP CBM TOOL FRAMEWORK

The Trans COMP CBM Tool Phase 1 and Phase 2 were conducted in stages. In total, there are 21 steps in the Trans COMP CBM Tool process, and each step is a critical part of the process.



Throughout the process there was ongoing and consistent support and capacity building at the internal level with the Focal Points and Data

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

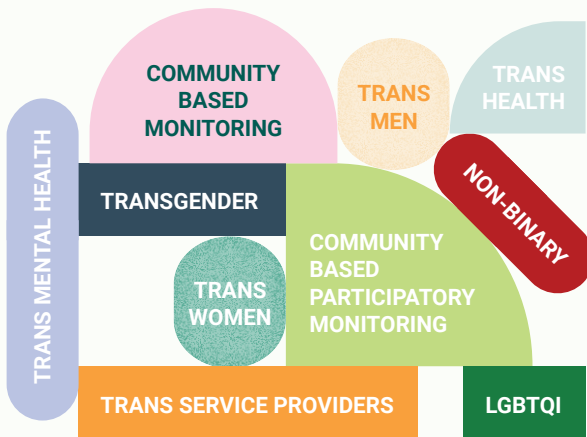


DESK REVIEW OF EXISTING CBM TOOLS

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

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

on contemporary trends/approaches to quality trans health provision, with a particular focus on mental health and social support. Core websites such as WPATH were also explored. From these a list of indicators was brought together.



During the desk review process, Project Coordinator also worked closely with the broader APTN team, as well as country partners who provided examples of further CBM guidance, and valued input towards the literature review.

While making reference to these tools, the eventual Trans COMP CBM Tool product is entirely an original piece of work, and the first of its kind in the region. The Tools for use in Phase 2 were in the same form as Phase 1, in order to ensure study integrity.

Project Coordinator also connected with a leading advocate for transgender health in Australia and participated in a virtual training

DEVELOPMENT OF INDICATORS

During Phase 1, through a process of extensive dialogue with country partners and stakeholders which led to eventual consensus, the indicator list was focussed on that considered locally appropriate, accessible and inherently interesting to trans people of all backgrounds.

Further, efforts were made to ensure the creation of indicators that could translate discourse elements into quantitative and qualitative evidence. All indicators were important for the clinic level,

but focus was placed on the selection of ones most useful for the purposes of analysis and advocacy and include those related to identity, inclusiveness, intersectionality, safety,

clinical competency, HIV/sexual health, patient empowerment and overall well-being from the lens of trans [cultural/clinical] competent care.

SECTION A: CLINIC EXPERIENCE

- A4** The operating hours of the clinic meet my needs
- A5** The staff including the receptionist asked and called me my preferred name and pronouns/ salutations
- A6** I was able to put my preferred name and pronouns/salutations and gender identity on the clinic's check-in form
- A7** I was provided with the option to use a unique identity code (UIC), in order to ensure my confidentiality
- A8** I have been informed of my rights as a patient
- A9** I am asked to complete an informed consent form when I visit the clinic
- A10** I felt safe in the public area of the health facility
- A14** The services available are disability inclusive (e.g for those who are hearing impaired, vision impaired, wheelchair friendly)
- A15** As a transgender youth I feel that my specific needs are attended to
- A16** I was able to access all information and treatments I needed at this facility
- A17** I can afford to pay the medical fees (consultation, tests and other services)
- A19** I have been offered referrals to another health provider/ facility upon request
- A20** I was offered the option for follow-up counselling via telephone, email or other media

SECTION B: PROVIDER EXPERIENCE

- B1** The nurse/doctor asked and called me my preferred name and pronouns/salutations
- B2** The healthcare provider explained that my confidentiality will be guaranteed regardless of my gender identity and health status
- B5** I understand that the provider does not have to force me to do anything that I don't want to do
- B6** I have the right to question or ask for further clarification
- B7** The language used by the service provider is easy to understand and delivered in a respectful manner
- B8** I feel that the doctor listens to and can understand my concerns
- B9** The doctor was patient in explaining to me the symptoms/ processes that I came to consult on
- B10** The doctor sought my consent before proceeding to do any examinations/ screenings
- B11** I didn't feel uncomfortable/unsafe or in pain when my private/ breast/ chest/ genital area was examined
- B12** My doctor explained why I should not self-medicate any medication (HIV/STI, Hormones, etc.)
- B13** I can discuss my concerns related to intimate partner violence with my provider
- B14** I am comfortable telling the staff I am a sex worker



SECTION C1: HIV PREVENTION, TESTING AND TREATMENT SERVICES

- C1.1** Female condoms and lubricants are available
- C1.2** Male condoms and lubricants are always available
- C1.3** The pre-test HIV counselling was helpful
- C1.4** The post-test HIV counselling was helpful
- C1.5** I was offered couples HIV counselling
- C1.5** My counsellor has suggested I invite my intimate partner for an HIV test
- C1.6** The doctor has explained the risks of sharing needles and blood borne viruses
- C1.7** I was provided information and offered PrEP
- C1.8** I was provided information about PEP
- C1.9** PrEP/ PeP is available at the clinic
- C1.10** The doctor explained to me my ART regime, including interaction of ART medications with hormones, and I understand how to start treatment
- C1.11** I was informed about the interaction between hormones, PrEP, PeP and ART as well as other medications
- C1.12** The doctor was able to advise me on monitoring my health status and tests needed while on ART and provided guidance for a follow up visit
- C1.13** Every time I need a refill of ART medications and PrEP, I am able to get it at this clinic
- C1.14** The doctor was able to refer me to another facility that provides PeP/ PReP and/ or ART medication

SECTION C2: STI DIAGNOSIS, TESTING AND TREATMENT SERVICES

- C2.1** The pre-test STI counselling was helpful
- C2.2** The post-test STI counselling was helpful
- C2.3** My counsellor has suggested I invite my intimate partner for an STI test
- C2.4** I was given a prescription when I have tested positive for an STI
- C2.5** I feel confident in making an informed decision about safer sex and reducing my risk now

SECTION C3: GENDER AFFIRMING CARE

- C3.1** The doctor explained the necessary steps I had to take before starting gender affirming hormone therapy (GAHT) (medical history examinations, liver function test, hormone count)
- C3.2** The doctor explained the safe dosage and correct way to administer hormones based on my medical history and records
- C3.3** My doctor explained the health implications of taking hormones on my fertility and suggested options based on my needs
- C3.4** Every time I need a refill of hormones I am able to get it at this clinic
- C3.5** My doctor explained to me the potential health risks of tucking/ binding for extended periods
- C3.6** I have been informed of the importance of screening for cancer (i.e. breast, prostate, anal or vaginal)
- C3.7** I feel comfortable talking about the side effects of hormones I'm having (e.g menstrual issues, decreased/ increased libido)
- C3.8** If I am interested in getting or facing complications from gender affirming procedures (top or bottom surgery, silicone injections, etc), my doctor can provide guidance on safety and risks or was able to offer me referrals

SECTION C4 : MENTAL HEALTH AND HARM REDUCTION

- C4.2** If I am depressed or feeling anxious, I feel I can tell my healthcare provider (doctor or counsellor)
- C4.4** I really appreciate having access to a peer counsellor or peer support groups
- C4.5** If I am worried about my substance use, I can discuss this with the healthcare provider
- C4.6** The doctor/counsellor was able to refer me to other harm reduction programmes
- C4.7** If I have experienced some form of sexual or gender-based violence, my counsellor can provide support or refer to other services
- C4.8** I can ask my counsellor for introduction to legal aid services if I need it

SECTION D : POST-SERVICE REFLECTION

- D1** I will definitely come back to this facility
- D2** After the clinic consultation, I feel reassured and more confident in making informed health decisions
- D3** I wasn't judged because of my gender identity
- D4** I wasn't judged because of my ability, religion, ethnicity, occupation, HIV status, or socio-economic background
- D7** My mental health improves after a visit to the clinic

As part of the Tools development phase, Project Coordinator considered it beneficial to consider ways to “brand” the product, to allocate a name that would be easy to remember and marketable. Several names were explored but eventually APTN decided upon:

TRANS COMP CBM TOOL

'COMP' meaning 'competence' but also an acronym for what the consultant understood to be the fundamental principles of the tool: connection, ownership, and meaningful partnerships. Careful consideration was also taken to name the other tools to streamline the approach and 'branding'.

This approach has been adopted for Phase 2 and continues to prove effective.



DEVELOPMENT OF IMPLEMENTATION APPROACH

During the implementation planning stage for Phase 1, Project Coordinator worked alongside APTN team to reflect upon past experiences in conducting regional studies (small and large scale) and construct an implementation approach that was deemed feasible given impending COVID19 restrictions of movement of people and service access, localised political instability, potentiality of natural disasters as well as imagined capacities of the proposed team of researchers.

Of primary concern was the well-being of the Data Gatherers and Focal Points in the data gathering process.

After internal consultations it was reasoned that as was the case with Phase 1, perhaps unlike other regional studies conducted by APTN and partners, submission of Ethics

Clearance was unnecessary (although required documents had been pre-prepared for this occurrence) also for Phase 2. As this study was a community based participatory research activity, wherein the study leads themselves were the subjects directly accessing the services with no intermediary

party or researchers, team have decided against pursuing Ethics Clearance, however made every effort to ensure that the study abided by research best practice, and that all engaged in the work demonstrated accountability and highest ethical standards in fieldwork.

REVIEW OF TOOLS BY COMMUNITY PARTNERS

In order to elicit community buy-in and ownership during the development of the Tools and the preparatory stages, concerted effort was made to conduct country level consultations for Phase 1.



Community consultation was framed around the following questions:

1

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

2

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

3

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

4

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

5

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

6

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

7

How do you think data from community-based tools can be used by both trans beneficiaries and healthcare providers?

Study team communicated with a number of Phase 1 partners at the country level, in the Philippines, Thailand, Nepal, Papua New Guinea, and Indonesia. Feedback was elicited either through zoom, whatsapp or skype interviews (ranging between 30 minutes to one hour) or through the submission of written responses. Notes were taken during the call. Support documents were also supplied by a number of respondents which were reviewed and further informed the CBM Tool.

Overall partners were supportive of having a trans-competent and responsive CBM tool and many indicators would be universal, however

there was also a need for country specific indicators as well as country specific approaches.

All efforts were made to ensure that the findings from the interviews were woven into the tool and helped provide local, community context. The findings from these consultations can be found in the Trans COMP CBM Tool Report.²

This step was not replicated for Phase 2 as the Tools have already been created and trialled.



² https://drive.google.com/file/d/1Z08tK4uRrZiAShrYcOEkuJNRSLbBovri/view?usp=share_link

DEVELOPMENT OF PROTOCOL

While preparing for the implementation stage of Phase 1 and Phase 2, in order to better guide the Focal Points and Data Gatherers, APTN created a Trans COMP CBM Tool Protocol, a key document that was also shared widely to the country stakeholders and partners.

It is well recognised that community engagement in research may enhance a community's ability to address its own health needs and health disparities issues while ensuring that stakeholders understand community priorities.³ Community Based Participatory Research (CBPR), an approach that was modified for the purposes of the Phase 1 and Phase 2 CBM implementation, is a collaborative approach to research that can reduce such historic mistrust and health disparities among hitherto marginalised populations. Nevertheless, while a meritorious model for improving community role and agency in the research process, community based participatory research is not infallible.

A key issue that was raised during the country consultations in Phase 1 was 'observer bias' and trust, in that while Ethics Clearance was not obtained, standard

research ethics should naturally still be applied. This includes the provision of mechanisms to protect both data gatherer and also study sites (for example, service providers).

"BASED ON LESSONS LEARNT FROM PHASE 1, PHASE 2 WORKS TO ENSURE THAT ANY CHALLENGES/ISSUES EXPERIENCED BY THE TRANS CBM DATA GATHERERS ARE REPORTED TO THE COUNTRY TRANS FOCAL POINTS WHO COORDINATE WITH THE CBM PROJECT COORDINATOR."

APTN acknowledged that without mitigation, due to the subjective nature of the study, observer bias was a possibility. Observer bias (also called experimenter bias or research bias) is the tendency to see what we expect to see, or what we want to see. When a researcher works with a certain group, they usually

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

For both Phase 1 and Phase 2 and before and throughout the Trans COMP CBM process, APTN considered carefully the issue of Observer Bias. APTN put in place certain parameters and frameworks to allay prejudice and help provide a corrective lens to decrease bias potential such as providing the observer with clear observable criteria or well-designed observational rubric (such as the Scorecard), through training (sensitisation on the meaning of observer bias and how to be cognizant of it during data gathering work), as well as with intelligent study planning and careful Data Gatherer screening and recruitment.

These methods are often used in community led

³ See for further discussion on the issue of observer bias and trust: Moore de Peralta, Arelis; Smithwick, Julie; and Torres, Myriam E. (2020) "Perceptions and determinants of partnership trust in the context of Community-Based Participatory Research," Journal of Health Disparities Research and Practice: Vol. 13 : Iss. 1 , Article 4. <https://digitalscholarship.unlv.edu/jhdrp/vol13/iss1/4/>

and/or qualitative studies, such as community based participatory research or participatory action research, and there is extensive literature discussing these (observer bias is in itself a field of inquiry).

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



ENSURING THAT OBSERVERS WERE WELL TRAINED



SCREENING OBSERVERS FOR POTENTIAL BIASES



HAVING CLEAR RULES AND PROCEDURES IN PLACE FOR THE EXPERIMENT



MAKING SURE BEHAVIOURS ARE CLEARLY DEFINED, AND STUDY TEAM MONITORED



SETTING A TIME FRAME FOR COLLECTING DATA

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

Based on lessons learnt from Phase 1, Phase 2 works to ensure that any challenges/ issues experienced by the trans CBM Data Gatherers are reported to the country trans Focal Points who coordinate with the CBM Project Coordinator. Fortunately, during Phase 1 there were no serious complaints or issues raised, however, where needed psycho-social support is provided during daily contact with focal points and APTN, and during weekly regional monitoring calls. During such calls, focal points provide mutual peer support and guidance.

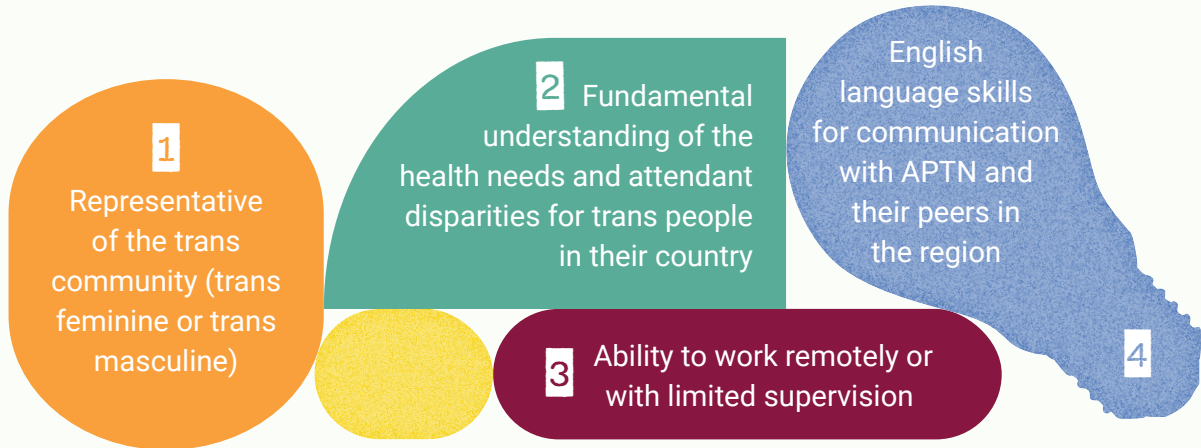
Further, in order to ensure both the safety of Data Gatherers and that the good governance upheld by APTN remained intact, both Phase 1 and Phase 2 Data Gatherers were also invited to sign a Disclaimer and APTN Code of Conduct before commencing data gathering.



RECRUITMENT OF FOCAL POINTS

APTN worked closely with the country partners to identify a Focal Point in each country site.

Criteria for the Focal Points included:



There were no particular challenges in the recruitment and engagement of country Focal Points (whose roles included the training and monitoring of Data Gatherers, service provider notification, virtual coordination with regional peers and APTN, timely submission of completed scorecards, support for Data Gatherers in the field, data input and verification and technical support for APTN during the final country stakeholder disseminations).

The Focal Points played a vital role in ensuring the completion of the activity, and demonstrated incredible resilience and flexibility, especially during challenging times at the local level, which

included moments of political instability and hostility towards transgender people, natural disasters and personal tragedies.

"THESE POSTS WERE EFFECTIVE IN COMMUNICATING THE PROJECT'S OBJECTIVES AND ALTHOUGH WELL-INTENDED, HOWEVER DUE TO TEAM SAFETY CONCERNS, PARTICULARLY IN INDONESIA, POSTS HAVE SINCE BEEN REMOVED TO PREVENT DOXING AND OPPORTUNITY FOR HATE CRIMES."

In order to socialise and promote Trans COMP CBM Phase 2 APTN created social media posts designed to

introduce the Focal Points and their affiliated organisations. These posts were effective in communicating the project's objectives and although well-intended, however due to team safety concerns, particularly in Indonesia, posts have since been removed to prevent doxing and opportunity for hate crimes.



MEET THE TRANS COMP CBM PILOT 2 TEAM



Vincent Santosa

I am Vincent Santosa, a trans man from Indonesia. I hold the position of Presidium and am one of the founders of Jaringan Transgender Indonesia (JTID). Additionally, I serve on the Supervisory Board of Transmen Indonesia. The core focus of JTID is to advocate for the respect,

protection, and fulfillment of transgender rights in Indonesia. I joined the APTN Trans COMP CBM Tool project with the intention of actively contributing to the advancement of transgender health and the realization of gender-affirming rights in Indonesia.

Ramkali

Greetings, I am Ramkali, a proud trans woman. I wholeheartedly embrace the identity I have chosen, and since that defining moment, I have never wavered.

My purpose revolves around raising awareness in society regarding the human rights of the transgender community. I strive to empower my fellow trans individuals to pursue their passions and aspirations. My ultimate aspiration is for a world where mutual understanding prevails, and every individual's choices are respected.



Phal Sophat

I am Phal Sophat, hailing from Cambodia. During the period of 2006-2012, I served as the director of Men's Health Social Services (MHSS), and currently, I hold the position of technical advisor with MHSS.

My motivation for joining and actively participating in the

APTN project stems from the objective of bolstering the CLM program. I aim to combat stigma, discrimination, and address the specific needs of transgender individuals.



RECRUITMENT OF DATA GATHERERS

Following the contracting of the Focal Points, APTN worked with the Focal Points and country partners to identify 4 Data Gatherers for each site.

In order to ensure full representation, APTN worked to recruit Data Gatherers from a variety of backgrounds, for example trans youth, trans sex workers, trans PLHIV, trans with disability, trans who use drugs, among others (see Annex 3 for Terms of Reference). To further mitigate any unwanted incidences during fieldwork Data Gatherers were required to submit a signed Disclaimer and Code of Conduct (see Annex 1 and Annex 2).

Although teams were established early on a number of Data Gatherers had to be replaced, and subsequently

trained. Based on experience in Phase 1 these events were disruptive and caused delays in the Data Gathering process. For instance, each time a Data Gatherer was replaced, they needed to complete and submit required documentation, fulfill donor administration requirements, and undergo training. In some circumstances the Data Gatherer was unable to complete all required scorecards, so the Focal Point needed to allocate more work to the other Data Gatherers or take on the duties themselves.

In Phase 1, the Focal Points also appreciated the

management skills they developed in their role as supervisor and monitor of the Data Gatherers in the country site. From progress to date, the study team assesses that the Data Gatherers for Phase 2 will have similar experiences however anticipate challenges.

Study team plans to connect Phase 2 Data Gatherers with Phase 1 Data Gatherers were needed to further facilitate peer support and learning, particularly with regards to issues in the field.

STAKEHOLDER CONSULTATIONS

Before commencing data gathering, APTN needed to reconnect with the country stakeholders and provide opportunities for partners to learn more about the proposed study plan and explore ways in which they could help to facilitate the process.

This too proved to be a time consuming (albeit necessary) part of the activity. Key issues revolved predominantly around competing stakeholder schedules, and language difficulties. In anticipation of this, APTN translated a powerpoint presentation on the Trans COMP CBM Tool into Hindi, Bahasa Indonesia

and Khmer. Sessions were facilitated by APTN and country partners.

In order to ensure efficiency, being mindful of stakeholders limited availability, each site was provided with alternative times and dates for the virtual presentation and recordings of the proceedings were made

available for those who could not attend. Overwhelmingly, partners were supportive of the proposed pilot and offered ongoing assistance. Many that attended these country sessions will also be invited to the final dissemination meetings.

VIRTUAL TRAINING FOR FOCAL POINTS

In order to capacitate the Focal Points in the Tools and ways in which to teach the Data Gatherers, APTN conducted virtual training.

Prior to training the Focal Points were given the translated Tools (Khmer, Bahasa Indonesia and Hindi), Module and access to the Trans COMP CBM Tool Video⁴ for review. Virtual training was carried out facilitated by APTN, and as part of this process APTN also developed

a Trans COMP CBM Tool Virtual Training⁵ that was made available to them for reference whenever needed.

Further to this, extra bilateral training was provided by APTN to the Focal Points as needed. Language differences proved to be particularly

challenging for Focal Point in Cambodia, however support was provided to attenuate this by the country partner.

⁴ https://drive.google.com/file/d/11gkAk6Ysy-VN_FVm2WP6LOyZJIYvSwxt/view

⁵ <https://drive.google.com/drive/u/0/search?q=type:video>

VIRTUAL TRAINING FOR DATA GATHERERS

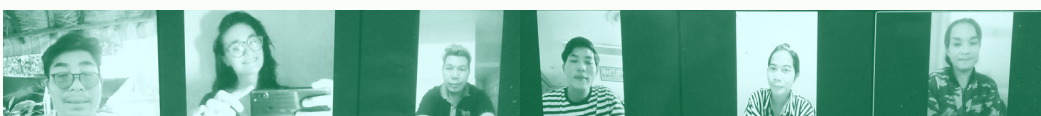
Following the training model provided by APTN to Focal Points, Focal Points were then tasked to capacitate the Data Gatherers in 2-hour individual country training sessions.

APTN provided support for the Focal Points during these sessions, and although conducted in local language, were stand by for troubleshooting throughout. This process was incredibly important as it allowed

opportunity for sensitizing the Data Gatherers in research ethics, community based participatory research methods, community-based monitoring, and ways in which to better engage service providers. For many

this is also the first time to collaborate with their trans country partners, and learn about trans health and the work of APTN.

Virtual Training of Data Gatherers in Cambodia, India, and Indonesia



SERVICE PROVIDER MAPPING

In the preparation stages of Phase 1 and also for Phase 2, it became evident that the Focal Points perhaps lacked awareness on the full range of services accessible to trans people outside that usually frequented by the community (particularly those under national/government healthcare schemes).



6 <https://drive.google.com/drive/u/0/search?q=type:video>

Assessment of the facilities preferred by the community would not have painted the entire picture, nor have been entirely helpful for national partners. Therefore, it was deemed necessary to establish tools for the Focal Points to map out services available in their study context, which would help to identify potential sites for data gathering while at the same time capturing key information on available services for the community.

APTN developed this supplementary tool not only for the Focal Points but also for the country partners to be a living document, to be updated as new information presents itself. This document can also be adapted for other key populations (as in the case of Nepal where it is being modified for the perusal of the female sex worker community).

The Service Provider Mapping tool is an excel spreadsheet with drop-down options

to present information on Accessibility, Availability, Affordability of the service, while the Quality and Acceptability was captured better in the Trans COMP CBM Tools. This exercise was conducted to see which of the broad range of services are available for trans people in their country context before commencing data gathering and which ones were free or incur out of pocket costs- this is identified by red when costs incurred, orange if subsidised and green if free of charge. If information on the service was not available, this was left blank. To support this activity, APTN capacitated the Focal Points in a training session and developed a Health Service Provider Mapping Virtual Tutorial.⁶

Although the Focal Points found the Mapping Tool easy to use, collating all the information for each site proved challenging. Focal Points explored facility websites and, in some instances, personally



called the centre to learn more about the facility in order to complete the spreadsheet. Nevertheless, some information was not available, therefore left blank. This was not to indicate that the Focal Point had not fulfilled their responsibility, this was more simply that the information had not been made available to them in time for submission of the Mapping

Tool. It is hoped that stakeholders and donors take notice of the information gathered in the Tool as it depicts the paucity of services for trans people as well as the out-of-pocket costs in one cohesive document. The Service Provider Mapping Tool will continue to be updated as Phase 2 progresses.

DEVELOPMENT OF FOCAL POINT MONITORING TOOL

A key component of the Trans COMP CBM Tool was creating an enabling environment wherein the Focal Points and Data Gatherers felt supported and engaged throughout.

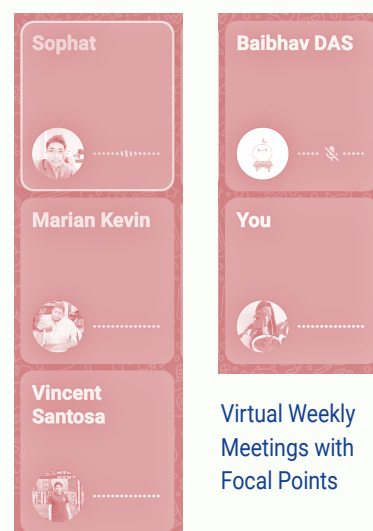
Early on it became evident that central to this process was the establishment of effective communication and platforms to share and problem solve. As coordination of the activity was conducted predominantly virtually it is necessary to communicate daily, weekly and monthly with the Focal Points.

"THE WEEKLY SESSIONS PROVED TO BE INCREDIBLY BENEFICIAL FOR FOSTERING A SENSE OF COLLABORATION AT THE REGIONAL LEVEL AND PROVIDE AN OPPORTUNITY FOR THE FOCAL POINTS TO SUPPORT EACH OTHER."

To support this APTN held weekly meetings and created a Bi-Monthly Report to be completed by the Focal Points. The weekly sessions

proved to be incredibly beneficial for fostering a sense of collaboration at the regional level and provide an opportunity for the Focal Points to support each other.

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



SERVICE PROVIDER NOTIFICATION

Service providers cannot legitimately assert that their services are trans friendly and trans inclusive, without actively supporting community-based monitoring work and actioning suggestions and feedback produced within such mechanisms.

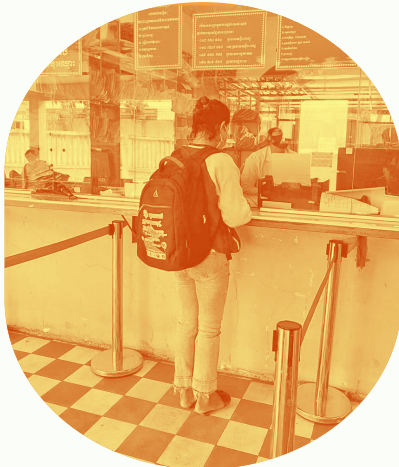


As with Phase 1, paving the way for the Trans COMP CBM Tool implementation involved connecting with service providers prior to data gathering. The purpose of formally informing the service providers and potential sites for data gathering is not to gain permission as such, but rather to notify them of the proposed activity

and to mollify any potential resistance. This aspect of the is time consuming and for some a difficult task, particularly as Phase 2 involves 2 separate sites.

This is important in helping keep record of the fact that APTN had done their due diligence in informing the health facilities prior to data

gathering, so that they would not question if the Focal Points reached out again to share the findings or invite them for the dissemination. Data gathering did not start until the Focal Point had sent the Service Provider information letter to the health facilities.

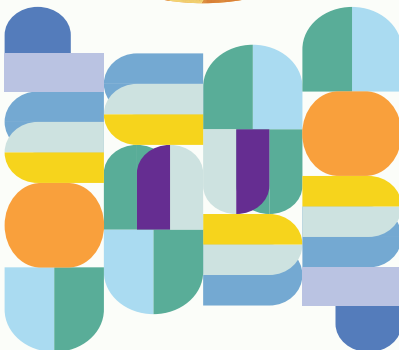


SCHEDULING OF DATA GATHERING SITES

To help guide the data gathering process, the Focal Points are working with the Data Gatherers to schedule visits for data gathering taking into consideration the availability of the facility as well as the Data Gatherer.

Each schedule is tentative, and the opening hours/ accessibility of the facility or service provider checked prior to visit.

APTN know where the Data Gatherers are at all times during the data gathering process and therefore support where necessary.



The purpose of this formal scheduling is to ensure the safety and well-being of the Data Gatherers as well as to make sure that Focal Points, Data Gatherers and



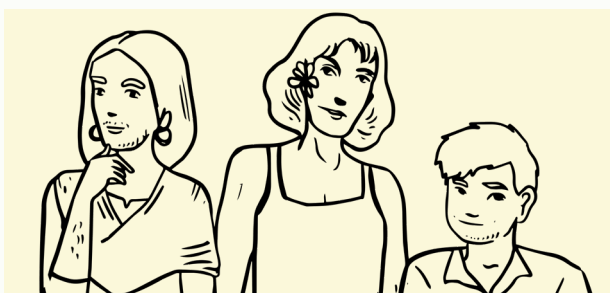
DATA GATHERING

Despite the team being fully capacitated and highly motivated and workplans formally scheduled and agreed upon, delays in data gathering were inevitable.

The Data Gatherers duty (under the supervision of the Focal Points with support from APTN) was to visit a designated facility, access a service (or a combination of services), pay for it if required (out of pocket costs were covered by APTN), compile proof of visit (see Annex 5 for Sample of Proof Of Visit from Laos), complete a Trans COMP CBM Tool Scorecard, submit this in a timely manner to the Focal Point and provide the Focal Point with a brief recap of their experience.



Text messages were also sent by the Focal Points to the Data Gatherers before, during and after visit to check on their well-being and experience. Focal Points reported back to APTN on their progress daily, and guidance provided where necessary. A total of 30 Scorecards were completed per country.



Flexibility was needed to ensure that Data Gatherers were supported during the data gathering process. For example, in the instance of Cambodia, the Data Gatherers were sometimes uneasy conducting the visit alone, so the Focal Point would attend with them. In India, visiting a facility they had never been to before proved daunting for the Data Gatherers, and in these circumstances, the Focal Point would accompany them, albeit at a distance. In addition to these challenges, as mentioned a number of Data Gatherers needed to be replaced, and visits rescheduled.



In Cambodia, the aftermath of a flood impacted the Focal Point personally and slowed down the data gathering process. It is critical to highlight these incidences and donors need to be sensitive to such concerns, regardless of pending deadlines. The adaptability and resilience of the Focal Points and Data Gatherers during this process should be applauded.

**TRANS COMP
CBM TOOL:
PHASE 2
FINDINGS**

All data gathered under Phase 2 was analysed and made available (at the clinic, national and regional level).

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

As data sample size was relatively small, data was analysed using excel spreadsheet software and

based upon the findings, the Service Provider was allocated a classification (see below).

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



**CLASSIFICATION:
GOLD**

Trans COMP Gold Class
76-100 points

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



**CLASSIFICATION:
SILVER**

Trans COMP Silver Class
61-75 points

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



**CLASSIFICATION:
BRONZE**

Trans COMP Bronze Class
0-60 points

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

In order for raw primary information gathered in the Trans COMP CBM Tool Scorecards to be processed into meaningful and verifiable data, excel spreadsheet software was used. Total analysis of the country level provided high level data on the level of trans-competency, trans-cultural competency or trans-clinical competency.

By way of definition:

Trans-Competent Care refers to healthcare that demonstrates both trans cultural competency and technical, clinical competency.

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

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

Total analysis of all correctly completed country Scorecards indicated that, surprisingly, both India and Indonesia rated Silver, with Cambodia rating Gold. This is possibly heavily

informed by the trans-cultural competency of the healthcare providers, not necessarily the trans-clinical competency, as in each of these sites the healthcare system has yet to fully incorporate the spectrum of gender affirming care that wholly meet the requirement

care facilities, and lack of integration (however potential) for mainstreaming of services into general healthcare facilities. Trans masculine people, trans youth and trans people living with disabilities are particularly underserved, as are those seeking harm reduction services. There is also a lack of services addressing intersectional needs. Broadly speaking, a number of key issues were identified in the analysis of all country Scorecards, which pose as both challenges and opportunities for service providers and stakeholders at the regional and country context.

"IT WAS EVIDENT THAT THERE IS A PAUCITY OF GENDER AFFIRMING CARE FACILITIES, AND LACK OF INTEGRATION (HOWEVER POTENTIAL) FOR MAINSTREAMING OF SERVICES INTO GENERAL HEALTHCARE FACILITIES."



of Availability, Accessibility, Acceptability, Affordability, and Quality or best practice.

From information gathered in the scorecards it was evident that there is a paucity of gender affirming



COUNTRY CHAPTER

CAMBODIA



Despite the prioritization of transgender people in the Cambodian HIV and human rights response, there is a dearth of strategic information and epidemiological data, which can support decision-making and facilitate investment in health services designed to support transpeople, outside the rubric of HIV programming.



For instance, until very recently transwomen had been included in health statistics relating to men who have sex with men, making it difficult to identify their unique health needs or develop tailored approaches, thereby diminishing opportunities to establish facilities that offer gender affirming care services.⁷ In this framing

and uneven focus on HIV, the individual agency of transpeople in Cambodia is ignored, gender identity is decontextualized, and competency and opportunity for improved transgender community advocacy and voice undervalued.

Insight into access to gender affirming care services is

sparse, with the majority being reportedly unregulated. Gender affirming healthcare services are not available and there are no documents stating whether such services are legal or illegal.

Gender affirming healthcare is not discussed in Cambodian law; it is neither legal nor illegal.⁸

Recent study indicated that 45.0% of transwomen reported ever used hormone or other substances such as contraceptive pills (45.0%), injection (18.3%), and skin patches (14.0%).



The injections were mostly reported to be performed by skilled personnel (67.8%), followed by non-skilled personnel (25.7%), and self-injection (6.5%). Only 9.2% had ever undergone some form of surgery to modify their physical appearance, and these are predominately sought in neighbouring Thailand⁹.

Most recent data that is available indicates that the overall prevalence of transwomen HIV nationwide was 5.9%, with the prevalence

of HIV being significantly higher among urban and peri-urban communities compared to rural counterparts (6.5%, 2.6% respectively). Other health statistics indicated that 45.0% of transwomen reported ever using gender affirming hormones; 29.8% had engaged in transactional sex, and 14.0% reported that they had experienced sexually transmitted infections. Amphetamine type substance use is also high, at 10%.¹⁰

Any social and health data accessible relates to

transwomen, and transmen and transmasculine health needs are all but absent in literature on health in Cambodia. While transgender women are often targets of HIV interventions, control by law enforcement, public health, and humanitarian or “anti-human trafficking” efforts, transmen are often invisibilized and left out of conversations and interventions.



Beyond health-related needs, there is also a lack of attention to manifestations of violence towards Khmer trans communities, lack of housing and issue of homelessness, unemployment, and other social, economic and emotional needs, such as hunger, poverty, family conflict, and mental health issues.

Data indicates that a significant number of transwomen had ever experienced some form of sexual violence or physical violence (39.2%, 23.6% respectively).

Indigenous vernacular and terminologies adopted by transgender people in Khmer include, *Srei sros* or ‘long hairs’ for transfeminine people, or *khteuy*, which can denote either transmasculine or transfeminine. Transpeople may refer to themselves as *khteuy*, however this term may be considered derogatory when used by others, with many preferring *srei sros*. Such argot is also recorded in ancient texts¹¹.

Despite the fact that Cambodia has had a rich history of divergent sexualities and identities, and diverse sexual practices, orientations and genders that have been present in Cambodia for hundreds of years, transgender people continue

and inclusion in social life in general¹². Many transpeople turn to sex work as a form of gender-identity validation and economic survival, especially in the two selected sites of Battambang and Banteay Meanchey for Trans COMP CBM Phase 2.

For illustration, transgender people involved in various forms of sex work in Banteay Meanchey are also particularly vulnerable to harassment gender-based violence in all its manifestations¹³. Lack of agency impedes ability to negotiate condom use and ensure safe sex.

Gender based violence is also reported to be experienced by transgender women especially those engaged in sex work- recent study found that (74%) of those interviewed had experienced sexual harassment, 40% cited physical assault in the past 12 months, and 55% said they had been forced to have sex against their will¹⁴.

Transgender people in Cambodia are frequently subject to familial violence as well as ostracization- 43% of transwomen have reported experiencing some manifestation of violence towards themselves during their lifetime, this includes physical violence, sexual assault, harassment in public places, denial of employment opportunities

and discriminatory or arbitrary arrest by law enforcement¹⁵.

Nevertheless, the Constitution of the Kingdom of Cambodia is the supreme law of Cambodia and Article 31 of the constitution states that:

“Every Khmer citizen shall be equal before the law, enjoying the same rights and freedoms and fulfilling the same obligations regardless of race, color, sex... or other status.”

Further, Article 35 guarantees the right of all Khmer citizens, regardless of sex, to participate actively in the political, economic, social and cultural life of the nation. Arguably, though there is no explicit mention of diverse gender identities in these provisions it can be implied that they extend to transgender people as the intent is to ensure equality regardless of personal characteristics or gender markers¹⁶. The dominant religion of Cambodia, Theravada Buddhism, is also relatively free of transphobic precepts¹⁷.

There are encouraging developments taking place in Cambodia that indicate the emergence of a nascent transgender mobilised community and increasing interest in transrights and

7 <https://ijmhs.biomedcentral.com/articles/10.1186/s13033-018-0206-2>

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

9, 10 Yi et al. BMC International Health and Human Rights (2017) 17:14 DOI 10.1186/s12914-017-0122-6

11 <https://southeastasiaglobe.com/queer-language-survives-cambodias-history/>

12 Yi et al. BMC International Health and Human Rights (2017) 17:14 DOI 10.1186/s12914-017-0122-6

13 y S, Saing CH, Yem S, Chhoun P, Tuot S, Yi S. Post-Gender-Based Violence Services Utilisation Among Female Entertainment Workers in Cambodia: A Cross-Sectional Study. Violence Against Women. 2023 Jan 8:10778012221147911. doi: 10.1177/10778012221147911. Epub ahead of print. PMID: 36617944

14 Davis, J.D., Miles G. 2018. "They chase us like dogs": Exploring the vulnerabilities of "Ladyboys" in the Cambodian sex trade. Dignity: A Journal on Sexual Exploitation and Violence. 3(2): Article 1. Available from: 10.23860/dignity.2018.03.02.01

15 World Bank. 2019. Cambodia Gender-based Violence Institutional Mapping Report. World Bank

16 <https://sithi.org/sogi/publication/2010-12-09-coming-out-in-the-kingdom-lesbian-gay-bisexual-and-transgender-people-in-cambodia>

17 UNDP, USAID (2014). Being LGBT in Asia: Cambodia Country Report. Bangkok

SERVICE PROVIDER MAPPING FOR BATTAMBANG

SERVICES PROVIDED*												
HIV Counselling and Testing												Y
HIV Treatment, Care, and Support												Y
STI Testing												Y
STI Treatment												Y
Male Condoms												Y
Female Condoms												Y
Lubricant												Y
PrEP												Y
PEP												N
Counselling												Y
Hormone Therapy												Y
Gender Affirming Care												N
Top Surgery												N
Bottom Surgery												N
Cancer Screening												N
IEC												Y
Mental Health Support												Y
Harm Reduction Programs												Y
Vaccine (Non COVID19)												Y
COVID19 Services												N
Other Health Services Referrals												Y
Other non-Health Services Referrals												Y

*Y FOR YES
*N FOR NO

Yes, Free/UHC

Yes, Half Subsidised

Yes, Not Free

awareness of transgender health needs. Trans COMP CBM Phase 2 was instrumental in this and for gaining insight into the health service provision experiences of transgender people in Battambang and Banteay

Meanchey and especially illuminating for community members and their affiliated partner organisations. The service provider mapping indicated that in both Banteay Meanchey and Battambang there is a paucity or total

absence of gender affirming healthcare services, and Battambang in particular being underserved and resulting in catastrophic out of pocket expenditure. There was little disparity between the ranking of Banteay

Meanchey and Battambang in the assessment by the Data Gatherers, which may lead us to conclude both are on equal footing towards becoming more trans-competent and evidence of more opportunity and willingness for growth.

Overall findings from the Trans COMP CBM Tool Phase 2 for the Kingdom of Cambodia were relatively positive (88% on the trans competency scale) however data gathered elicited a number of key findings.

From information gathered in the scorecards it was evident that there is a serious paucity of gender affirming care facilities in both Battambang and Banteay Meanchey, and lack of integration or mainstreaming (however potential) of services into general healthcare facilities. Nevertheless, it is also important to note that the

healthcare system of the country in general has much space for improvement and services for all citizens particularly in rural or remote areas are rudimentary at best.

Specifically with regards to misgendering this was an issue across all sites with 87% of Data Gatherers reporting that the staff including the receptionist did not ask or call them by their preferred pronoun or call them by their preferred name and pronouns/ salutations nor were there appropriate forms with gender markers for them to complete.

Positively, 72% stated that they had a positive experience in interacting with the service provider and that provider was patient in explaining to me the symptoms/processes that they came to consult on:

"I feel comfortable and safe, the

healthcare provider kept me confident in my information. They were friendly, respectful to me when I accessed the service in the facility."

Data Gatherers also explained however that there was a lack of appropriate washroom facilities they felt comfortable using, and, stigma and discrimination towards transpeople continues to be a concern, as does patient confidentiality.

Data Gatherers in Battambang identified new services and



88.0% OVERALL FINDINGS FROM THE TRANS COMPETENCY SCALE IN CAMBODIA WERE RELATIVELY HIGH

allies during the Data Gathering process, with one explaining:

“In the province of Battambang where I live, hormone therapy, gender-affirming care, and top surgery for transgender women were discovered services.”

However, one reported on a paucity of sexual and reproductive services for transgender women in Banteay Meanchey:

“Particular STI treatment services for transgender women were not available, which is bad because the behaviours and experiences of transgender women are different.”

Only **30%** in each site agreed that all of their service needs were met.

Transmasculine people are especially underserved. With

regards to the Accessibility of services, Data Gatherers reported that:

“Working hours is meant issues for me in accessing the service for the transgender women like me, and some services were not available in my province”

Furthermore in Battambang:

“During my visit to the health facility, working hours were not unexpected” long waiting time” Sometimes it took a long time for transgender women's services.”

Despite some gaps in service and lack of skills, there is much room for improvement and opportunity as well as a willingness of providers to learn more about transhealth and become engaged in transgender health advocacy,

as the Focal Point explained:

“I learned that transgender health competency in Cambodia through implementing the Trans COMP CBM Tools that, stigma and discrimination were decreased in the health care sector in health facilities through the transgender scorecard and that they want to learn more about our needs.”

This sentiment was resonated also in consultations with policy makers and power brokers in both the project sites.





COUNTRY CHAPTER INDIA

In India, transgender people traditionally, “hijra”, “aravanis”, and “kothis” have an important religio-cultural function, and were often invited to birth celebrations, marriage ceremonies, and other similar social events.



Nevertheless, despite their long history in the culture, Indian society largely perceives transgender and gender diverse people as other and marginalise¹⁸.

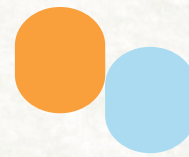
There is also a reported social disconnect between traditional transgender and gender diverse identities and nomenclature, such as *tritiya prakriti* which are considered

third gender however typically subjected to social exclusion, as are *hijra*, who face entrenched stigmatization in society, vis a vis modern transgender people.

Pushed to precarity and marginality, *tritiya prakriti* and *hijra* subsist through begging and transactional sex and informal labour, live in slums and remote areas with

limited access to resources and infrastructure, and areas worst affected by floods, droughts or other environmental catastrophes resulting from climate change.¹⁹

On the other hand, contemporary “transgender people” position themselves as belonging to the middle class by adopting middle-class markers such as education and activism and other ‘modern’ status indicators.²⁰ Transmasculine and transmen have limited acknowledgment in traditional spaces, however are increasingly embraced by these modern transgender communities and networks.



According to the National Human Rights Commission of India, nearly 96% of transgender people have extremely limited employment options and may be denied work, and 60% are unable to access schooling.



Transgender children experience bullying and discrimination both within their community and in educational institutions²¹.



Transgender people face discrimination on all fronts including education and employment, and experience challenges in obtaining identity documents and social protection mechanisms such as passports, voter IDs and driving licences.

India has demonstrated progress to the acknowledgement of gender diversity with the recently enacted (2019) and adapted (2020)

Transgender Persons (Protection of Rights) Act or “Transgender Law”.

The Transgender Persons (Protection of Rights) Act or “Transgender Law” prohibits all forms of stigma and discrimination to transgender people as well as outlines the creation of new forms of identity documents such as the Aadhaar national identity cards/unique identifying codes stipulating three gender categories- male, female and transgender²².

Possession of this new form of documentation is necessary for those wishing to access government support for gender-affirming surgery or care.

Recent data indicates that nationally over 19,000 transgender people have been issued Aadhaar cards that recognize them as a third gender²³. However, the process to change gender markers on official documents remains protracted, and the corresponding rules mandate the production of medical certificates in order to obtain a certificate for change of gender.²⁴

This protracted and laborious process involves individuals completing and submitting applications to the District Magistrate, who can issue a certificate of transgender status and update all documents, including change of name,

under the *Transgender Persons (Protection of Rights) Act 2019*: sections 5-6. Further, the Act discusses legal rights in:

“Isolation of praxis, structural support and, more

importantly, lacks guidelines needed to substantively access rights”.

Therefore, despite justly celebrated as progress towards recognition of transgender

SERVICE PROVIDER MAPPING COMBINED INDIA

SERVICE PROVIDER MAPPING COMBINED INDIA											
SERVICES PROVIDED*	HIV Counselling and Testing										Y
	HIV Treatment, Care, and Support										Y
	STI Testing										Y
	STI Treatment										Y
	Male Condoms										Y
	Female Condoms										Y
	Lubricant										Y
	PrEP										Y
	PEP										N
	Counselling										Y
	Hormone Therapy										Y
	Gender Affirming Care										N
	Top Surgery										N
	Bottom Surgery										N
	Cancer Screening										N
	IEC										Y
	Mental Health Support										Y
	Harm Reduction Programs										Y
	Vaccine (Non COVID19)										Y
	COVID19 Services										N
	Other Health Services Referrals										Y
Other non-Health Services Referrals										Y	

*Y FOR YES
*N FOR NO

Yes, Free/UHC

Yes, Half Subsidised

Yes, Not Free

identity, such a disconnection relegates human rights to merely legal changes with limited practice, and many transgender individuals carry a transgender identity card along with the conventional heteronormative identity document²⁵. In other words, for many the new ID card is merely a symbolic marker, as the *de facto* or 'official' birth documentation stays the same and without an affirming change in other documents the legal and social positioning of transgender people remains vulnerable in many contexts²⁶.

Indian society, contrary to the vast literature and evidence documenting rich history of gender variant deities, and plurality of religious, cultural, caste, and other identities, is still largely uninformed about SOGIESC and pervading gender normative assumptions serve to perpetuate the exclusion and marginalisation of gender minorities and fail to recognise the bodily autonomy of trans and gender diverse people.²⁷

Transgender people in India, especially in the two chosen sites for Trans COMP CBM Phase 2, that is Delhi and the Gautam Buddha Nagar district in Uttar Pradesh, experience multifarious gender-based distal stressors, such as discrimination, victimization, and rejection in various environments, in the workplace, familial realm, schools, personal relationships, public restrooms,

as well as in healthcare facilities.²⁸

There is a paucity of facilities and capacitated healthcare professionals that provide gender affirming care services, as illustrated in our Service Provider Mapping for Delhi and Gautam Buddha Nagar, however there is increasing interest in and commitment towards improving healthcare for transgender individuals outside of those on the HIV continuum of care, particularly in larger urban centres.

Currently, gender affirmation surgery can cost 300,000 to 800,000 rupees, a prohibitive sum for most. Requirements for psychiatric evaluation using the *Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the International Classification of Diseases (ICD)* before provision of hormones and/or surgery may add to the expense and constitute gatekeeping.

Public subsidies for gender affirming surgeries are rare or non-existent. Further, a lack of national guidelines and formalised regulation dissuades many healthcare professionals to provide hormone therapy to trans people²⁹.

18 <https://www.mdpi.com/2313-5778/6/4/92>

19 <https://india.mongabay.com/2023/03/transgender-activists-highlight-the-impacts-of-climate-change-and-environmental-issues-on-the-community/>

20 <https://theconversation.com/transgender-women-are-finding-some-respect-in-india-but-a-traditional-gender-nonconforming-group-hijras-remains-stigmatized-177197>

21 <https://www.roundtableindia.co.in/beyond-boundaries-strengthening-transgender-lives-in-india/>

22 <https://www.amnesty.org/en/wp-content/uploads/2022/11/ASA0161972022ENGLISH.pdf>

23 <https://jurnal.uns.ac.id/bestuur/article/view/51997>

24 <https://www.amnesty.org/en/wp-content/uploads/2022/11/ASA0161972022ENGLISH.pdf>

25 <https://academic.oup.com/jhrp/article-abstract/14/2/676/6566269?redirectedFrom=fulltext>

26 <https://www.frontiersin.org/articles/10.3389/fpos.2022.963033/full>

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

28 <https://digital.library.unt.edu/ark:/67531/metadc1703360/>

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

Private clinics and community-led providers were deemed to be more sensitive and welcoming than the public facilities. There was also identified difference between service providers in rural and urban contexts. One Data Gatherer explained:

"I had an incredibly positive experience at the district hospital. The staff members were not only aware of transgender issues but were also actively engaged in creating an inclusive environment. The staff showed interest and I felt supported. Their openness and empathy made me feel valued and encouraged."

However, others stated:

"The staff seemed uninformed about our needs. The lack of understanding led to uncomfortable situations during data collection, with ancillary staff displaying ignorance or insensitivity"

With another stating:

"At a particular hospital, staff members lacked awareness about

transgender individuals and their healthcare needs. Even being the largest hospital that is supposed to open a separate wing for transgender, the staff still don't have basic knowledge on transgenders which was absolutely disheartening."

Further there was an overall lack of services for transpeople with disabilities, a lack of appropriate bathroom facilities for trans people (36% said they were not allowed to use the bathroom of their choice), particularly trans masculine people which causes discomfort and embarrassment.

Positively, 75% said that were provided the option to use their preferred pronoun, however only 50% said they felt safe in the public area of the facility. 65% said they questioned whether or not their confidentiality would be guaranteed and only 32% said consent was requested before examination. Not only did many Data Gatherers feel that they were judged because of their gender identity, disappointingly only 24% agreed that they weren't judged because of their ability, religion, ethnicity, occupation, HIV status, or socio-economic

background. Further, only 40% said that their mental health improved after visiting the facility, particularly in the district or public facilities. This feeling slightly improved after interaction with private or community-based providers.



76.0%

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

Opportunity for growth and capacity building was identified through the data collection process as did trans-friendly providers, despite perhaps lacking the services required to be considered “trans-clinical competent”, it is evident that there were sites unquestionably identified as trans-culturally competent. As the Data Gatherers explained:

“One notable positive experience occurred at a Lal Bahadur Shastri hospital. The staff members were not only aware of transgender issues but also went above and beyond to create a welcoming environment. The positive atmosphere at the clinic made me feel respected and acknowledged, emphasizing the importance of inclusive healthcare spaces.”

Another explaining:

“I discovered an unexpected ally at Noida District Hospital. A specific service provider stood out for their genuine interest in learning about transgender health and showed a commitment to creating a trans-friendly space. They took the initiative to ask ME questions, seeking to understand the unique needs of transgender individuals.”

With another saying:

“Dr Tapeshwar at the Aura Clinic emerged as an unexpected ally. The staff members at

the clinic were not only sensitized but actively engaged in conversations about transgender health. This ally played a crucial role in fostering a positive environment within the clinic and enhancing the overall experience of the visit.”

Interestingly, Data Gatherers also reported positive interactions with aestheticians and dentists. Relationships with such allies should be cultivated and strengthened and it would behoove APTN to further capacitate these potential partners and advocates moving forward.



COUNTRY CHAPTER INDONESIA



In spite of an ancient and long documented socio-cultural history of gender diversity and proclivities, with some provinces recognising five genders such as South Sulawesi where we find *men-calabai-bissu-balaki-women*³⁰, Dutch colonisation ratified the prohibition of homosexuality and shaped the pervasive heteronormativity seen in Indonesia in contemporary times.



JAKARTA

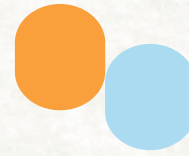
Further, religious conservatism and populism perpetuates state sanctioned stigma and discrimination and human rights abuses towards transgender people in Indonesia.

Transgender people in Indonesia experience poverty, ostracization, social marginalisation, as well

as diminished access to education and employment, legal identity documents and social protection mechanisms and citizenship documents such as birth certificates, Identity Cards (*Kartu Tanda Penduduk*), excluded from the right to vote³¹, targeted by law enforcement and experience arbitrary arrest, have limited

access to health care, to adequately trained health care professionals, inconsistent access to safe housing and legal recourse. These realities are compounded when transgender people are living with HIV, engaged in sex work or drug use, or are at the intersect of these.³²

Transgender women in Indonesia have disproportionately high rates of HIV and experience barriers accessing HIV services and health in general. Seeking out more supportive environments, both transmen and transwomen often relocate to larger cities or safer spaces, such as the province of Bali, one of the two sites for Trans COMP CBM Phase 2, where they are able to access guidance peer and support.³³



In Indonesia, transgender people, particularly transgender women, have access to HIV and sexual and reproductive health services, and to trans-specific HIV services including within CBOs and NGOs and are included in the national HIV Strategy.



There are also organisations and networks that focus on young transgender people as well as specifically for transmen and non-binary people. Gender-affirming healthcare is also legal but unregulated in Indonesia, and many access without prior health screening or recommended consultation.

Estrogen, and anti-androgens are available for transfeminine people as is testosterone for transmasculine people and accessed via both informal and formal channels however these are unregulated as are gender affirming healthcare surgeries and body modifications³⁴.

Gender-affirming surgeries are available but there is no health insurance covering the cost of surgeries or hormones which are prohibitively expensive. Further, the Indonesian Psychiatric Association pathologises and classifies transgender and gender diverse people as people suffering from mental disorders, despite ongoing advocacy to counter this.³⁵

Indonesia's Constitution outlines provisions granting all citizens the right to equal protection by law, including the right to "non-discrimination, education, health, physical and spiritual prosperity and the right to establish a family and procreate"³⁶. In addition, access to healthcare is covered under Law No. 36 which declares the right of every Indonesian for unfettered access to basic healthcare provided without discrimination.³⁷ Nevertheless, there are several other mechanisms that work against the pursuance of universal rights for transgender people.

In 2008, Indonesia passed the Pornography Law, *UNDANG-UNDANG (UU) Nomor 44 Tahun 2008*³⁸, states that pornography includes "pictures ... conversations, movements of the body ...

in public which contain obscenity or sexual exploitation which violates the moral norms in society.”

More recently, on December 6, 2022, the Indonesian

government released a new law containing provisions that potentially violate international human rights law and principles. Articles in this new code violate the rights of women, religious minorities,

and lesbian, gay, bisexual, and transgender people, and undermine rights to freedom of speech and association.³⁹

In addition there are numerous provincial regulations

SERVICE PROVIDER MAPPING COMBINED INDONESIA

SERVICES PROVIDED*											
HIV Counselling and Testing	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Half Subsidised	Yes, Half Subsidised	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Y
HIV Treatment, Care, and Support	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Half Subsidised	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Y
STI Testing	Yes, Not Free	Yes, Not Free	Yes, Half Subsidised	Yes, Free/UHC	Yes, Not Free	Yes, Not Free	Yes, Half Subsidised	Yes, Half Subsidised	Yes, Not Free	Yes, Half Subsidised	Y
STI Treatment	Yes, Not Free	Yes, Not Free	Yes, Half Subsidised	Yes, Free/UHC	Yes, Not Free	Yes, Not Free	Yes, Half Subsidised	Yes, Half Subsidised	Yes, Not Free	Yes, Half Subsidised	Y
Male Condoms	Yes, Half Subsidised	Yes, Free/UHC	Yes, Free/UHC	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Y
Female Condoms	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Y
Lubricant	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Y
PrEP	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Half Subsidised	Yes, Half Subsidised	Yes, Half Subsidised	Yes, Half Subsidised	Yes, Half Subsidised	Yes, Half Subsidised	Y
PEP	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Half Subsidised	Yes, Half Subsidised	Yes, Half Subsidised	Yes, Half Subsidised	Yes, Half Subsidised	Yes, Half Subsidised	N
Counselling	Yes, Not Free	Yes, Not Free	Yes, Free/UHC	Yes, Free/UHC	Yes, Not Free	Yes, Half Subsidised	Yes, Half Subsidised	Yes, Half Subsidised	Yes, Half Subsidised	Yes, Half Subsidised	Y
Hormone Therapy	Yes, Not Free	Yes, Half Subsidised	Yes, Not Free	Yes, Half Subsidised	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Y
Gender Affirming Care	Yes, Not Free	Yes, Half Subsidised	Yes, Not Free	Yes, Half Subsidised	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	N
Top Surgery	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Half Subsidised	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	N
Bottom Surgery	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	N
Cancer Screening	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Half Subsidised	Yes, Not Free	Yes, Not Free	Yes, Half Subsidised	Yes, Half Subsidised	Yes, Not Free	Yes, Half Subsidised	N
IEC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Half Subsidised	Yes, Not Free	Yes, Not Free	Yes, Half Subsidised	Yes, Half Subsidised	Yes, Not Free	Yes, Half Subsidised	Y
Mental Health Support	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Half Subsidised	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Y
Harm Reduction Programs	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Half Subsidised	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Yes, Not Free	Y
Vaccine (Non COVID19)	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Y
COVID19 Services	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Half Subsidised	Yes, Half Subsidised	Yes, Half Subsidised	Yes, Half Subsidised	Yes, Half Subsidised	Yes, Half Subsidised	N
Other Health Services Referrals	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Y
Other non-Health Services Referrals	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Yes, Free/UHC	Y

*Y FOR YES
*N FOR NO

- Yes, Free/UHC
- Yes, Half Subsidised
- Yes, Not Free

(*Peraturan Daerah*) which are explicitly discriminating and endanger transgender peoples, such as those in the Autonomous Province of Aceh and in Depok which impose restrictions on public visibility, gender expression and same sex relations.⁴⁰

To find safe space for gender expression and improved quality of life, many transgender people move to the more *laissez faire* Hindu province of Bali, one of the selected sites for Trans COMP CBM Tool 2 or to the second Phase 2 location of metropole Jakarta, both of which host a number of healthcare facilities that are inclusive and gender affirming as evidenced in the Service Provider Mapping, albeit arguably not yet trans-clinically competent.

Data collected by Data Gatherers in both of the sites in Indonesia elicited a number of key findings. These include, in addition to a severe paucity of health services for trans people, there was a lack of informed consent and counselling (outside that related to HIV testing):

“They didn’t explain to me what they were going to do, instead went right ahead and took my blood without properly explaining the process.”

Nevertheless, both sites met

the sexual and reproductive health needs of Data Gatherers, with over **87%** reporting so. Bali was viewed as generally more inclusive and trans-friendly than the more conservative Jakarta area.

Similar with India, private clinics and community-led providers that engaged trans peers in Indonesia were deemed to be more sensitive and welcoming than the public, government run facilities:

“I would much prefer to go to the peer led organization even if they don’t have everything I need.”

However, there was an identified overall lack of services for people with disabilities who are trans or trans youth- 68% said that their needs were not met. 40% of Data Gatherers were unsure about their mental health after visiting the facility, and whether or not they felt it improved.

30 <https://society.fisip.ubb.ac.id/index.php/society/article/view/113>

31 <https://en.tempo.co/read/1638625/voting-rights-of-indonesian-trans-women-kpu-explains-issues-on-transgender-group-in-elections>

32 Rowe, et. al. 2020 “Our Voice, Our Needs”: Exploring and Advocating for the Escalated Access of Sex Workers to Social Protection Mechanisms in 3 Cities in Indonesia, aidsfonds, Unpublished report.

33 <https://pubmed.ncbi.nlm.nih.gov/31815531/>

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

35 https://weareaptn.org/wp-content/uploads/2021/03/Conversion-Therapy-2020-Indonesia_28Dec.pdf

36 https://en.mkri.id/download/constitution/constitution_1_1625426222_4c1e13f466840d7ed721.pdf

37 Fisk, Kylie, and Jack Byrne. *The Cost of Stigma: Understanding and Addressing Health Implications of Transphobia and Discrimination on Transgender and Gender Diverse People. Evidence from a Trans- Led Research in Nepal, Indonesia, Thailand, and Vietnam.* Bangkok: Asia Pacific Transgender Network (APTN), 2020

38 <https://peraturan.bpk.go.id/Details/39740>

39 <https://www.hrw.org/news/2022/12/08/indonesia-new-criminal-code-disastrous-rights#:~:text=“Indonesia%27s%20new%20criminal%20code%20contains,Andreas%20Harsono%2C%20senior%20Indonesia%20researcher>

40 <https://weareaptn.org/resource/transgender-youth-inclusion-in-healthcare-in-southeast-asia-insights-from-indonesia-thailand-and-the-philippines/>

72.0% OVERALL FINDINGS FROM THE TRANS COMPETENCY SCALE IN INDONESIA WERE RELATIVELY POSITIVE

Any existing services for transgender people are unaffordable and hard to access- trans healthcare services in both sites were not fully covered by universal health coverage schemes or mechanisms. Understandably these cost barriers can impede accessibility:

"I wish I could have afforded what they were offering, but it just isn't feasible for me right now".

Further there were limited reported service catering to the health needs of trans

masculine people and a lack of harm reduction services and those that respond to intersectional needs.

Many trans people face discrimination in general healthcare settings. In Indonesia, Data Gatherers felt discriminated against and intimidated by staff and 51% of Data Gatherers said they were misgendered, and felt disempowered:

"I corrected them when they called me by the wrong pronoun as a transman, but they did it anyway."

60% said that they felt that their confidentiality would not be guaranteed. There is a clear need for further collaboration and capacity building in trans health for all levels of healthcare providers, and this could be supported by further engaging the providers deemed trans-culturally competent and as identified allies.



DISCUSSION AND RECOMMENDATIONS

The Trans COMP CBM Tool Phase 2 has been instrumental into gaining further insight into the lived experiences of transpeople accessing health-care services at the local level in Cambodia, India and Indonesia.



Our findings indicate that many of the facilities accessed were deemed to be trans-culturally competent however not yet trans-clinically competent which shows promise for opportunity however is also dependent on availability and affordability of gender affirming care, and the health and social policy environment in each country. Our Data Gatherers in each country reported that providers often lack relevant skills and appear unsupportive or hostile to their specific healthcare needs.

The absence of knowledgeable service providers, and their lack of training in providing trans-competent care, is a formidable barrier that needs to be addressed and mitigated. Nevertheless, the findings from the Trans COMP CBM Phase 2 open up opportunity for dialogue and capacity building of identified allies, including perhaps through the modules contained within the Towards Transformative Healthcare curricula and other core references. Further, there

is a need to recognize more individual, diffused combinations of care, and services responding to the intersectional health and social needs of transgender people of all backgrounds and socio-economic statuses.

"DATA GATHERERS REPORTED EXPERIENCING SOME LEVEL OF DISCRIMINATION, HUMILIATION, STIGMA AND HOSTILITY AND ALMOST EVERY STAGE OF THE MEDICAL PROCESS, FROM THE REGISTRATION DESK TO THE POINT OF ADMISSION."

There are a range of negative experiences transgender people may encounter trying to access healthcare in a predominately cisnormative society. Data Gatherers reported experiencing some level of discrimination, humiliation, stigma and hostility and almost every stage of the medical process, from the registration desk to the point of admission.

Discrimination experienced in one area of health can

impact negatively on whether trans people would seek other forms of healthcare. Repeated interactions with a discriminatory healthcare system will inevitably increase the likelihood of having further negative experiences. These negative experiences, both systemic and interpersonal can further lead directly to negative health outcomes, including poor physical or mental health. Discrimination in a healthcare setting can lead to future avoidance of medical care in general and perpetuate ill health.

In order to achieve equitable, quality healthcare for all, it is critical that healthcare providers are capacitated in the provision of gender affirming care, regardless of whether or not gender affirming healthcare interventions fall within the parameters of their field of work. Gender affirming care services include, but are not limited to, hormone therapy, surgical interventions, facial hair removal, interventions for the modification of speech and communication, and behavioural/aesthetic



adaptations such as genital tucking or packing, or chest binding. Each of these interventions can have unintended negative implications, however with guidance and support from the provider, can be mitigated.

At the stakeholder level, it is advised that the Trans COMP CBM Tool into be imbedded into existing national level monitoring mechanisms. More iterations in other countries will provide more insight. In addition, ongoing

collaboration and meaningful engagement of transgender people of all backgrounds in national healthcare program design, health strategic plan development with implicated stakeholders and policy makers, including in conversations regarding health budget advocacy for investment into gender affirming care service provision (for both trans feminine and trans masculine people) is highly recommended.

"IN ORDER TO ACHIEVE EQUITABLE, QUALITY HEALTHCARE FOR ALL, IT IS CRITICAL THAT HEALTHCARE PROVIDERS ARE CAPACITATED IN THE PROVISION OF GENDER AFFIRMING CARE, REGARDLESS OF WHETHER OR NOT GENDER AFFIRMING HEALTHCARE INTERVENTIONS FALL WITHIN THE PARAMETERS OF THEIR FIELD OF WORK."

FURTHER READING

- ACON 2019 A Blueprint for Improving the Health and Wellbeing of the Trans and Gender Diverse Community in NSW, **AIDS Council of New South Wales, Sydney, Australia**
- Advancing Partners & Communities 2018 Community Scorecard Toolkit: Empowering Communities and Healthcare Providers to Partner in Leading Change. **Arlington, VA.: Advancing Partners & Communities**
- APCOM 2020 A Guide to Implementing Community Based Monitoring: Prepared for the Sustainability of Key Populations in Asia (SKPA) Program, **APCOM**
- Australian Medical Students' Association Limited 2017 Transgender Healthcare, **AMSAL**
- Baptiste, S. 2019 Community-Led Monitoring and Advocacy for Health, **ITPC**
- CARE Malawi 2013 The Community Scorecard: A Generic Guide for Implementing CARE's CSC Process to Improve Quality of Services, **CARE**
- Coleman, E. et al. 2022 Standards of Care for the Health of Transgender, and Gender- Nonconforming People, Version 8, **International Journal of Transgender Health**
- Ding, J. et al, 2020 A Model for Improving Health Care Quality for Transgender and Gender Nonconforming Patients, **The Joint Commission Journal on Quality and Patient Safety 2020; 46:37–43**
- Giblan, R. et a., 2017 Health care availability, quality, and unmet need: a comparison of transgender and cisgender residents of Ontario, Canada, **BMC Health Services Research (2017) 17:283**
- Health Policy Project, Asia Pacific Transgender Network, United Nations Development Programme. 2015. Blueprint for the Provision of Comprehensive Care for Trans People and Trans Communities. **Washington, DC: Futures Group, Health Policy Project**
- FY 2020 COP Guidelines for all PEPFAR Countries, **PEPFAR**
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