YouthLEAD

ASIA PACIFIC TRANSGENDER NETWORK

Transgender youth inclusion in healthcare in Southeast Asia: Insights from Indonesia, Thailand, and the Philippines

ALEGRA WOLTER, MD AND BENJAMIN HEGARTY, PHD

TRANSGENDER YOUTH INCLUSION IN HEALTHCARE IN SOUTHEAST ASIA: INSIGHTS FROM INDONESIA, THAILAND, AND THE PHILIPPINES

Alegra Wolter, MD and Benjamin Hegarty, PhD
Edited by Leo Villar

Youth LEAD, Asia Pacific Network of Young Key Populations
75/20 Ocean Tower 2, 17th Floor
Soi Sukhumvit 19, Khlong Toey Neua, Khet Wattana Bangkok, 10110, Thailand
www.youthleadap.org info@youth-lead.org

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Acknowledgements

Transgender youth inclusion in healthcare in Southeast Asia:
Insights from Indonesia, Thailand, and the Philippines, is a situational analysis developed by Youth LEAD to explore the healthcare inclusion of transgender youth in the Asia-Pacific, particularly in Indonesia, Thailand, and the Philippines. This study was conducted as a formative research in understanding the challenges and opportunities on good practices of transgender health for youth and proposing culturally-appropriate recommendations. This study was conducted under the partnership umbrella between Youth LEAD and Asia Pacific Transgender Network (APTN), under the Project "Transcending Borders: Strengthening trans and gender diverse movements towards transformative leadership, legal protection and trans-competent healthcare in Asia-Pacific and Africa" funded by the Robert Carr Fund (RCF).

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This situational analysis aims to provide evidence to support the development of a training module on transgender youth for healthcare providers. It was developed through collaborative efforts between experts and community leaders—deepest gratitude to all representatives playing their instrumental role in the creation of this report. For more information about the situational analysis report, contact Youth LEAD:
E-mail: info@youth-lead.org

Executive summary

Overview

This report is a situational analysis of transgender youth access to healthcare in three countries; Indonesia, the Philippines, and Thailand. It is based on two methods: 1) an online survey (qualitative/mixed-methods) for a) transgender youth, b) healthcare providers, and c) family members of transgender youth; and 2) a desk review of policies and regulations relevant to transgender youth access to healthcare in three countries. These are broken down by country into sections and outlined below. The survey was translated and made available to participants from each country, who were able to select from Bahasa Indonesia, Thai, Tagalog, or English. The survey was open between December 2022 and February 2023. The survey was promoted via social media channels, emails, and direct communication apps. A total of 64 transgender youth (aged 18-30), 15 healthcare providers, and 5 parents/families/legal guardians completed the survey. Only those who completed the survey were included in the final analysis.

Responses varied widely between countries, with the largest number from Indonesia, the second from the Philippines, and the smallest from Thailand. Thus, results should be interpreted with this bias in mind; the research results for Thailand in particular are so small as to be difficult to be representative. Additionally, when reading the research findings, it must be remembered that the majority of data is from Indonesia. Data has not been weighted to account for this difference between survey responses between the three countries. Where possible, data is broken down between countries and between gender identities, in order to give a more accurate understanding of the findings. The desk review is presented as a table broken down into sections relevant to it. Given limited scholarly sources (which have been cited where possible) on the topic of transgender health, the desk review draws on reports, regulations, and in some cases media reports. It should therefore be seen as a general overview of the policy situation. However, the information cannot be fully verified as accurate according to scholarly standards. This suggests the need for further research on this topic. A brief summary of the most relevant findings from the survey is included per population group below. A detailed presentation of data and analysis can be found in the following section, with results broken down according to country and identity category, where relevant.

Young transgender people

Despite high rates of discrimination in access to healthcare, a significant number of transgender youth (68.75%) self-reported their physical health condition as good (n=25) or very good (n=19). However, respondents reported struggling with mental health issues for an average of 11.17 days in the last 30 days, close to one-third of the month, reflected in responses related to mental health conditions. Around 71% of respondents reported that they experienced having a mental health problem (n=28), and the highest responses related to depression (n=21) and anxiety (n=20). In addition, the proportion of respondents who reported a mental health condition was similar across trans masculine, trans feminine, and non-binary respondents. This suggests that any programs related to transgender health for transgender youth should include a specific focus on mental health, particularly depression and anxiety.

Over half of the respondents reported that they were undertaking hormonal therapy, with the average age of commencing hormone therapy at 21 years old. This suggests that a primary target of transgender healthcare programs and information pertaining to literacy should be young adults. In each country, a proportion of differences between countries were pronounced. In Indonesia and the Philippines, most respondents reported using hormonal therapy without medical supervision (81.25%; n=13 and 47.06%; n=12, respectively), whereas in Thailand, four out of five participants reported taking hormonal therapy with medical supervision (80%). Overall, trans-masculine-identified respondents were more likely to seek medical supervision while undergoing hormonal replacement therapy compared to respondents within the trans-feminine categories. Many trans youth resorts to their peers (44.12%; n=34) and the internet (38.24%; n=27) for information on hormonal therapy. This makes peer-based education and support programs for hormonal therapy an important priority. The DIY use of hormones, reflecting the challenges of access in Indonesia in particular, suggests the need for targeted harm reduction and transgender health literacy campaigns focusing on transgender youth, addressing the needs in all identity spectrums.

The findings captured multiple barriers to care, including the lack of available services, providers' lack of knowledge, financial cost, difficulty in pathways, and discrimination. The lack of services and proper pathways was evident from 55 respondents who reported on the absence of specific gender clinics that could provide high-quality gender-affirming care. This study further highlights how out-of-pocket expenditure remained the primary health financing method for transgender individuals accessing health services (56.17%; n=50), suggesting the need for further investigation into the dynamics of universal health coverage, gender equality, and social protection within the context of transgender health. In this vein, the survey captured the high levels of discrimination that trans youth experience when accessing healthcare, with the most common being the intentional use of a wrong name or misgendering (33.68%; n=32), refusal to provide transition-related healthcare (14.74%; n=14), and the use of harsh and abusive language (14.74%; n=14). Four respondents also reported instances of unwanted sexual contact and one reported experiencing physical abuse. The speculation that Thailand is a destination for gender-affirming care from other nations in Southeast Asia is indirectly reflected in the results, which revealed that a majority of respondents from Indonesia (55.56%; n=20) and the Philippines (68.18%; n=15) preferred to access surgeries overseas, whereas all respondents from Thailand reported that they would like to access surgeries in their own country (n=6).

Healthcare providers

Of the healthcare providers who responded to the survey, the majority appeared to hold non-discriminatory attitudes towards transgender people and a willingness to learn, given that a majority had learned about providing transgender healthcare based on their own initiative (n=10). Some professional barriers listed by healthcare providers in treating transgender patients include the lack of training on transgender health (n=11), lack of knowledge about transgender care among other healthcare staff (n=9), lack of exposure to transgender patients (n=7), lack of familiarity with current guidelines (n=6), and lack of regulation or guidance (n=5). These findings correspond with the desk review on transgender health guidelines and policies in the three countries. Despite the lack of training, healthcare providers responded that they could provide routine care for transgender patients. Regardless, healthcare providers reported certain limitations in the type of care they provided and their willingness to refer patients for certain services. Healthcare providers expressed less willingness to provide or refer for certain types of care, such as hormonal treatment (especially for those under 18), surgery referrals, and legal support.

In addition to strengthening and aligning policies, guidelines, and regulations, there is a need for greater education and advocacy for healthcare providers to enhance their confidence, ability, and cultural competency in providing gender-affirming care; especially based on the principles of informed consent approach. Such needs were evident through 15 recorded responses that mentioned social barriers in providing gender-affirming care; for example, the fear of being sued for providing care, fear of what other professionals or people might think, and other cultural, social, personal, and religious beliefs. Furthermore, information delivery models should be considered in sharing transgender health information, including community and professional sharing sessions (n=11), the use of medical guidelines (n=9), health conferences or seminars (n=9), training workshops (n=8), university lectures (n=8), and online webinars or courses (n=7).

Family

Five responses for this survey were received, the majority from Indonesia; 3 from Indonesia, 1 from Thailand, and 1 from the Philippines. The majority of respondents reported either being fully accepting or neutral towards the young transgender person they referred to, with only one describing that they were not accepting of the young person's identity. "Fear for my child's future" remained a top barrier for parents, legal guardians, or family members to fully accept their transgender youth (n=4), followed by religious beliefs (n=3), fear of others' opinions (n=3), other personal beliefs (n=2), and safety concerns (n=1). Additionally, there seemed to be a higher response for those who "would not allow" surgery-related interventions for their youth, compared to other gender-affirming practices, such as hormonal therapy or social transition (e.g., names, pronouns, clothes).

All respondents reported preferring medical supervision for the transition of their youth, which sits at odds with the finding that a majority of trans youth respondents use hormones without medical supervision. Public hospitals were the top type of healthcare facility accessed by youth and their families (n=4). This suggests that public hospitals and other healthcare facilities should remain a priority for efforts to improve education and advocacy. Similar to responses from transgender youth, discrimination towards transgender youth experienced by parents included the use of the wrong name (misgendering) and abusive or discriminatory language, as well as barriers related to cost; similar to youth, most respondents accessed healthcare using the out-of-pocket cost (n=4), and only one responded on the use of government insurance. Furthermore, four out of five family respondents reported the expectation of access to universal healthcare coverage which incorporates transgender health. This resonates with the finding for transgender youth, who also reported a high preference for transgender health to be included within universal health coverage or public insurance.

Moving forward, rigorous efforts in improving quality healthcare for transgender individuals should include the component of trans advocacy, which brings forth a collaborative medium between providers, communities, and their families. Most parents, family members, and legal guardians would prefer online deliveries as the primary methods of receiving transgender health information, such as social media, online groups, websites, videos or podcasts, emails, and chat applications, while some do prefer seminars and gatherings.

Analysis

This report emphasizes the need to align transgender healthcare with the country and cultural context in Southeast Asia by involving a participatory approach involving community leaders and experts, in developing healthcare policies, guidelines, and regulations. It suggests that there are significant variations between countries in understanding gender and transgender health guidelines, making it crucial to develop trans-inclusive health policies and clinical pathways, including for people under 18 years of age.

Universal healthcare coverage and insurance, inclusive of gender-affirming care, mental health, and general healthcare, is a top priority for transgender individuals in their social safety net. Many respondents pay for transgender healthcare privately, indicating a structural barrier to access, especially for economically disadvantaged populations. Healthcare inclusion for trans individuals should be guaranteed using a human rights-based approach, with availability, accessibility, acceptability, and quality being of utmost importance.

The study found that transgender young people were accessing hormonal treatment without medical supervision, which is attributed to discrimination and lack of access to quality care and poses a danger to their health. To address this, information on hormones and gender-affirming care could be distributed via peer-led pathways, relevant to each country's context, following a harm reduction approach. Transgender youth, families, and providers can also benefit from online and peer-supported information about diversity and gender-affirming care. Proper social and behavior change communication strategies should be developed to support those who choose to medically transition by themselves. Approaches to transgender health should move beyond gatekeeping and stigma towards a basis of consent and empowerment.

This research highlights the need for quality healthcare for transgender individuals delivered in discrimination-free environments and via an integrated service delivery model that offers a range of necessary gender-affirming services. Monitoring and evaluating the quality of transgender health services is important, with a focus on clinical outcomes and quality of life. This report also stresses the need to educate the health workforce as a whole, including those in supporting roles, and to consider country-specific guidelines and engagement with professional organizations, accreditation bodies, and training providers. Community engagement efforts can also improve the quality and acceptability of care, including the involvement of transgender individuals in healthcare delivery, professional exchange between providers and caregivers, and the addition of transgender advocacy programs, community advisory boards, and health insurance.

Although the number of responses to the family survey was low, those responses highlighted that parents were worried about their child's future after transitioning, which could potentially affect their acceptance. Therefore, it is recommended that parents, legal guardians, and family members of transgender youth receive support in navigating the transition journey as well, through forms of peer support and education. Collaboration between transgender communities, family members, and healthcare providers is also crucial in advocating for the needs of transgender individuals.

Future research

This research is a preliminary situational analysis of the context for transgender youth access to healthcare in the three countries, with findings serving as an essential starting point for further, more detailed research. Specifically, there is a need for qualitative and quantitative research focusing on specific impacts of national policies and regulations (or their absence), exploration of social and behavioral patterns, and dimensions of universal health coverage for transgender individuals. Additionally, community empowerment and education of healthcare providers, trans youth, and families are also critical. Although not in the scope of this research, future research could work on identifying factors that influence parental acceptance and ways to advocate for greater family acceptance.

Future research should focus specifically on each country rather than on Southeast Asia as a whole, given the significant differences and the need for linguistic and cultural expertise when researching each setting. Any more detailed research undertaken should include members of the transgender community in the specific country context in the research process and dissemination plans.

Limitations

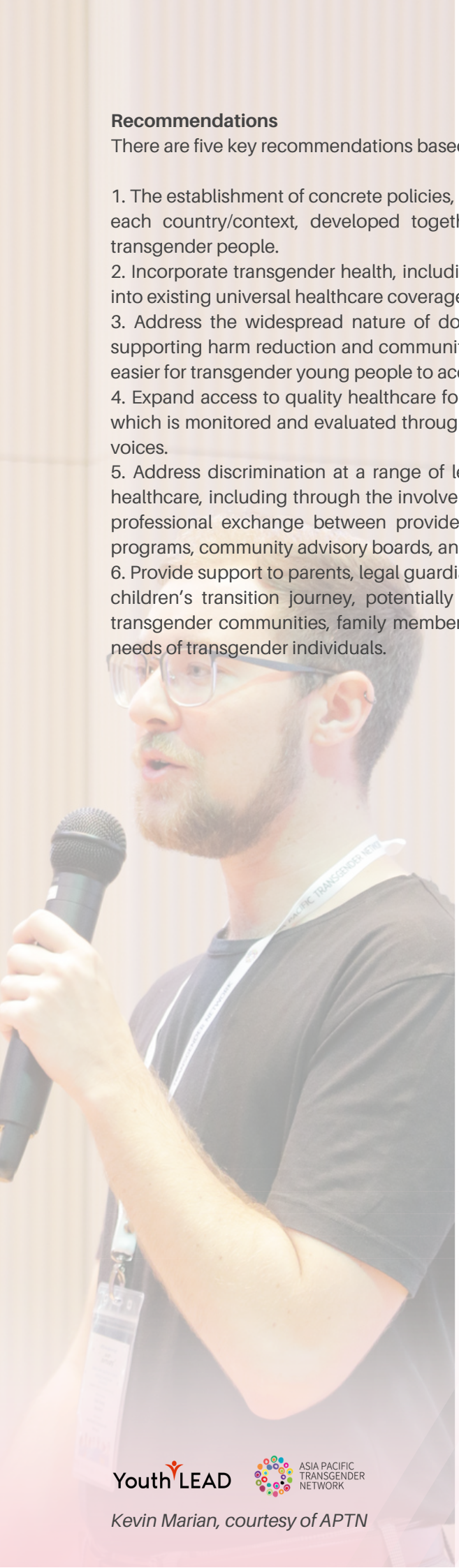
The most significant limitation of this study was the initially short time frame given for conducting a situational analysis of three different countries, although the data collection and analysis phase were extended. This had implications for data collection and analysis. With respect to data collection, it was not possible to spend time on survey design and testing translations or accessing networks widely in order to ensure the even distribution of the survey in each of the three countries. The biggest implication of the timeframe was the uneven distribution of responses to the survey, particularly for the largest group, transgender youth respondents (n=64). There were 36 trans youth respondents from Indonesia, 22 from the Philippines, and only 6 from Thailand. Despite attempts to distribute the research widely, the researchers were unable to make significant inroads into the Thai context in particular due to the limitations of language and networks.

Finally, given that it is an anonymous online survey, there is no way to validate the inclusion criteria of participants. However, a qualitative analysis of those responses received for a survey of this complexity and length suggests that most participants meet the inclusion criteria. Despite these limitations, the survey's mixed method/qualitative design helps offset the skewed number of participants between countries and the relatively small sample size.

Recommendations

There are five key recommendations based on the research:

1. The establishment of concrete policies, guidelines, and regulations for transgender health appropriate to each country/context, developed together with transgender community members, including young transgender people.
2. Incorporate transgender health, including gender-affirming care, mental health, and general healthcare into existing universal healthcare coverage to ensure equity of access.
3. Address the widespread nature of do-it-yourself hormone injections through a twin approach: both supporting harm reduction and community education based on gender-affirming principles and making it easier for transgender young people to access gender-affirming care by reducing medical gatekeepers.
4. Expand access to quality healthcare for transgender individuals based on an informed consent model, which is monitored and evaluated through accompanying research that includes transgender community voices.
5. Address discrimination at a range of levels where transgender people, youth, and their families seek healthcare, including through the involvement of transgender communities in healthcare system delivery, professional exchange between providers and caregivers, and the addition of transgender advocacy programs, community advisory boards, and health insurance.
6. Provide support to parents, legal guardians, and family members of transgender youth in navigating their children's transition journey, potentially through peer support and education. Collaboration between transgender communities, family members, and healthcare providers is also crucial in advocating for the needs of transgender individuals.



Kevin Marian, courtesy of APTN

"I experienced an incident while accompanying my partner as a caregiver, where an officer asked for my identity card and made fun of me. This made me feel uneasy as it occurred twice. As a result, I have avoided healthcare services except for COVID-19 tests, which are required for certain activities."
—29 years old trans masculine individual, Indonesia

Introduction

In the Asia-Pacific region, young transgender people frequently face systematic discrimination when accessing healthcare. Healthcare for transgender young people is often limited to HIV-related testing and treatment and to populations of transgender women. While these are important issues, transgender healthcare incorporates a wider range of concerns and populations, including general, mental, as well as gender-affirming services, for transgender women, transgender men, and other gender identities (Newman et al., 2021; Winter et al., 2016). Exclusion from healthcare services has been demonstrated to have adverse health effects and result in transgender people avoiding healthcare services. Current evidence from around the world shows a significant association between delays in accessing treatment (due to fear of discrimination), and poor general and mental health among transgender people (Seelman, Colón-Diaz, et al., 2017).

In Southeast Asia, transgender youth (aged 18-30 years of age) face inadequate access to healthcare, particularly gender-affirming care and transition-related information. This has resulted in reports of young people throughout Southeast Asia accessing unsafe do-it-yourself (DIY) hormone treatments and silicone injections (ASEAN SOGIE Caucus, 2016; Idrus, 2013; Ivanka Custodio, 2019). Despite the presence of transgender and youth-led organizations throughout Southeast Asia, restrictive legal and policy frameworks limit their capacity to support young trans people (in Thailand, see Save the Children, 2018). A recent Amnesty International report has found that the COVID-19 pandemic led to decreased funding for essential health and social services for transgender people, compounding access to services for transgender youth (Amnesty International, 2022).

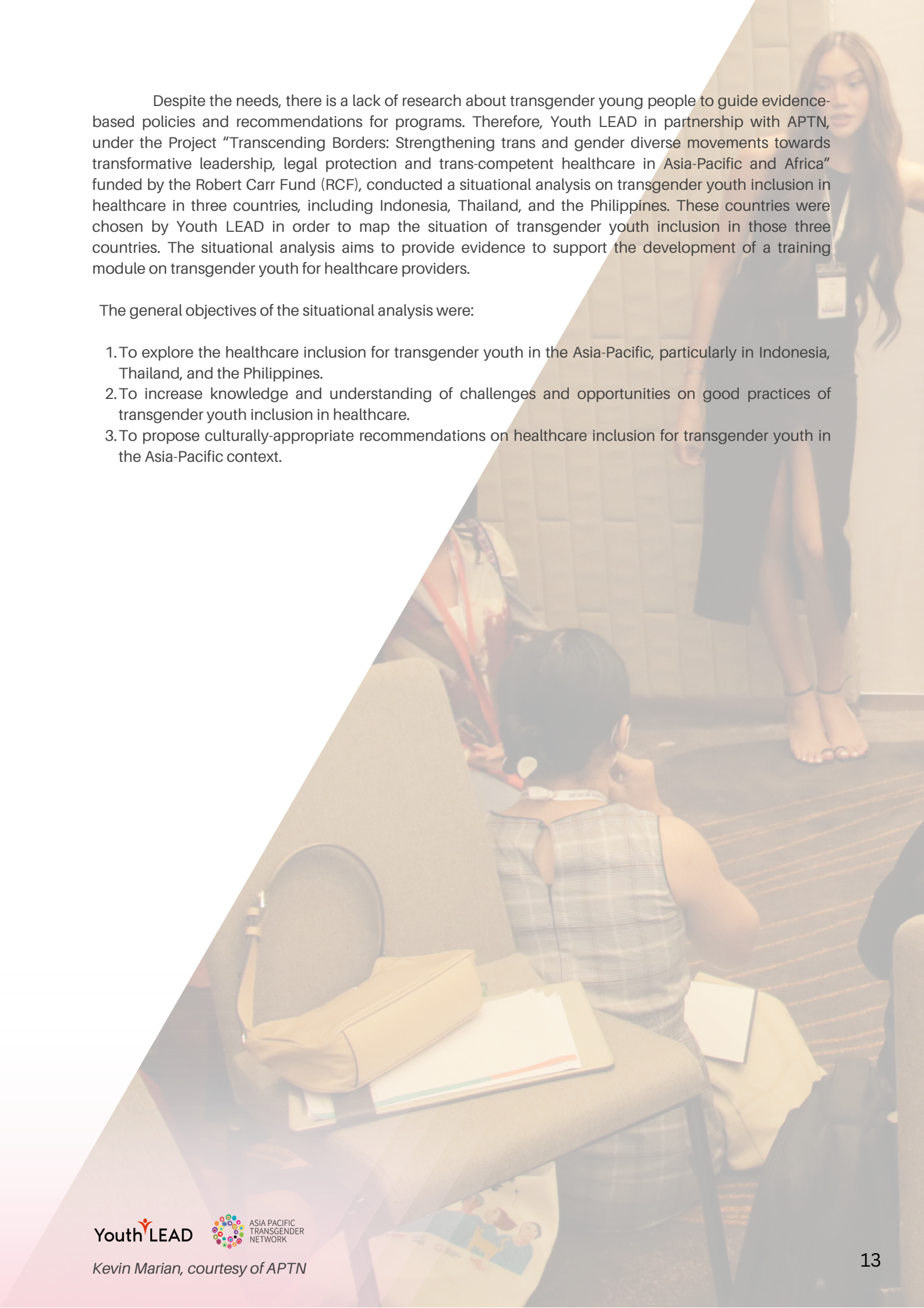
This raises questions not only of the availability of care but also of how well a healthcare system delivery model might provide quality services to the most vulnerable populations (Boyd et al., 2022; Ding et al., 2020). Ideally, quality transgender healthcare should be delivered with the involvement of transgender people in healthcare delivery, interaction with community organizations, professional exchange between health providers and caregivers, as well as with the availability of health insurance and culturally competent providers (Koehler et al., 2021). There are examples of the delivery of the components of quality transgender healthcare in Southeast Asia as in the example of the co-location of gender-affirming healthcare (hormones) with HIV services in Thailand (Lynne & Enteen, 2022). There is a need for further research and policy to address transgender youth inclusion in healthcare, particularly for the training of inclusive and culturally competent healthcare providers.

Based on survey assessments conducted by the Asia Pacific Transgender Network (APTN), there is a lack of capacity building and development for younger trans people to serve as leaders in their respective organizations and communities. The existing barriers to health and social services for young trans people call for the leadership and meaningful engagement of trans youth to develop appropriate interventions. Greater effort must be taken to recognize the realities of young transgender people's lives and to enable transgender youth to take up leadership roles to address their community's needs (APTN, 2020, 2021a, 2021b; UNDP & APTN, 2017).

Despite the needs, there is a lack of research about transgender young people to guide evidence-based policies and recommendations for programs. Therefore, Youth LEAD in partnership with APTN, under the Project "Transcending Borders: Strengthening trans and gender diverse movements towards transformative leadership, legal protection and trans-competent healthcare in Asia-Pacific and Africa" funded by the Robert Carr Fund (RCF), conducted a situational analysis on transgender youth inclusion in healthcare in three countries, including Indonesia, Thailand, and the Philippines. These countries were chosen by Youth LEAD in order to map the situation of transgender youth inclusion in those three countries. The situational analysis aims to provide evidence to support the development of a training module on transgender youth for healthcare providers.

The general objectives of the situational analysis were:

1. To explore the healthcare inclusion for transgender youth in the Asia-Pacific, particularly in Indonesia, Thailand, and the Philippines.
2. To increase knowledge and understanding of challenges and opportunities on good practices of transgender youth inclusion in healthcare.
3. To propose culturally-appropriate recommendations on healthcare inclusion for transgender youth in the Asia-Pacific context.



Kevin Marian, courtesy of APTN

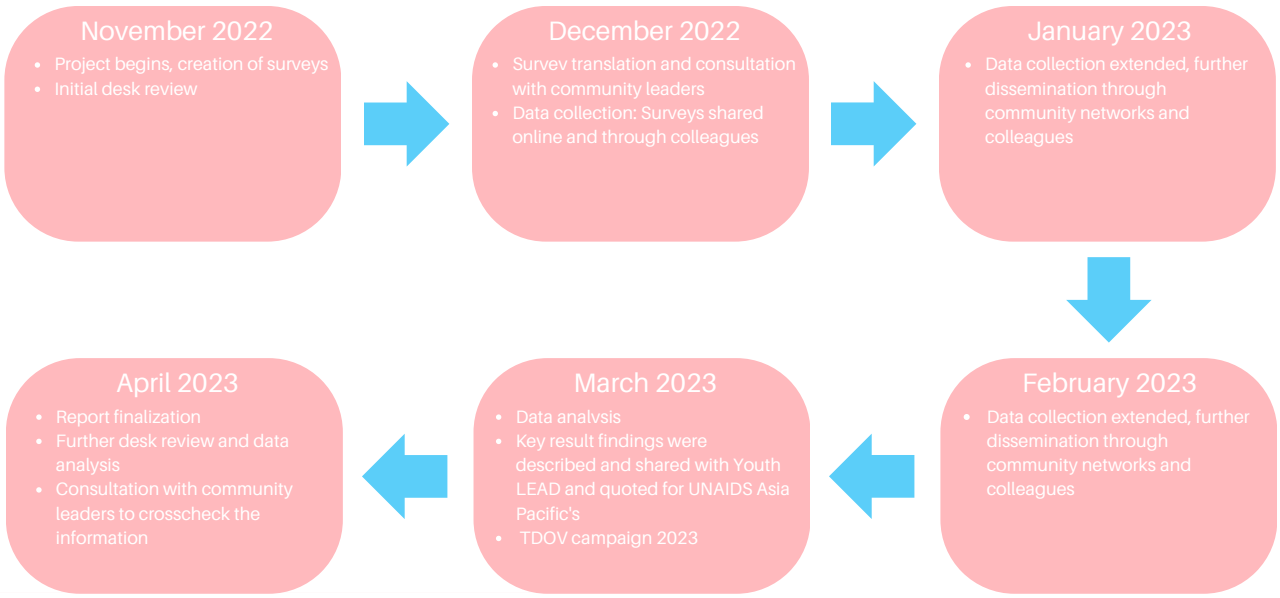
Methods

This situational analysis of transgender youth inclusion in healthcare in Southeast Asia used mixed methods (qualitative and quantitative) and drew on an ethnographic approach, which considers the importance of the cultural and social context at all stages of research (Sangaramoorthy & Kroeger, 2020). The research was a collaborative effort between Youth LEAD and other regional-national networks of youth, transgender, and gender-diverse individuals. The research consisted of an online survey promoted via networks from three participant groups:

1. transgender youth (18-30 years old)
2. healthcare providers
3. parents/families/legal guardians of transgender youth

The survey was made available to respondents between December 2022 to February 2023. Desk reviews were conducted to gain holistic perspectives on transgender youth inclusion in healthcare systems in Indonesia, Thailand, and the Philippines. Researcjers promoted the survey to respondent groups through direct emails to relevant organizations, social media (mainly Instagram and Facebook), and messenger apps (mainly WhatsApp, LINE, Messenger, and Telegram). Online surveys were made available in English but were translated into national languages (Bahasa Indonesia, Thai, and Tagalog), which respondents could select based on their preferences. Community leaders from the regional office, Indonesia, Thailand, and the Philippines were consulted in the creation of the surveys and throughout the research process.

Figure 1. Research timeline



Researchers aimed to recruit 100 transgender youth, 30 healthcare providers, and 10 parents/families/legal guardians of trans youth. To aid recruitment of participants coordinated with regional, as well as local transgender and youth organizations in each country. Some of the contributing colleagues came from different organizations (see Table1).

Table 1. Contributing organizations

Country	Some Contributing Organizations in the Survey Dissemination Process
Regional	Youth LEAD, Asia Pacific Transgender Network (APTN), Asian Professional Association for Transgender Health (AsiaPATH), Equal Asia Foundation
Indonesia	Inti Muda Indonesia, Jaringan Transgender Indonesia (JTID), Sanggar Swara, Transmen Indonesia
Thailand	Institute of HIV Research and Innovation (IHRI), Tangerine Clinic, Rainbow Sky Association of Thailand, GendersMatter
Philippines	LoveYourself Inc., LakanBini Advocates Pilipinas, Inc.

Recruitment strategies differed slightly for the healthcare providers and family members. For healthcare workers, we distributed through local networks of healthcare professionals focused on transgender health, such as AsiaPATH. Healthcare providers were requested to share details of the survey with prospective respondents in the family member group. Respondents' participation was voluntary and informed consent was obtained digitally. Data were collected according to ethical standards on confidentiality and on an encrypted survey platform, Qualtrics. Survey responses were only accessible to researchers. Target respondents and inclusion-exclusion criteria for participating in the survey are indicated in Table 2.

Table 2. Inclusion and exclusion criteria

Target Respondents	Inclusion Criteria	Exclusion Criteria
Transgender youth	1. Trans-identified youth aged 18-30 years old 2. Had experience navigating the healthcare system in their respective country in any form (public/private, hospital/clinics, and others).	1. Those who declined to participate, or 2. Had no experience navigating the healthcare system in their country.

[1] There is no universally agreed international definition of the youth age group. For statistical purposes both the United Nations and the World Health Organization defined "youth" as individuals aged 15-24 years of age (United Nations, 2023). We decided upon 18-30 years of age as our criteria for both ethical reasons (difficulties of gaining informed consent for minors under 18 years of age). We included young adults aged between 24-30 years of age for the reason that this age group both underrepresented in understandings of transgender health and able to access healthcare independently (National Center for Transgender Equality, 2022).

Healthcare providers	1. Healthcare providers with experience helping transgender people - who have a professional degree in medicine, psychology, nursing, midwifery, and others, 2. Had their experience meeting transgender patients/clients aged < 30 years old within the last 12 months 3. Had experience delivering gender-affirming services, which include any form of health support for transgender people (Clinical, programs, and research).	1. Those who declined to participate, or 2. Had no experience delivering any form of gender-affirming services, or 3. Have not seen a trans patient/client for the last 12 months.
Parents, families, and legal guardians of trans youth	1. Parents, families, and legal guardians of a young trans person (aged 18-30 years of age) who may have been referred by doctors or other health providers where they were aware of their children's gender identity Had their experience meeting transgender patients/clients aged < 30 years old within the last 12 months 2. Had experience navigating the healthcare system in their respective country in any form (public/private, hospital/clinics, and more).	1. Those who declined to participate, or 2. Parents/legal guardians were unaware of their children's gender identity.

Research instruments and survey design

In line with the ethnographic method, instruments were developed specifically for the three target respondents (trans youth, healthcare providers, and parents/families/legal guardians). Several guiding instruments for health and gender-affirming care were adapted from the transgender health surveys conducted in the US in the year 2014 and 2022 (National Center for Transgender Equality, 2022; One Colorado, 2014), as well as the national study on transgender people's experiences in Australia (Jones et al., 2015). To understand barriers, we evaluated knowledge, perceived barriers, religiosity, and other factors to understand the provider's willingness (Rowan et al., 2019; Shires et al., 2018; Unger, 2015). The instruments to evaluate discrimination in healthcare were guided through the victimization in healthcare survey (Kattari et al., 2021), while attitudes about gender were evaluated using the transphobia scale (Stroumsa et al., 2019). Parental barriers, attitudes, and acceptance were also evaluated (Pullen Sansfaçon et al., 2020; Riggs et al., 2023). Income bands were based on Asian Development Bank's classification (Asian Development Bank, 2022). Screening questions on alcohol, cigarettes, and drugs were modified based on several instruments (Piccinelli et al., 1997; Sherratt et al., 2016). With the authors' technical expertise in medicine, medical anthropology, and relevant cultural background, they were several sub-parts:

1. Trans youth: Demographics, health status and conditions, hormone replacement therapy, transition-related surgery, healthcare access, discrimination and abuse in healthcare, access to health resources and priorities for funding.
2. Healthcare providers: Demographics, personal and clinical exposure, attitudes about gender, perceived barriers, capability, willingness to provide care, and preferences for health education.
3. Parents/families/legal guardians: Demographics of guardians, demographics of trans youth, attitudes about gender, acceptance and support, transition-related questions, healthcare access to gender-affirming care, discrimination and abuse in healthcare, access to health resources, and priorities for funding.

Data analysis

After the data collection, descriptive analyses were used to summarize and describe the characteristics of each data set, on the basis of questions and country. Qualtrics, SPSS version 27 (Descriptive analytics; crosstabs), and qualitative interpretation of Excel data sets were used to analyze the data, in line with ethnographic methods.

Kevin Marian, courtesy of APTN

Healthcare context for transgender youth: Indonesia, Thailand, and the Philippines

Indonesia

Table 3. Healthcare context for transgender youth in Indonesia

Types of Care	Details	Description
General health services and insurance	Availability to general services	Available in both public and private settings, in the primary, secondary, and tertiary level of care (BPJS Kesehatan, 2020). Access to specialist healthcare is limited in regional and remote areas of Indonesia (Wenang et al., 2021).
	Government insurance	Universal healthcare insurance is provided by various government providers over public and private settings medical treatment, within a wide variety of limits. As of February 2022, the total number of JKN-KIS (Universal health coverage program) is 236.8 million people (86% of the Indonesian population), with financial protection as the main element of this government-based insurance (BPJS Kesehatan, 2022b).
HIV/STIs, sexual health	Inclusion in national programs	Adult trans women, as well as gay men and other MSM, were included in the national HIV/STIs program as part of the key population (Menteri Kesehatan Republik Indonesia, 2022; Paralegal.id, 2022).
	Age of consent	Determined age of consent for HIV testing is 18 years old. Those who were under 18 required parental/guardian consent to do HIV testing (Menteri Kesehatan Republik Indonesia, 2022; Taggart et al., 2019).
	Provision and cost of treatment	ARV is free. HIV/STIs care and treatment are provided in public health facilities, as well as some private clinics (Menteri Kesehatan Republik Indonesia, 2022).
	PrEP	A PrEP demonstration trial commenced in 2022 in several regions in Indonesia, aimed at key populations, including transgender women (Saya Berani, 2023). It is unclear whether the demonstration trial will be expanded into a national program for key populations available within the public health system. PrEP is commonly imported from overseas for personal use (Hegarty, 2022).

Mental health	General mental health services	Mental health services are available in both public and private settings (Kemenkes RI, 2022).
	Insurance coverage to mental health services	Government insurance covers mental health services but is not specific to gender-affirming care (BPJS Kesehatan, 2022a).
	Mental disorder classification	Gender dysphoria or gender incongruence is still listed as a "gender identity disorder" through PPGJ III, the Indonesian version of DSM (Departemen Kesehatan RI, 1995). There is no law/regulation that protects LGBT individuals from conversion therapy (APTN, 2021b; Azwar, 2021). In 2016, some Indonesian psychiatrists declared that LGBT is a mental disorder (Yosephine, 2016). This is contrary to international standards, including the World Health Organization ICD-11, which defines gender incongruence as a marked and persistent incongruence between a person's experienced gender and assigned sex (WHO, 2023)
	Conversion therapy	Not banned. Conversion efforts are layered through the micro to macro level, practiced by religious groups/leaders/organizations, mental health professionals, media, and government institutions or officers (APTN, 2021b).
	Youth mental health services	Available in public and private settings (Erskine et al., 2023; Kemenkes RI, 2022), but those who were under 18 require parental/guardian consent to access mental health services, similar to general services (Golo, 2022).
Gender-affirming care	Availability	Exists through referrals and private services, however, it is not well-integrated (ASHM, 2022). Most trans individuals seek self-medication or through peer-to-peer information (APTN, 2021b).
	Legality and regulations	Gender-affirming care is possible in Indonesia. However, it is not well-regulated (ASHM, 2022).
	General insurance coverage for gender-affirming care	No formal insurance (public or private) that cover gender-affirming care, mostly through out-of-pocket expenditure (ASHM, 2022). Even so, mental health consultations through public health facilities are covered (Kemenkes RI, 2022).
	Mental health evaluation and diagnosis requirements	In general, a diagnosis is required to gain hormonal and surgical care (Merdekawan, 2018). However, practice might vary per health professionals and trans individuals, depending on their situation and availability (ASHM, 2022).

	Age of consent	Since there are no formal regulations for adults, gender-affirming care follows the local regulations on the minimum of 18 years for the age of consent (Golo, 2022). Information on parental consent is not available, as most interventions for children and adolescents remained only in the psychosocial area (ASHM, 2022).
	Gender clinics	There is no clinic that branded itself as a gender clinic. However, referrals and friendly clinics/hospitals are available, for example, RSCM (RSCM, 2023), and Angsamerah Clinic (Angsamerah Clinic, 2023).
	Supporting guidelines	There are no formal supporting guidelines. Each institution might have its own regulations(Merdekawan, 2018) that might not adhere to WPATH's guidelines (for standards of care, see Coleman et al., 2022).
Hormonal therapy	Availability and prescription	Hormonal therapy are available, but not accessible to all. Prescription through medical consultation was mostly available in private settings, and not widely available in both urban or rural parts of Indonesia; Most trans people reside on self-medication and the black market, without medical supervision (APTN, 2020, 2021a; ASHM, 2022).
	Insurance coverage for hormonal therapy	No formal insurance (public or private) that cover gender-affirming care, including hormones. Mostly through out-of-pocket expenditure (APTN, 2020; ASHM, 2022)
	Types of hormones available	Registered types and brands of hormones available varies, some of our general record findings (BPOM RI, 2023):1. Feminizing hormones: Progynova, Cycloprogynova, Oestrogel, birth control (Cyclofem, Cyclogeston, Yaz, Neyynna, Angeliq, Diane 35, Yasmin, Andalan, Eva, Synfonia 24, Microgynon, Gestin), and others.2. Anti-androgens: Spironolactone, Finasteride, Dutasteride. 3. Masculinizing hormones: Androgel, Andriol Testocaps, Nebido, Sustanon 250.
	Puberty blockers	None available known (BPOM RI, 2023).
Surgeries	Availability	Sex reassignment (SRS) is only available in tertiary referral hospitals. Top/breast and facial surgery are available in private clinics and hospitals, although not specifically dedicated to trans individuals (APTN, 2020).
	Insurance coverage for gender-affirming surgeries	No formal insurance (public or private) that cover gender-affirming care, including surgeries. Mostly through out-of-pocket expenditure (APTN, 2020; ASHM, 2022)

	Quality concerns	Some quality concerns existed for surgeries (APTN, 2020).
Training, Research, and Advocacy	Training	Not widely available. Most have to access training from international or regional organizations (ASHM, 2022).
	Research	Good resources can be found through the regional APTN network publications and recognized journals. There is a very large body of research related to transgender women as subjects of HIV prevention (see e.g., Januraga et al., 2018), in addition to reports on various topics related to health (Praptoraharjo et al., 2015). Apart from transgender women and HIV, there is very little research specific to transgender health, particularly concerning masculine trans identities, in the Indonesian context (APTN, 2023).
	Advocacy	Advocacy is mostly led by NGOs and transgender communities; there is no strong advocacy through healthcare institutions (APTN, 2020, 2021a).
Legal	Criminalizing law	A new Criminal Code was passed by the Indonesian parliament in 2022 and includes several passages that violate the rights of LGBT people, mostly concerned with cohabitation law (Human Rights Watch, 2022). Transgender women are more likely to be subject to discrimination and abuse by the general population and the authorities (Harsono, 2018). Additionally, regional regulations in force in different parts of Indonesia impose restrictions on the public visibility and livelihoods of transgender people (Katjasungkana et al., 2016). In line with the understanding of Sharia law implemented in the Autonomous Province of Aceh, transgender women have been instructed to wear men's clothing (Thajib, 2022).
	Name change	Though difficult to access, a name change is possible through a court order. A court order is required to modify important documents such as ID cards, health insurance cards, and driver's licenses. The birth certificate will show the new name alongside the birth name. School certificates cannot be changed once it is published, so a court order must be presented alongside them to prove identity when necessary (Chiam et al., 2020).

	Legal gender marker	Accessing legal gender marker change is possible but challenging due to prohibitive requirements (Chiam et al., 2020) and the usual need for medical intervention and a court case. There is a lack of clarity with respect to regulations governing legal gender. A court ruling in 1973 set a precedent for individuals to change their legal gender, and in 1978 the government introduced guidelines for the medical management of both transgender and intersex individuals (Hegarty, 2019). These guidelines are now primarily interpreted as only relevant to intersex patients (Wieringa, 2015). Indonesia's legal and civil registration system defines sex strictly in binary terms based on biological sex and assumes a heterosexual definition of the family (Rahmi et al., 2021). While a district court can authorize a "change of sex" using population administration provisions, the criteria lack clear legal specifications. Family members may be called upon to provide evidence during court proceedings, and if the request is approved, a positive decision, along with the transgender individual's national ID card and family card, is submitted to amend the sex details. Although no laws require gender-affirming medical steps, judges often rely on expert testimony as legal evidence, drawing from the persuasive precedent set by the 1973 Vivian Rubianti case, in which a transgender woman obtained a gender marker change after undergoing gender-affirming surgeries (Chiam et al., 2020).
	Anti-discrimination law	Indonesia does not have an overarching anti-discrimination law, but a patchwork of laws and sector-specific regulations prohibit discrimination and encourage equality, e.g., labor law, elimination of racial and ethnic discrimination (AmCham Indonesia, 2014). However, there are no specific regulations that specifically mention or protect against discrimination on the basis of sexual orientation and gender identity (Outright International, 2023).

Thailand

Table 4. Healthcare context for transgender youth in Thailand

Types of Care	Details	Description
General health services and insurance	Availability to general services	Available in both public and private settings (ILO, 2016; International Citizens Insurance, 2023b; Sumriddetchkajorn et al., 2019).
	Government insurance	Started in 2001-2002, now every Thai citizen is entitled to preventive, curative, and palliative health services through Thai tax-based universal coverage schemes (UCS). Civil servants have a separate welfare system for healthcare coverage, while private employees are often covered through payroll contributions. Foreigners working in Thailand's private sector may also be eligible for this coverage, or have their own private insurance. Some mandated insurance for Thai visitors is applicable, especially for those on longer stay time periods (ILO, 2016; International Citizens Insurance, 2023b; Sumriddetchkajorn et al., 2019).
HIV/STIs, sexual health	Inclusion in national programs	Trans women, as well as gay men and other MSM, were included in the national HIV/STIs program as part of the key population (UNAIDS, 2021; van Griensven et al., 2021; Weir et al., 2022).
	Age of consent	Age of consent for HIV testing is 18 years old. Those under 18 years, can independently consent to HIV testing if it is determined that they are capable of understanding the testing process, or if they have parental/guardian consent (Taggart et al., 2019).
	Provision and cost of treatment	HIV/STIs care and treatment are provided freely in health facilities (UNAIDS, 2020).
	PrEP	PrEP services are available in Thailand through government and non-government-based health facilities, with and without cost (Ramakant et al., 2023; UNAIDS, 2018).

Mental health	General mental health services	Mental health services are available in both public and private settings (Wannasewok et al., 2022; WHO, 2006).
	Insurance coverage to mental health services	Government insurance covers mental health services but is not specific to gender-affirming care. Mental health funding from governments is only 2.3% of their total health spending, with most going toward mental hospitals (Wannasewok et al., 2022).
	Mental disorder classification	Through official government documents, often classified as gender identity disorder (ILO, 2014; Knight, 2021), even though terms like gender dysphoria and gender congruence were commonly mentioned in newer, progressive medical documents, like the Thai Handbook of Transgender Healthcare Services (Center of Excellence in Transgender Health, Chulalongkorn University, 2021).
	Conversion therapy	There is no specific law/regulation that protects LGBT individuals from conversion therapy (APTN, 2020; Equaldex, 2023b; ILO, 2014).
	Youth mental health services	Available in public and private settings. Age of consent to medical care is not specified in the National Health Act B.E. 2550. According to the Civil and Commercial Code, the age of majority in Thailand is 20 years. However, in the Mental Health Act, the age of consent is set at 18 years old. It's important to note that a 2019 amendment removed the mandatory requirement for parental consent in mental health matters (UNICEF et al., 2022).
Gender-affirming care	Availability	Gender-affirming care is available in the country, with prominent hospitals and clinics providing care (amfAR, 2023; van Griensven et al., 2021; Wangvanichapan, 2021). Some clinics and hospitals were well-integrated with gender-affirming care, however, it is not widely available in all parts of Thailand (Itthipongmaetee, 2023; Lynne & Enteen, 2022; Samuel, 2021).
	Legality and regulations	Gender-affirming care is legal in the country and available through mostly community-based clinics, however, it is not regulated as a country-whole health system or program (APTN, 2020).
	General insurance coverage for gender-affirming care	No formal insurance that covers gender-affirming care, mostly through out-of-pocket expenditure (Center of Excellence in Transgender Health, Chulalongkorn University, 2021; Itthipongmaetee, 2023).

	Mental health evaluation and diagnosis requirements	According to the Medical Council of Thailand Regulations on Gender Affirmation Treatment B.E. 2552 (A.D. 2009), psychiatrists are responsible for evaluating, diagnosing, and providing counseling and confirmation for gender-affirming treatment. Based on the Thai Handbook of Transgender Healthcare Services, the following criteria should be met for hormonal therapy: 1). The diagnosis of gender dysphoria must be confirmed; 2). Individuals must be competent to make their own decisions and able to give consent for treatment; 3). Their age requirement is fulfilled in the country in which they are to receive treatment; 4). Any comorbidities or concomitant psychiatric diseases that may affect gender-affirming hormone therapy should first be treated and medically controlled. However, in some specific circumstances, healthcare providers may administer hormonal therapy to individuals who do not fully meet the criteria, such as those who have already received hormone treatment without medical supervision, but now wish to do so, or those who have lived their life as a transgender person, e.g., transitioning socially. Psychological evaluation is needed for those who seek genital surgery. However, the Medical Council of Thailand does not currently have clear guidelines for other types of surgeries. (Center of Excellence in Transgender Health, Chulalongkorn University, 2021)
	Age of consent	Children or adolescents under 18 years old need parental consent and are treated on a case-by-case basis. Based on Chulalongkorn's guideline, for surgeries, the age of consent is 20 years old; people who were 18-20 years old still require parental consent (Bumrungrad Hospital, 2023; Center of Excellence in Transgender Health, Chulalongkorn University, 2021).
	Gender clinics	Gender clinics and hospitals are available in the country, namely the King Chulalongkorn Memorial Hospital of the Thai Red Cross Society and Faculty of Medicine, Chulalongkorn University (Wangvanichapan, 2021), Rainbow Sky Association of Thailand (RSAT) and the Tangerine Clinic by IHRI (amfAR, 2023; Samuel, 2021), the PRIDE Clinic at Bumrungrad International Hospital (Bumrungrad Hospital, 2023), SISTERS Foundation (APTN, 2021a), and more.
	Supporting guidelines	There are some formal supporting guidelines available, combining both WPATH updated guidelines with local regulations and country context (Center of Excellence in Transgender Health, Chulalongkorn University, 2021; Coleman et al., 2022).

Hormonal therapy	Availability and prescription	Hormonal therapy are available, however not covered or recognized in national health insurance. Some trans people reside in self-medication and the black market, without medical supervision (APTN, 2020, 2021a; Itthipongmaetee, 2023).
	Insurance coverage for hormonal therapy	No formal insurance (public or private) that covers hormonal therapy for gender dysphoria (APTN, 2021a).
	Types of hormones available	Registered types and brands of hormones available varies, some of our general record findings (Caremat Foundation, 2023; Thailand Medical News, 2023):1. Feminizing hormones: Estrofem, Progynova, Cycloprogynova, Oestrogel, Climara, Progynon, Proluton, Oestradiol benzoate, Phenokinon "F", Duotone Fort TP, and more.2. Anti-androgens: Spironolactone, Androcur, Finasteride, Dutasteride. 3. Masculinizing hormones: Androgel, Andriol Testocaps, Nebido, Sustanon 250.
	Puberty blockers	Available in some practices (Bumrungrad Hospital, 2023; Yanhee Hospital, 2019).
Surgeries	Availability	Genital and non-genital surgeries are available in Thailand (Center of Excellence in Transgender Health, Chulalongkorn University, 2021; Tan, 2022).
	Insurance coverage for gender-affirming surgeries	No formal insurance (public or private) that covers surgical gender-affirming care (APTN, 2021a; Center of Excellence in Transgender Health, Chulalongkorn
	Quality concerns	Some quality concerns existed for surgeries, due to the wide variety of providers (APTN, 2020). However, Thailand has become one of the main destinations for gender-affirming surgeries in Asia (Tan, 2022).
Training, Research, and Advocacy	Training	Trainings are available through university hospitals, as well as private and public health facilities (APTN, 2020; Preecha Aesthetic Institute, 2023; Wangvanichapan,
	Research	Research is available and can be found through local and international journal publications, as well as organizational publications (APTN, 2023; Center of Excellence in Transgender Health, Chulalongkorn
	Advocacy	Advocacy was led through NGOs, trans communities, university academics, and health institutions (amfAR, 2023; APTN, 2020, 2021a; Wangvanichapan, 2021).

Legal	Criminalizing law	Since 1956 Thailand decriminalized homosexuality when it allowed private and consensual non-commercial sodomy among adults. Being transgender is not a criminal activity in Thailand (UNDP, 2014b).
	Name change	Thai citizens have the option to change their names, but their new name only becomes legally recognized once it is registered. However, there have been reports of registrars rejecting name change requests from transgender individuals; this is based on an operational manual guideline that requires a person's name to reflect their gender as male or female, typically determined by their assigned sex at birth. It's worth noting that Thai citizens do not have the ability to change their prefix or salutation on official documents, which is based on their assigned sex at birth. The use of the prefix or salutation is legally mandatory, so even if a person changes their name, their prefix or salutation remains unchanged (Chiam et al., 2020).
	Legal gender marker	Sex reassignment surgery is not criminalized or discriminated against in Thailand. However, Thai law does not allow for gender markers to be changed on legal documents. Because there is no legal gender marker change, trans and non-binary identities are not recognized, making it difficult to access healthcare, education, and employment (Human Rights Watch, 2021; UNDP, 2014b).
	Anti-discrimination law	Under the Gender Equality Act 2015, discrimination is illegal, however, some observed exceptions on the basis of religion, education, and public interest has significantly reduced the strength of this law (Human Rights Watch, 2015).

Philippines

Table 5. Healthcare context for transgender youth in the Philippines

Types of Care	Details	Description
General health services and insurance	Availability to general services	Available in both public and private settings (International Citizens Insurance, 2023a).
	Government insurance	The government's health insurance program (PhilHealth) was first established in 1995 to provide affordable universal coverage. But it was not until 2019, that the Philippine Government signed Republic Act 11223 or the Universal Health Care (UHC), allowing all Filipinos, including those who worked overseas, to get coverage of at least 50% on medical expenses (ITA, 2022).
HIV/STIs, sexual health	Inclusion in national programs	Transgender women were included as part of the key populations in the national HIV/STIs program (APTN, 2020; WHO Regional Office for the Western Pacific, 2016).
	Age of consent	The Philippines raised the age of sexual consent from 12 to 16. The recently signed law on HIV/AIDS allows individuals aged 15 and above to be tested without the consent of their parents or guardians, using proxy consent. With the rising cases of HIV among the youth ages 15-24, the Proxy Consent Protocol was developed to ensure that children can access HIV/AIDS services (Crisostomo, 2019; Francia, 2018; Save the Children, 2017).
	Provision and cost of treatment	Available through government, private, and NGO-based health facilities. Most were covered through reimbursements, by the Philippines' national government insurance (LoveYourself Inc, 2023; Philippine Health Insurance Corporation, 2021).
	PrEP	Scale-up programs are available through community-based organizations, but some are out-of-pocket (WHO Western Pacific Philippines, 2019).
Mental health	General mental health services	Mental health services are available in both public and private settings. The Philippines has recently passed its first Mental Health Act (Republic Act no. 11036), to establish rights and access to comprehensive and integrated mental health services. In general, mental healthcare in the Philippines faced continued challenges in lack of investments, a lack of mental health professionals, and underdeveloped community mental health services (Lally et al., 2019).

	Insurance coverage for mental health services	Philippine Health Insurance Corp. (PhilHealth) has newly introduced a new benefits package for Filipinos with mental health illnesses requiring interventions at the primary care level. At present, PhilHealth only covers up to P7,800 for patients hospitalized for certain mental health conditions, namely dementia, bipolar, anxiety disorders, and schizophrenia (Lally et al., 2019; Magsambol, 2023; Villa, 2023).
	Mental disorder classification	The Psychological Association of the Philippines utilized the DSM-5 and used the gender dysphoria diagnosis; DSM-5 302.6/F64.2; DSM-5 302.85/F64.1 (Psychological Association of the Philippines, 2020). The same insights were practiced by psychiatrists as well (ASHM, 2022).
	Conversion therapy	Conversion therapy in the Philippines is not banned (Equaldex, 2023a; UN General Assembly, 2020).
	Youth mental health services	Although the recent Mental Health Act legislation has provided a legal framework for the delivery of comprehensive mental healthcare (Lally et al., 2019). LGBTQ children still faced threats to their right to mental health, resulting from their experience of violence and discrimination and lack of access to SOGIE-responsive health services and education (Ivanka Custodio, 2019). There are only five government hospitals with psychiatric facilities for children, 84 general hospitals with psychiatric units, and 46 outpatient facilities from which there are only 11 that are designated for children and adolescents. Additionally, there are only 60 child psychiatrists practicing in the Philippines, with the majority of them practicing in urban areas (Malolos et al., 2021). In the Philippines, guidelines require assent from minors in health and health-related research involving the pediatric population, for example, those under 7 years old, no formal assent is needed unless dissent is expressed; for ages 7-12, verbal assent must be documented; for ages 12-15, a simplified assent form approved by the ethics committee is required; and for ages 15-18, minors can sign the same informed consent document as their parents. However, there is a lack of national guidelines, legislation, or jurisprudence regarding assent in clinical healthcare for children, and healthcare providers often rely on research guidelines or specific statutes for obtaining assent (Tejam, 2019).

Gender-affirming care	Availability	Gender-affirming services were available and integrated into some primary and referral care systems, but mostly in big cities (amfAR, 2023; Eustaquio et al., 2022).
	Legality and regulations	Gender-affirming care are legal in the country. However, there are no specific regulations on gender-affirming care (Abesamis, 2022; Eustaquio et al., 2022).
	General insurance coverage for gender-affirming care	Mostly comes from out-of-pocket expenditure (Abesamis, 2022; Eustaquio et al., 2022).
	Mental health evaluation and diagnosis requirements	In general, mental health evaluation might be required to proceed with the transition. However, practice might vary depending on each situational context (ASHM, 2022).
	Age of consent	Since there are no formal regulations, gender-affirming care follows the local regulations on the minimum of 18 years for the age of consent. Information on parental consent is not available. There is a lack of access to gender-affirming care for children (Ivanka Custodio, 2019).
	Gender clinics	Local non-government organizations (NGOs), such as The LoveYourself Inc. (through Victoria, since 2016), PULSE Clinic, and other organizations, have made substantial progress in providing gender-affirming care, integrated with HIV/STIs testing and referrals (Abesamis, 2022; amfAR, 2023; LoveYourself Inc., 2023; PULSE Clinic Manila, 2023).
	Supporting guidelines	The Philippine government, NGOs, and relevant providers were currently developing a national transgender health framework that is envisioned to help provision gender-affirming care in the country (Abesamis, 2022).

Hormonal therapy	Availability and prescription	Hormonal therapy are available. However, there is a huge number of individuals who were already on gender-affirming hormone therapy without medical supervision (Eustaquio et al., 2022).
	Insurance coverage for hormonal therapy	There is no specific insurance to cover for hormonal therapy (Abesamis, 2022; Eustaquio et al., 2022).
	Types of hormones available	Registered types and brands of hormones available varies, some of our general record findings (Food and Drug Administration, Philippines, 2023; Ngalob et al., 2013):1. Feminizing hormones: Oestrogel, Congest-0.625, Conjurin, Premarin, Cypress, Faye, Althea, Diane 35, Chloe, Cybelle, Cyproterone2. Anti-androgens: Spironolactone, Finasteride, Dutasteride. 3. Masculinizing hormones: Testosterone enanthate, testosterone undecanoate (Nebido), Androgel
	Puberty blocker	There was no specific information on puberty blocker availability in gender-affirming services. Goserelin (e.g., under the brand Zoladex) is available on the Philippines FDA website (Food and Drug Administration, Philippines, 2023).
Surgeries	Availability	Surgeries were available in the country (APTN, 2020; Eustaquio et al., 2022; Grana, 2022; TransHealthCare, 2017)
	Insurance coverage to gender-affirming surgeries	There is no specific insurance to cover for gender-affirming surgeries (Abesamis, 2022; Eustaquio et al., 2022).
	Quality concerns	There is no reported information on quality concerns (APTN, 2020).

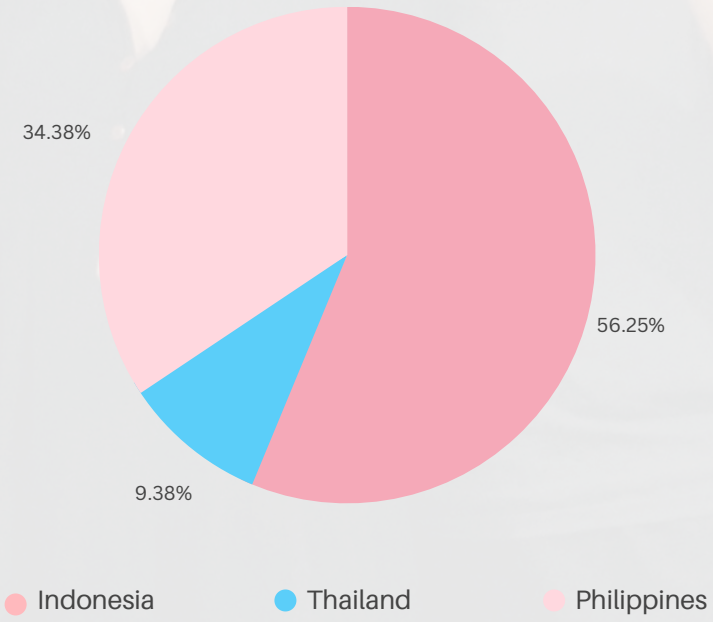
Training, Research, Advocacy	Training	Some formal and informal training were available. Some were done through the HIV/STIs space, to promote inclusivity (Gray, 2019; LoveYourself Inc., 2023; Restar et al., 2020).
	Research	Some research were available, and can be found through local and international journal publications (Abesamis, 2022; Eustaquio et al., 2022).
	Advocacy	Advocacy process is a total collaboration between the government, NGOs, and healthcare providers (amfAR, 2023; APTN, 2020; LoveYourself Inc, 2023). The newly established Philippine Professional Association for Transgender Health (PPATH) was part of the advocacy process of initiating the dialogue between healthcare providers and the community (PPATH, 2023). Furthermore, the Gender Ombud of the National Human Rights Institution (NHRI) has jurisdiction to oversee cases of violation against transgender people, provide legislative recommendations, and conduct activities concerning the reproductive health of trans and LGBTI people (APTN, 2020; GANHRI & Asia Pacific Forum, 2018).

Legal	Criminalizing law	In the Philippines, same-sex sexual activity is legal and being transgender is not criminalized (Equaldex, 2023a).
	Name change	It is not legislated in the Philippines and is deemed not possible. However, according to the ILGA 2020 report, there may be some potential for trans people to change their legal name and even gender marker in certain lower provincial courts (Chiam et al., 2020). This possibility requires further investigation and mapping to determine the specific conditions and processes involved.
	Legal gender marker	Based on the 2007 supreme court ruling, Filipinos who undergo gender reassignment surgery were not permitted to change their legal gender, which has led to a lot of discrimination (Equaldex, 2023a; UNDP & APTN, 2017).
	Anti-discrimination law	There is no specific law that protects the rights of LGBT people. This has led to various forms of discrimination and violence (Equaldex, 2023a; Human Rights Watch, 2017; UNDP, 2014a). Despite the challenges, there have been efforts to protect LGBT rights in the Philippines. In 2000, the Philippine Congress introduced the SOGIE Equality Bill, which aims to protect the rights of LGBT people against discrimination. The bill has yet to be passed, but it represents a significant step forward in the recognition of LGBT rights in the country (Moya, 2022; The Manila Times, 2023).

Results and key findings

A total of 100 trans youth, 25 HCPs, and 8 parents/legal guardians/family members responded to the survey from December 2022 to February 2023. After verifying and removing invalid and incomplete responses, the data we analyzed was from 64 transgender youth, 15 healthcare providers, and 5 parents/legal guardians/family members who completed the survey. Responses varied significantly per country, for example, there were 36 trans youth respondents from Indonesia, 22 from the Philippines, and 6 from Thailand. Although the number of respondents varies per country, this survey is valid as an overall snapshot of the situation of transgender youth inclusion in healthcare in three countries in Southeast Asia with differing sociocultural backgrounds.

Figure 2. Trans youth's country of residence



Because the Thai sample is small relative to the Indonesian and Philippines data, overall data from the three countries must be either weighted for this bias or interpreted with this difference in mind. The small Thai sample also means that this data is less robust than for Philippines and Indonesia. There is a moderately larger number of trans feminine respondents (and cognate country terms) which also requires weighing for purposes of analysis. In the future, with larger funding and time frame, the research could be expanded to deliver targeted quantitative and qualitative insights with larger samples and in other countries. A limitation of this survey was that it was online only and therefore did not access communities that were not linked via recruitment methods (social media) including more marginalized populations (e.g., younger, economically disadvantaged, geographically remote, refugee populations, and others). Future research will need to incorporate local community-based organizations in each country to collect offline surveys, interviews, and observations as well.

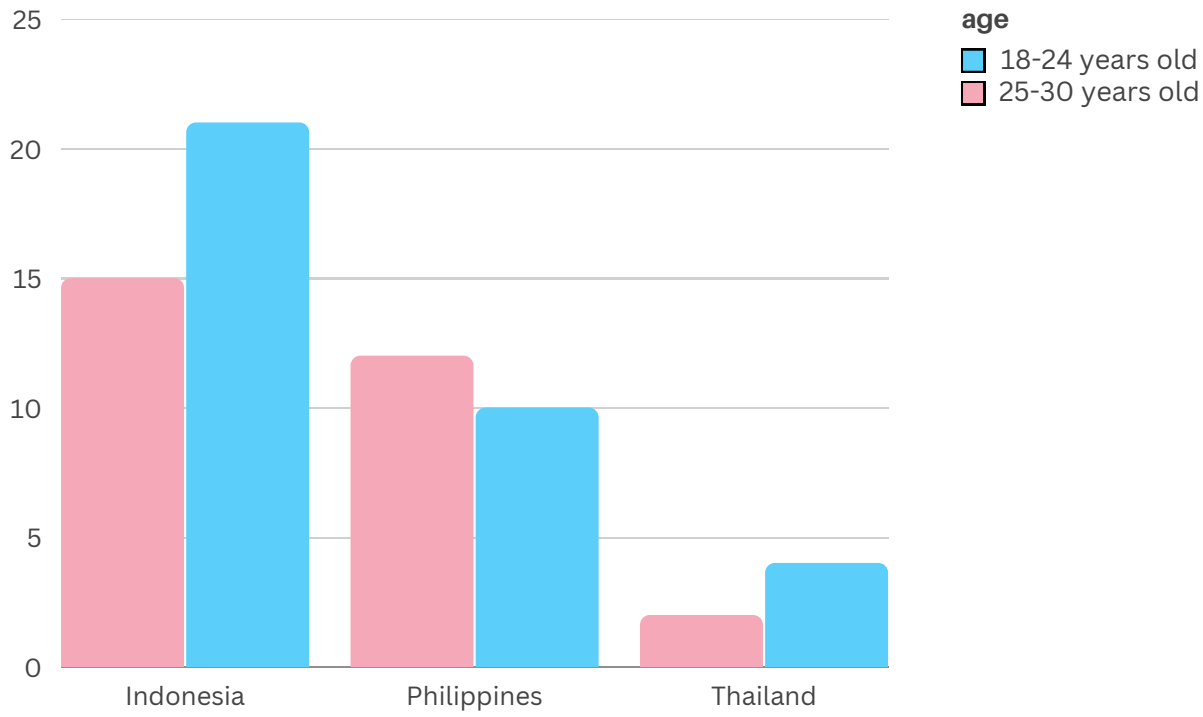
Renz Narciso courtesy of TMPH

Responses from transgender youth

Demographics of transgender youth

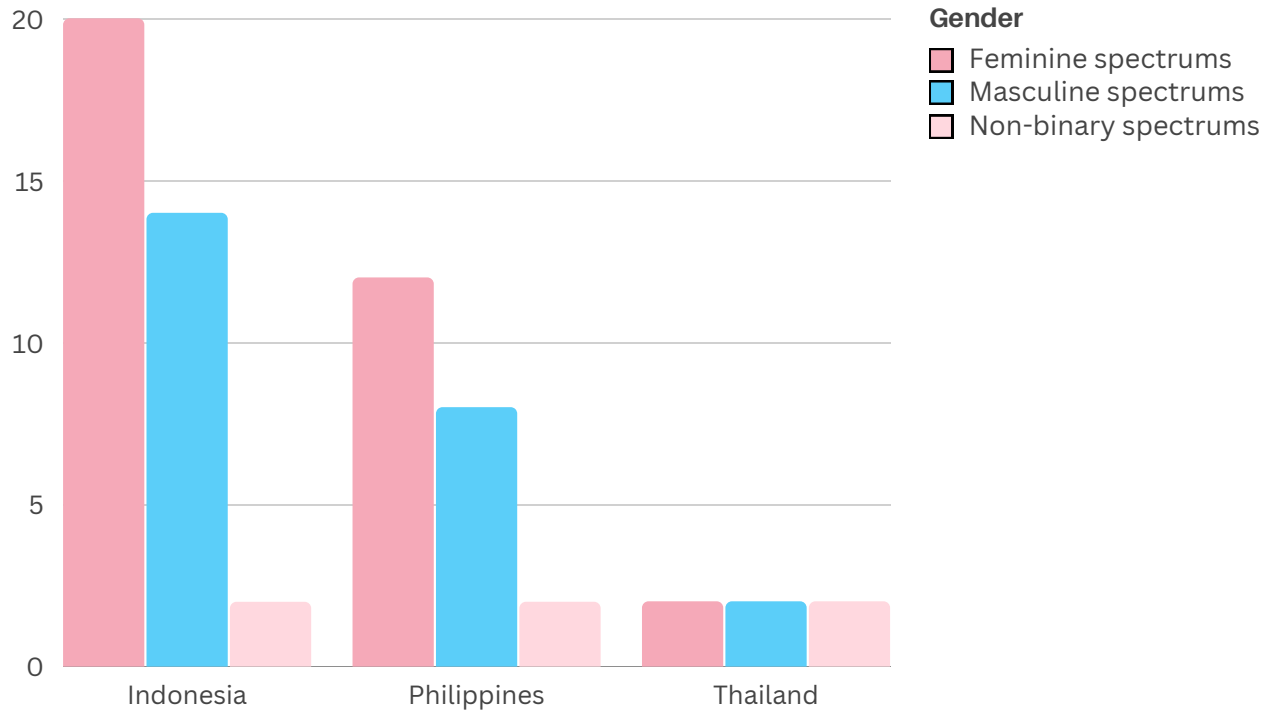
Around 36 respondents (56.25%) came from Indonesia (Jakarta, West Java/Tangerang, East Java, Central Java, West Sumatra, East Nusa Tenggara, Lampung, North Sumatra, North Sulawesi, South Sulawesi, and more), continued by 22 (34.37%) from the Philippines (Manila, Batangas, Cavite, Pasig City, Talisayan Misamis Oriental, Pangasinan, Laguna, San Pablo City, Zamboanga del Sur, and more), and 6 (9.37%) from Thailand (Bangkok, Sukhothai, Khon Kaen). Based on age, 54.68% of respondents were around 25-30 years old (n=35), continued by 45.13% of respondents who were 18-24 years old (n=29).

Figure 3. Age demographics per country



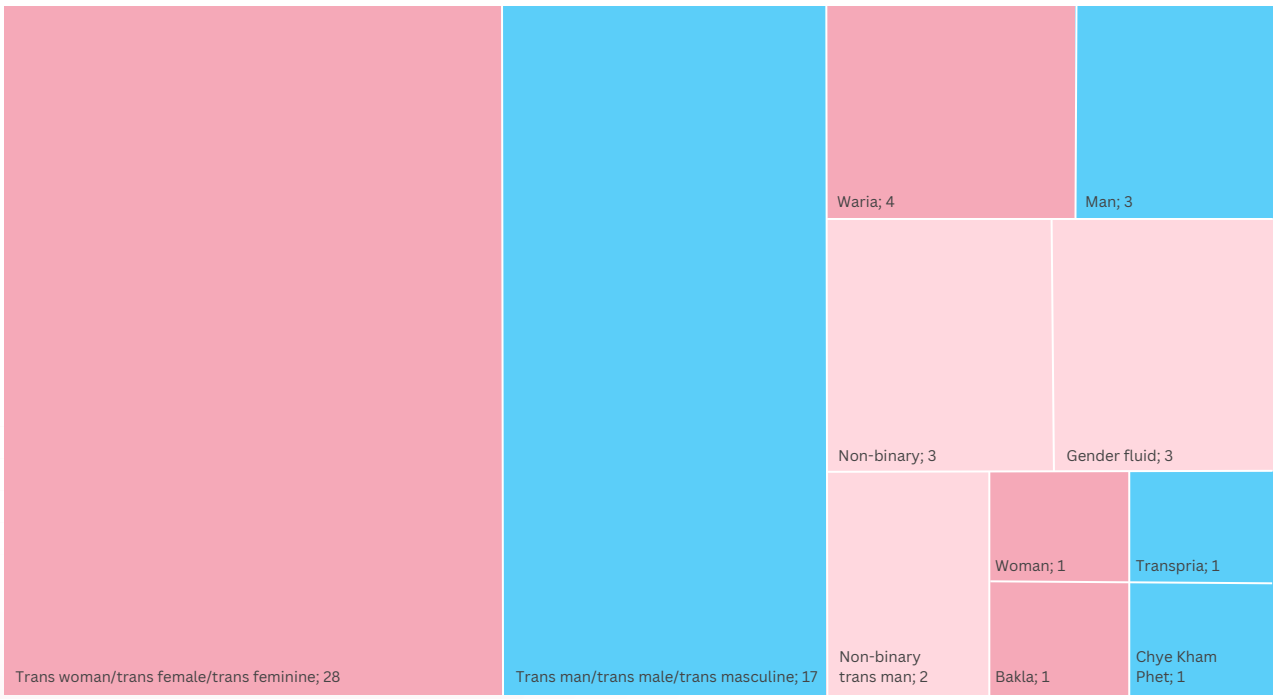
Sex and identity categories reported in this survey were quite balanced, with a total of 34 and 26 respondents assigned male and female at birth respectively, and around 4 respondents preferring not to disclose their sex assigned at birth. None of the respondents identified as intersex. There was a wide range of gender identities represented (the survey included options for local terminologies and categories used in each country). The largest response received was for those who identify in the feminine spectrums (53.12%) and the second largest was for those who identify in the masculine spectrums (37.50%), continued by 9.3% who identify in the non-binary spectrums. This is also reflected in the country analysis listed below.

Figure 4. Gender identities per country



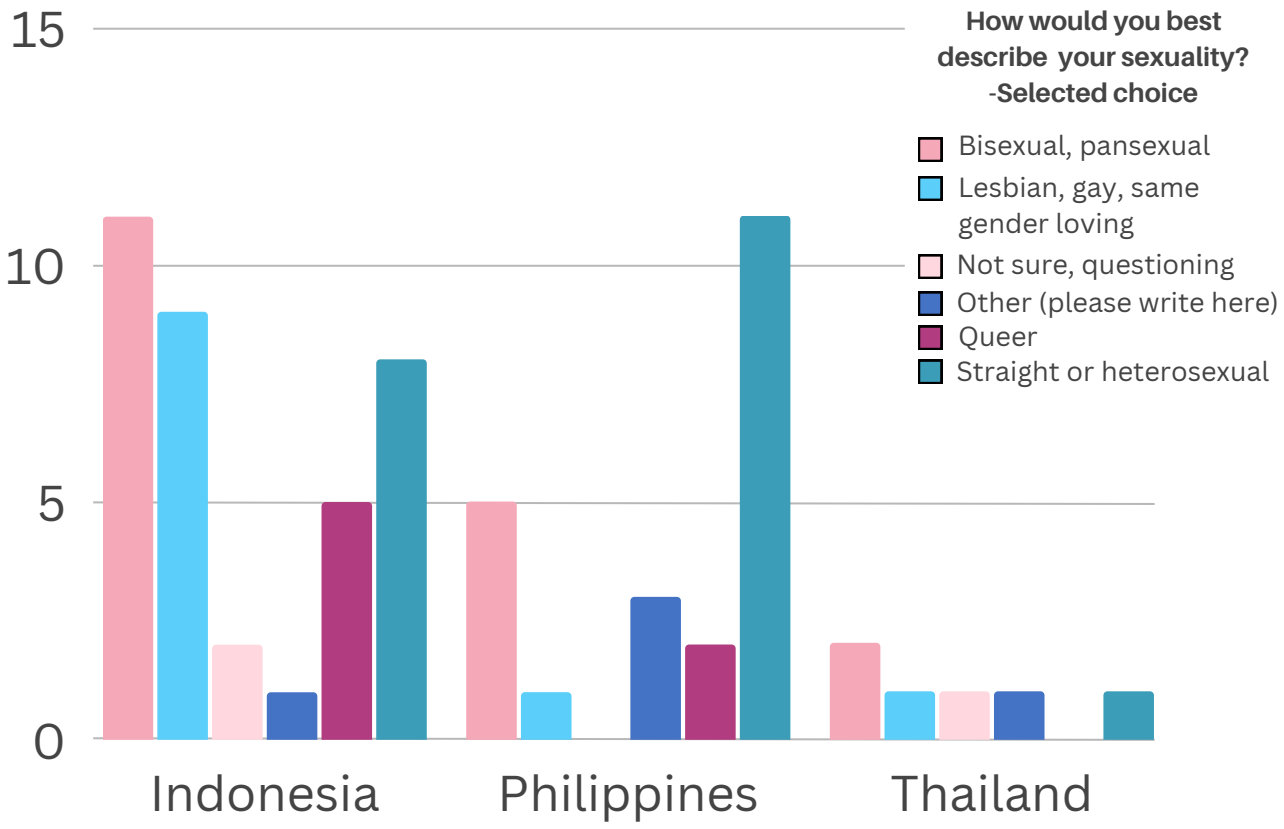
Specifically, 34 respondents (53.12%) identify in the feminine spectrums (28 trans women; 1 woman; 4 waria; 1 bakla; none identify as Ying Kham Phet); and 24 respondents (37.50%) identify in the masculine spectrums (17 transmen; 3 men; 1 transpria; 1 Chye Kham Phet; 2 non-binary trans men, none identify as tomboy), and 6 respondents (9.3%) identify in the non-binary spectrums (3 non-binary, 3 gender fluid, none identify as Khon Kham Phet).

Figure 5. Gender identities



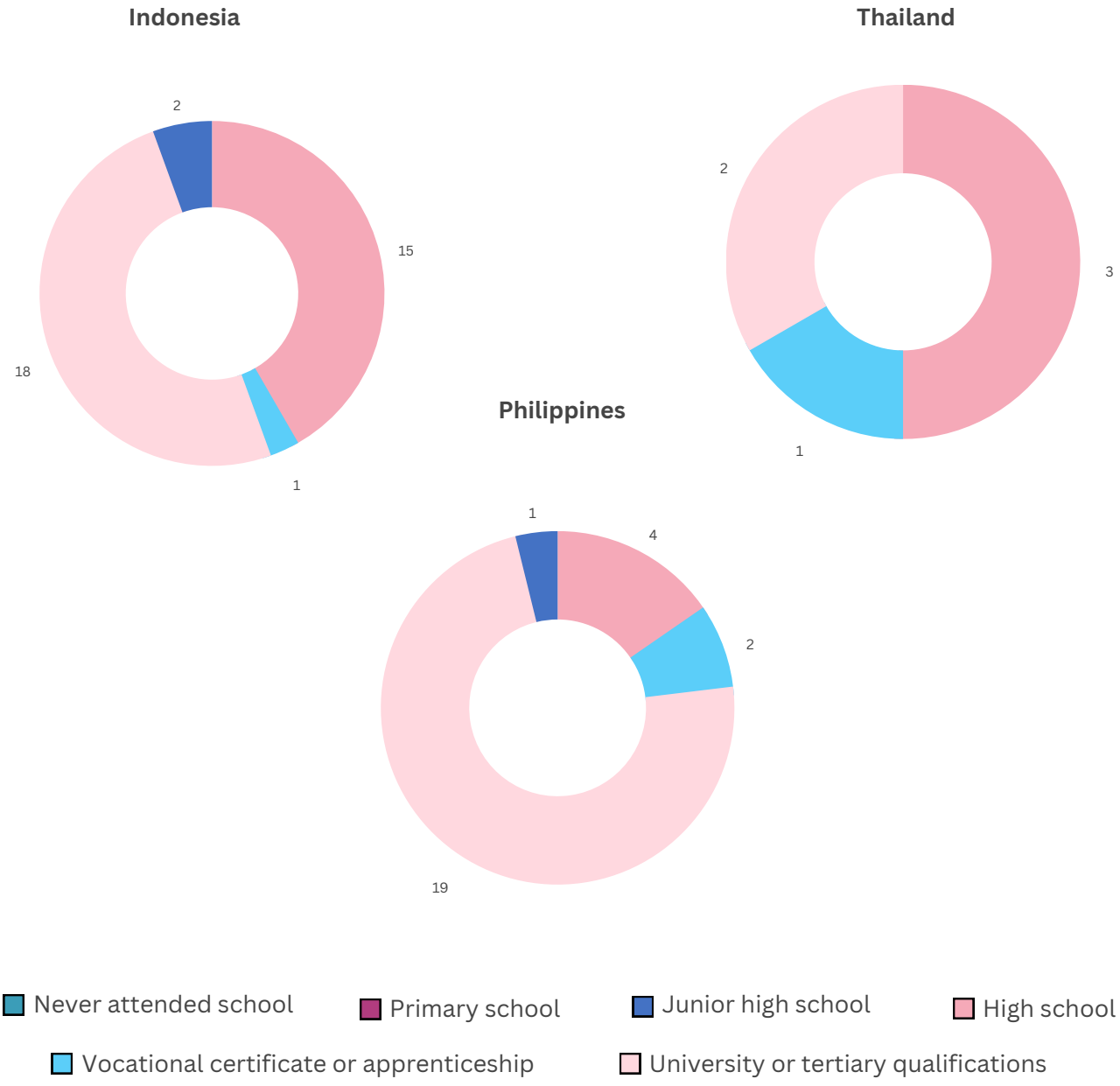
Respondents reported a wide array of sexualties among respondents, revealing the need for further research on the sexual health needs of transgender populations. Almost 30% identified as straight (n=20), with smaller numbers identifying as bisexual, pansexual, polysexual (n=18), same-gender loving (n=11), queer (n=7), questioning (n=3), and other (n=3); for those who answered "other", their sexuality listed as aromantic-asexual, asexual, and demisexual; such sexual diversity is also evident in per country analysis. Moreover, most of respondents reported that they were single, never married (60.94%), continued with partnered, but not living together (n=12), married with a domestic partner, or living partner (n=7), polyamorous, non-monogamous (n=3), and divorced (n=1).

Figure 6. Sexual orientation per country



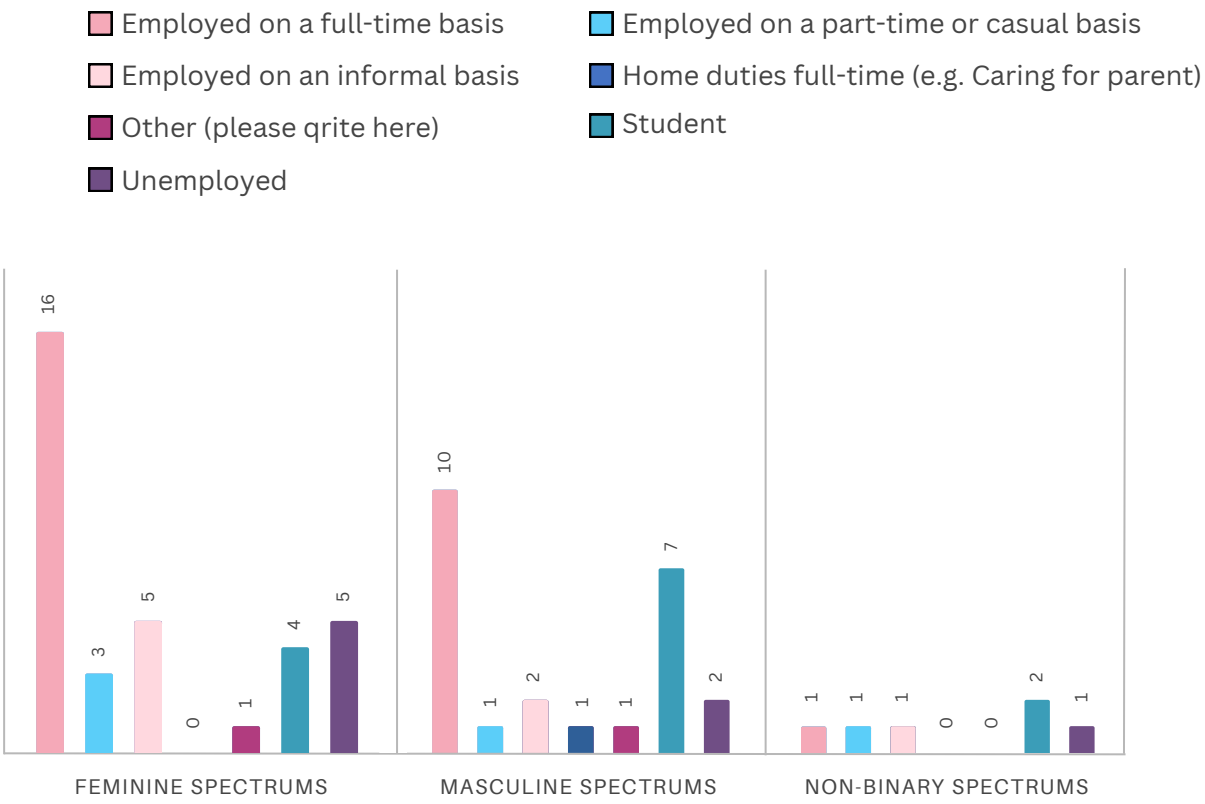
Furthermore, more than half of the total trans youth respondents had a university education (54.69%), continued by high school (34.48%), vocational apprenticeship (6.25%), and junior high school (4.69%). Education levels did not differ widely from one country to another, however, the percentage of those attending university or tertiary level of education were slightly higher in the Philippines (73.08%; n=19), compared to Indonesia (50%; n=18) and Thailand (33.33%; n=2).

Figure 7. Education level based on country



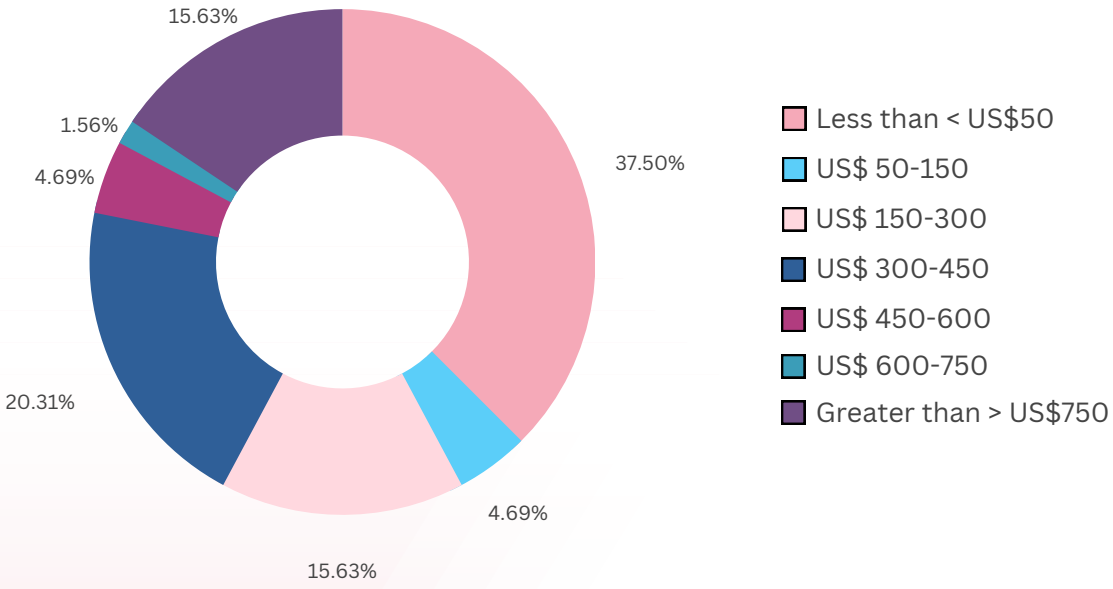
Most respondents were employed on a full-time basis (42.18%; n=27), continued with being students (n=13), employed on an informal basis (n=8), unemployed (n=8), employed on a part-time or casual basis (n=5), other (n=2), and full-time home duties (n=1). Those who chose the "other" option wrote (a free text field was available) that they were business owners and did not fit into the above classifications. The number of respondents unemployed and employed on an informal basis (n=10) was higher among those who identified with the trans feminine categories, compared to those who identified with the masculine (n=4) and non-binary spectrums (n=2) (although the number of trans feminine respondents was higher overall).

Figure 8. Employment status based on gender identity spectrums



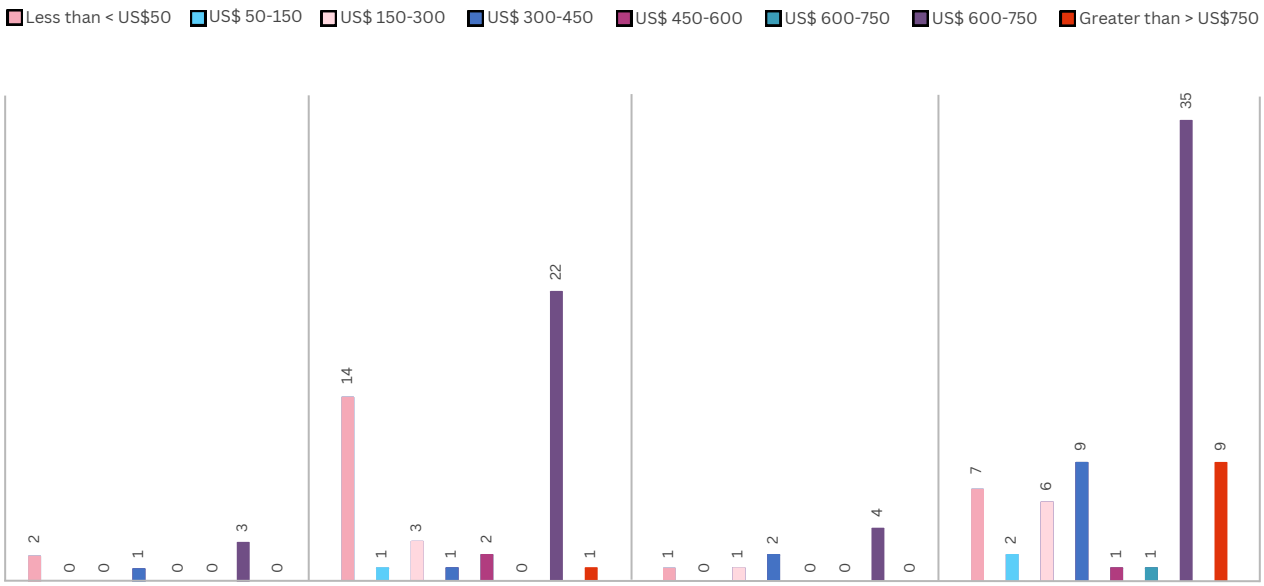
In terms of income, 37.50% of respondents reported living on less than US$50 per month (n=25), continued by those who made around the range of US$ 300-450 (20.31%; n=14) and US$ 150-300 (15.63%; n=11), which mirrors the average salaries in our three target countries (Asian Development Bank, 2022). This is in line across gender identity categories, with most respondents, either those who identify in the feminine (n=9), masculine (n=10), or non-binary spectrums (n=5) making less than US$50 per month.

Figure 9. Income levels



Furthermore, those who made less than < US$50 per month were more likely to have a high school education (n=14), and those who made more than US$600 per month were more likely to have a university or tertiary level of education (n=35). Around a third of the respondents who had university qualifications were more likely to be employed on a full-time basis (32.81%).

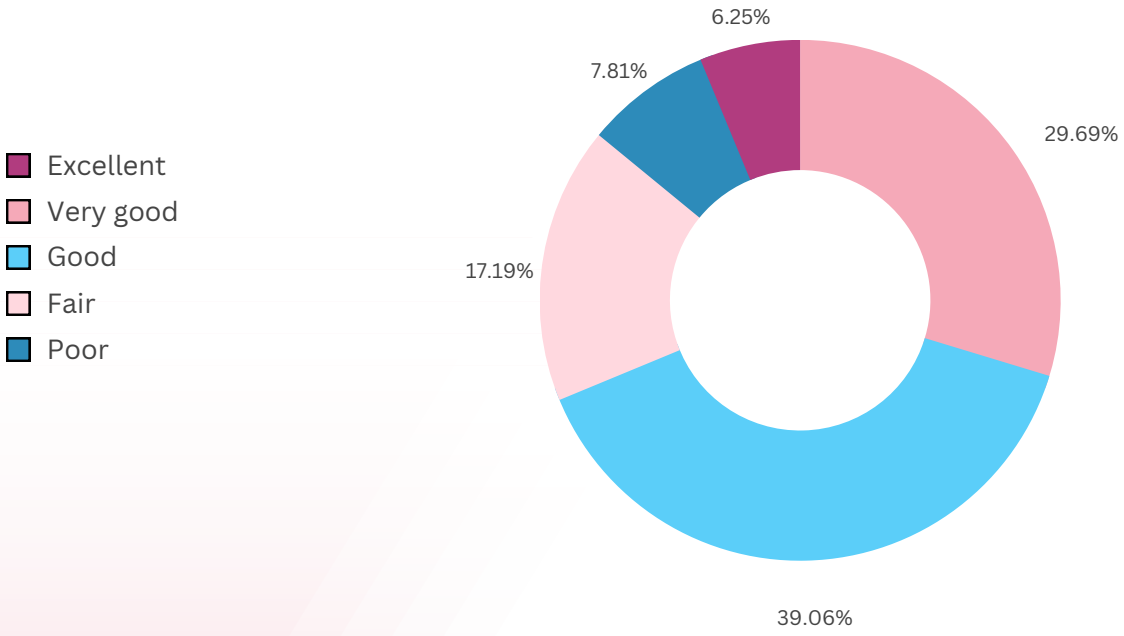
Figure 10. Education and income level



Health status and conditions of transgender youth

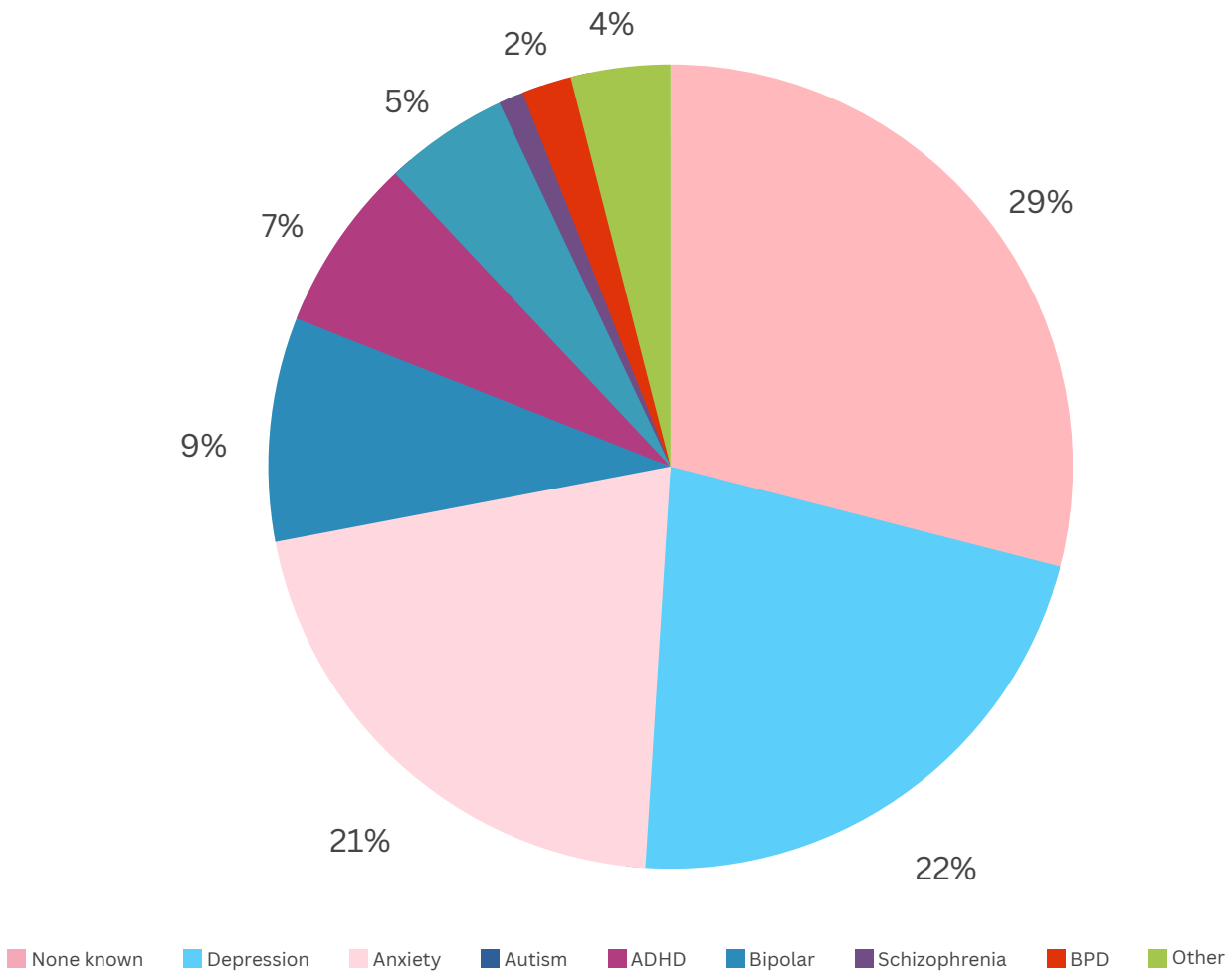
Using the five Likert scale, 68.75% of respondents perceived their overall health conditions as good (n=25) and very good (n=19), continued with fair (n=11), poor (n=5), and excellent (n=4). On average, transgender youth respondents reported experiencing physical illness for about 6.10 days and mental health issues for approximately 11.17 days in the last 30 days. In total, they had approximately 8.45 days of physical or mental health problems that prevented them from conducting usual activities, such as self-care, work, or recreation.

Figure 11. Perceived overall health conditions



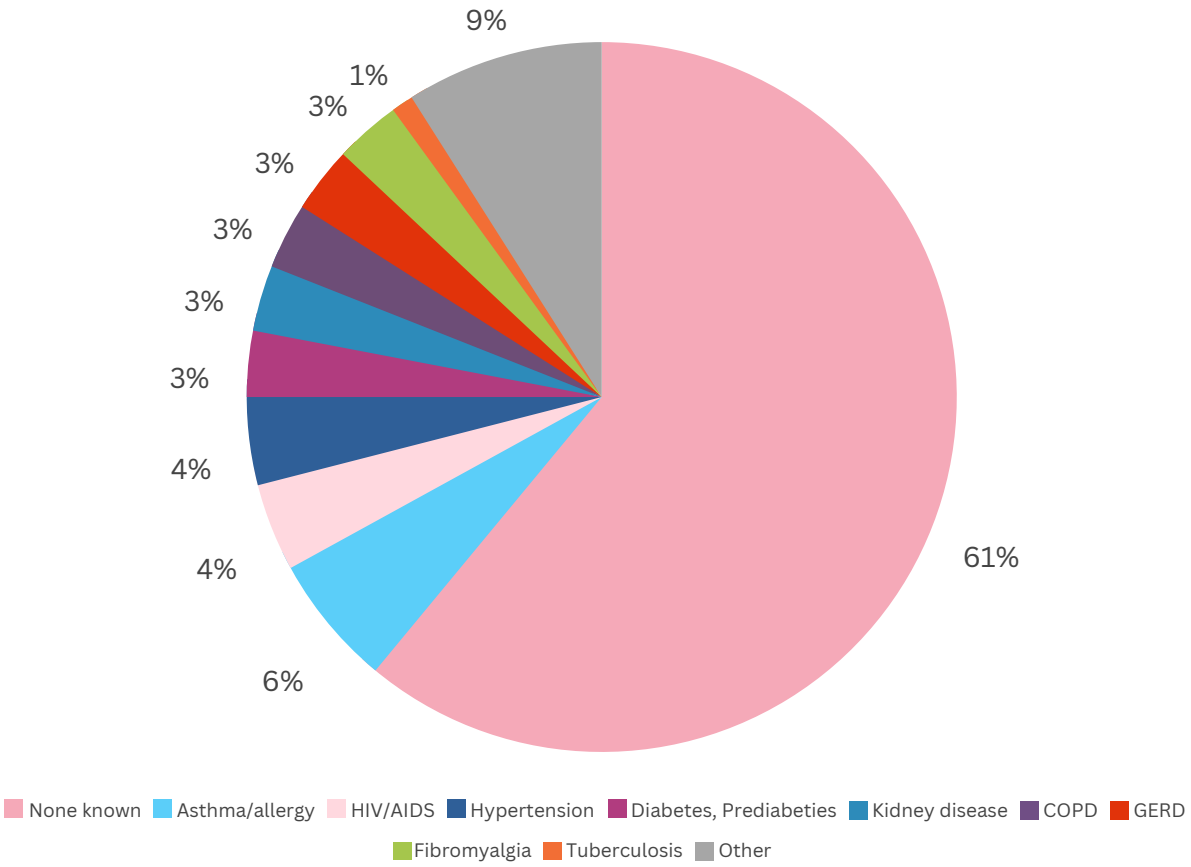
The number of respondents who reported mental health conditions was high with 71% reporting a mental health diagnosis. Of those reported a mental health diagnosis (n=28), reported mental health conditions were depression (n=21), anxiety (n=20), autism (n=9), ADHD (n=7), bipolar (n=5), borderline personality disorder/BPD (n=2), schizophrenia, and others (n=4); among the non-listed diagnoses were other mental conditions, such as complex post-traumatic stress disorder (CTPSD), communication disorder, histrionic personality disorder (HPD) and mood disorders, or having obsessive-compulsive disorder (OCD) traits.

Figure 12. History of previous mental health conditions



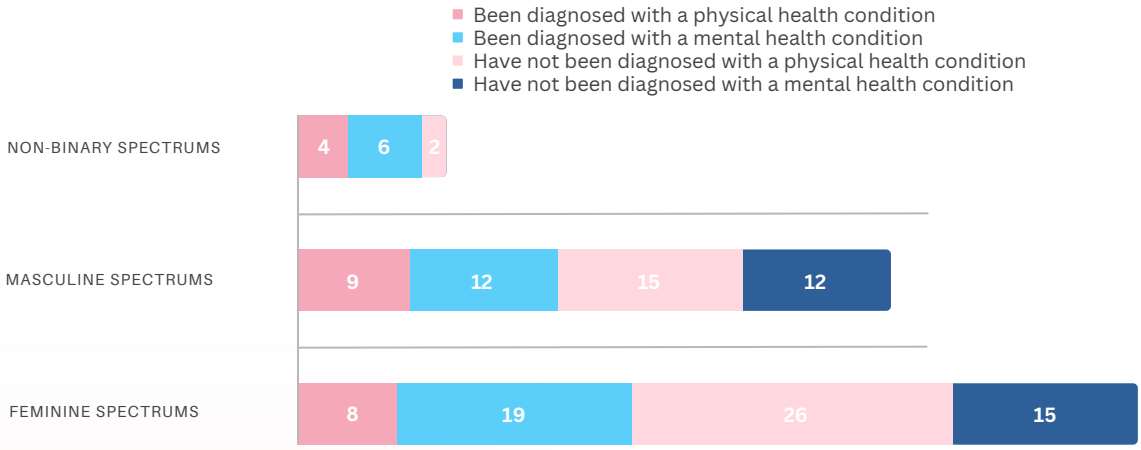
With respect to physical condition, around 61% of respondents reported not knowing or were never diagnosed with any specific physical disorders (n=43). Reported physical health conditions included asthma/allergies (n=4), HIV/AIDS (n=3), hypertension (n=3), diabetes, prediabetes (n=2), kidney disease (n=2), COPD (n=2), GERD (n=2), fibromyalgia (n=2), tuberculosis (n=1), and others (n=2); IBS/IBD, sinusitis, tumor, vertigo, anemia, scoliosis, costochondritis.

Figure 13. History of previous physical health conditions



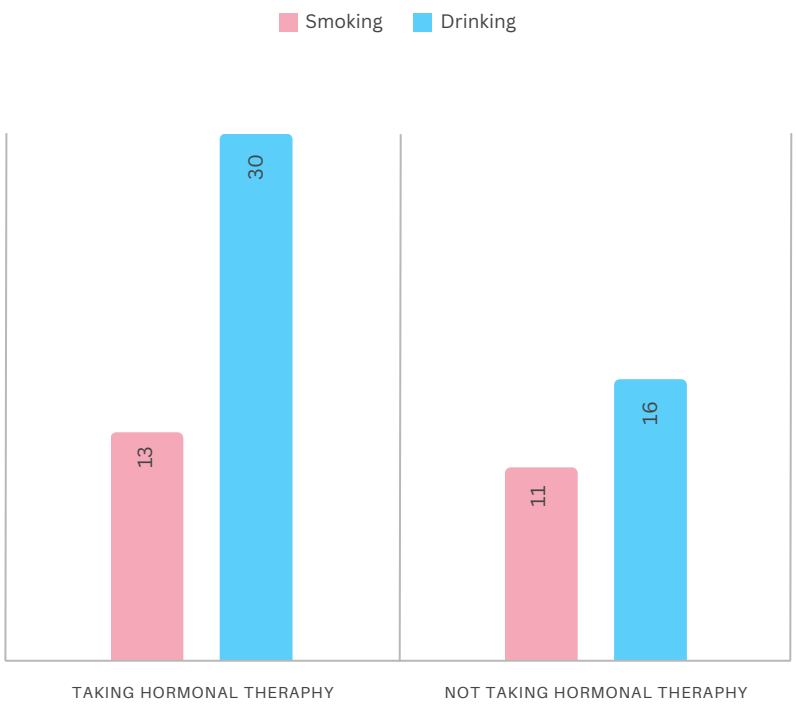
Some respondents from different gender identity spectrums reported having been diagnosed with a health condition. Around 23.52% of trans feminine (n=8), 37.50% of trans masculine (n=9), and 66.67% of non-binary spectrum individuals (n=4) had been diagnosed with a previous physical health condition. On the other hand, more than half of the respondents had been diagnosed with a previous mental health condition; around 55% of trans feminine (n=19), 50% of trans masculine (n=12), and all non-binary individuals (n=6).

Figure 14. Previous diagnoses of health conditions based on gender identity spectrums



In terms of smoking and alcohol consumption, as well as the use of illicit, prescription, and over-the-counter drugs to get high, our respondents had varying responses. In total, there were six respondents who used drugs (9.38%). Most respondents never smoked (62.50%; n=40), while others reported smoking socially (20.31%; n=13) and regularly (17.19%; n=11). When it comes to alcohol, 64.06% of respondents (n=41) reportedly drank alcohol on a monthly basis or less, continued by those who reported never drinking alcohol (28.13%), 2-3x per week (4.16%), and 2-4x per week (3.13%). Some respondents were reportedly smoking (n=13) and drinking (n=30) while on hormonal therapy.

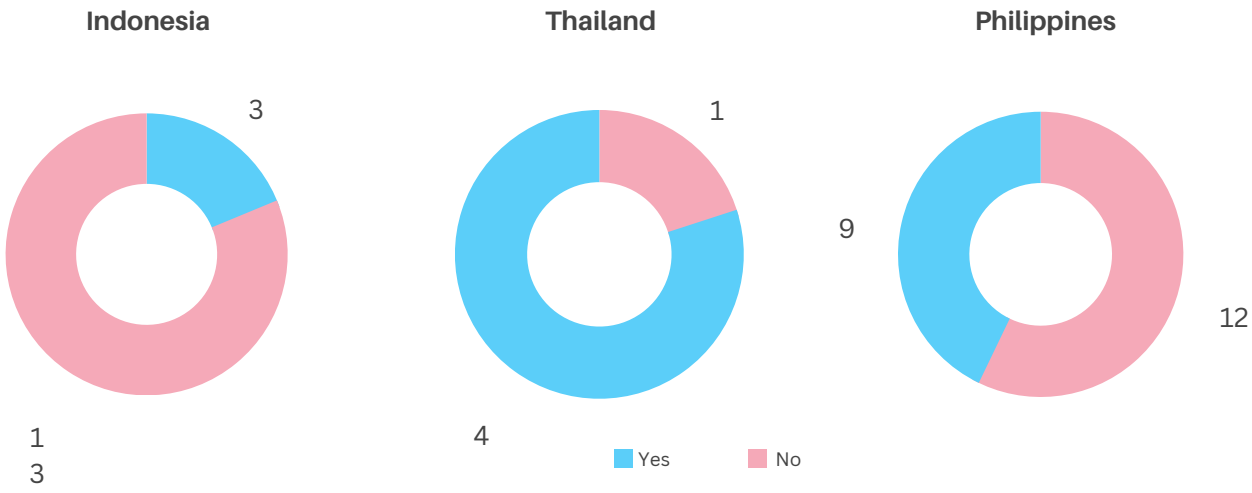
Figure 15. Hormonal therapy, smoking, and drinking



Transition-related health experiences of transgender youth

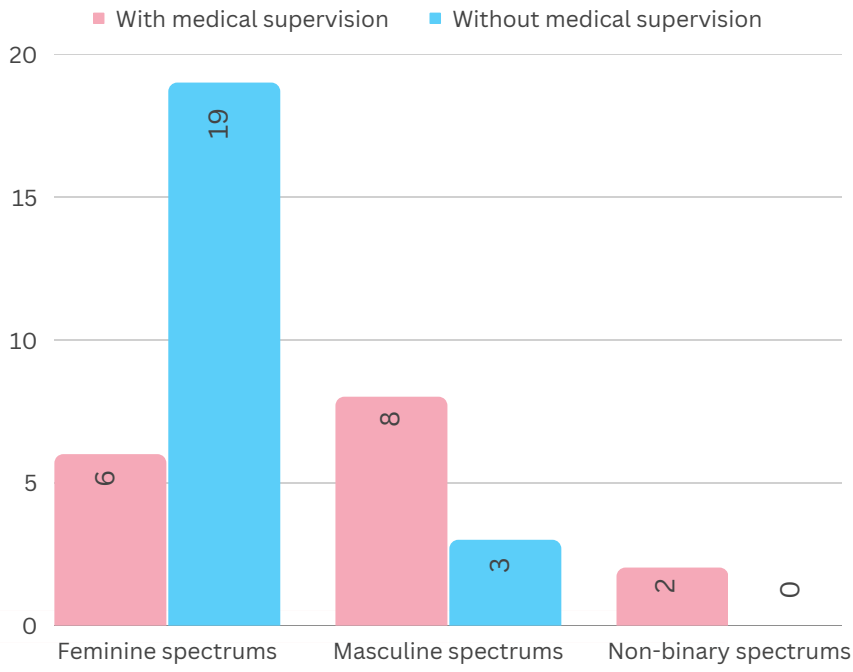
More than half of the trans youth respondents reported that they were currently undertaking hormonal therapy (59.38%; n=38). The average age of commencing hormones for relevant respondents was 21 years of age, with the youngest starting their transition journey at the age of 14. Out of 26 respondents who were not taking hormonal therapy, most were expecting to do it in the future (69.23%; n=18), continued by those who were unsure (26.92%; n=7) and preferred not to (3.85%; n=1). However, when asked whether they did their hormonal therapy with medical supervision, only less than half answered yes (42.11%; n=16). A greater percentage of trans youth in Indonesia (81.25%; n=13) and the Philippines (47.06%; n=12) underwent hormonal therapy or transitioned without medical supervision. Thailand was very different, with the largest percentage of trans youth undergoing hormonal therapy or transition with medical supervision (80%; n=4).

Figure 16. Hormonal therapy with or without medical supervision based on country



Trans masculine-identified respondents were more likely to seek medical supervision while undergoing hormonal replacement therapy compared to respondents within the trans feminine categories, with nineteen respondents in the trans feminine categories reporting taking hormonal therapy without medical supervision, compared to three from the masculine spectrum.

Figure 17. Transitioning with/without medical supervision based on gender identity spectrums



Moreover, only a small percentage of respondents (17.65%; n=12) received information about hormonal therapy from healthcare providers while the majority did not. Instead, many of them (44.12%; n=34) acquired knowledge on this subject from peers, support groups, or communities, while a significant number (38.24%; n=27) resort to the internet for information. Among those who did their hormonal therapy without medical supervision, around 72% listed the internet and peers as trusted sources of information.

Figure 18. Information on hormonal therapy

Respondents who identified with feminine categories tended to seek support from their peers and the internet when searching for information on hormonal therapy, compared to those in the masculine spectrum (2:1).

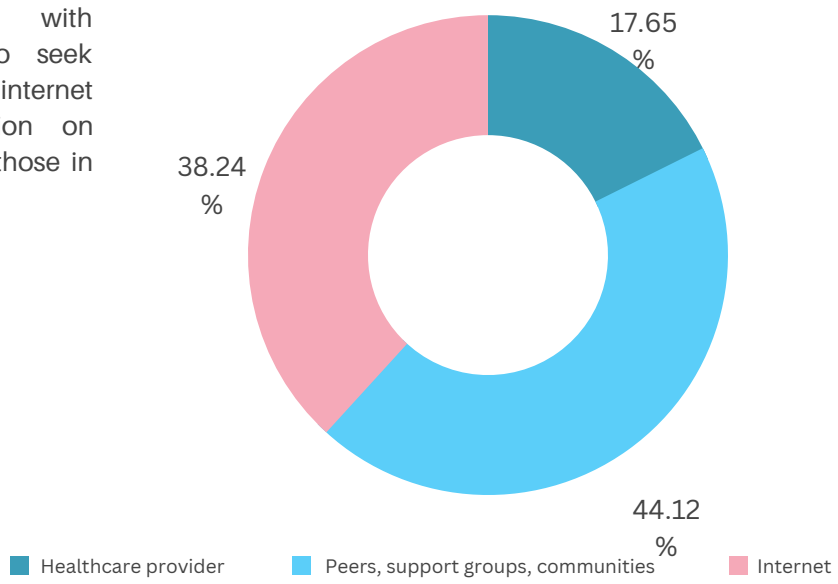
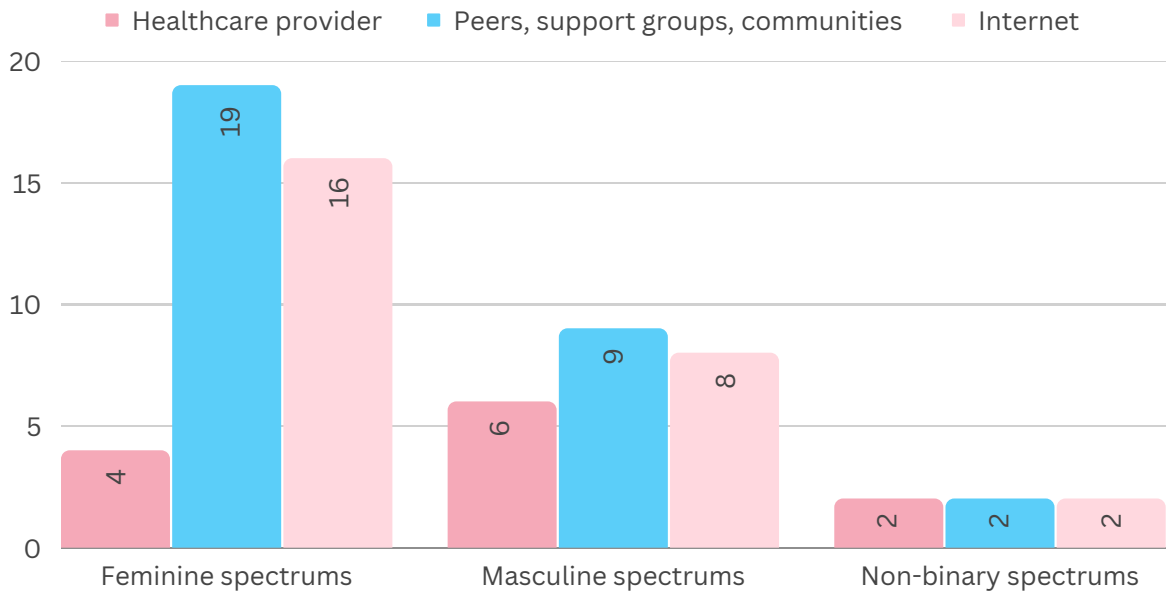
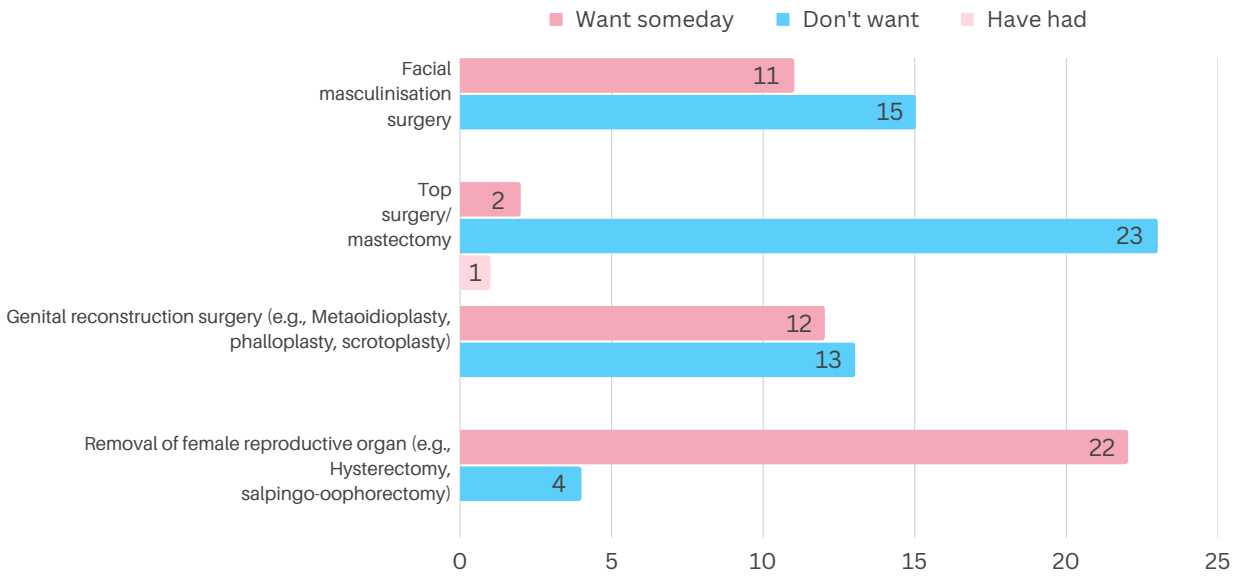


Figure 19. Source of information on hormonal therapy based on gender identity spectrums



In regards to the types of hormones, 12 assigned-female-at-birth (AFAB) individuals were mostly taking testosterone injections (83.33%), and continued with transdermal deliveries using creams, gels, or patches (16.67%). In terms of the surgeries that respondents reported wanting, most AFAB individuals surveyed tend to prefer top surgery (mastectomy; n=23) and removal of female reproductive organs (hysterectomy, salpingo-oophorectomy; n=22). The least desired procedures preferred were facial masculinization surgery and genital reconstruction surgery, with 15 and 13 respondents saying that they do not want those procedures. Of the total AFAB individuals surveyed, only one respondent had done top surgery. Among answers to other possible surgeries, one responded that they desired voice masculinization, fat removal, and height-increasing procedures.

Figure 20. Types of surgeries for AFAB individuals



On the other hand, 26 assigned-male-at-birth (AMAB) individuals mostly used oral estrogen pills/tablets (40%) and antiandrogens (36%), continued with oral contraceptive pills (12%), injections (8%), and transdermal creams, gels, or patches (4%). The survey revealed consistent results among AMAB individuals, who reported a desire to undertake the following in the future: breast augmentation surgery (n=21), facial feminization surgery (nose, forehead, jaw, and others; n=23), genital reconstruction surgery (vaginoplasty; n=23), and the removal of male reproductive organs (orchiectomy; n=23). Two respondents shared that they had undergone breast augmentation surgery, followed by those who had undergone genital reconstruction surgery (n=1) and removal of the male reproductive organ (n=1).

Genital reconstruction surgery (e.g., Metaoidioplasty, phalloplasty, scrotoplasty)

Kevin Marian, courtesy of APTN

Figure 21. Types of hormones for AMAB individuals

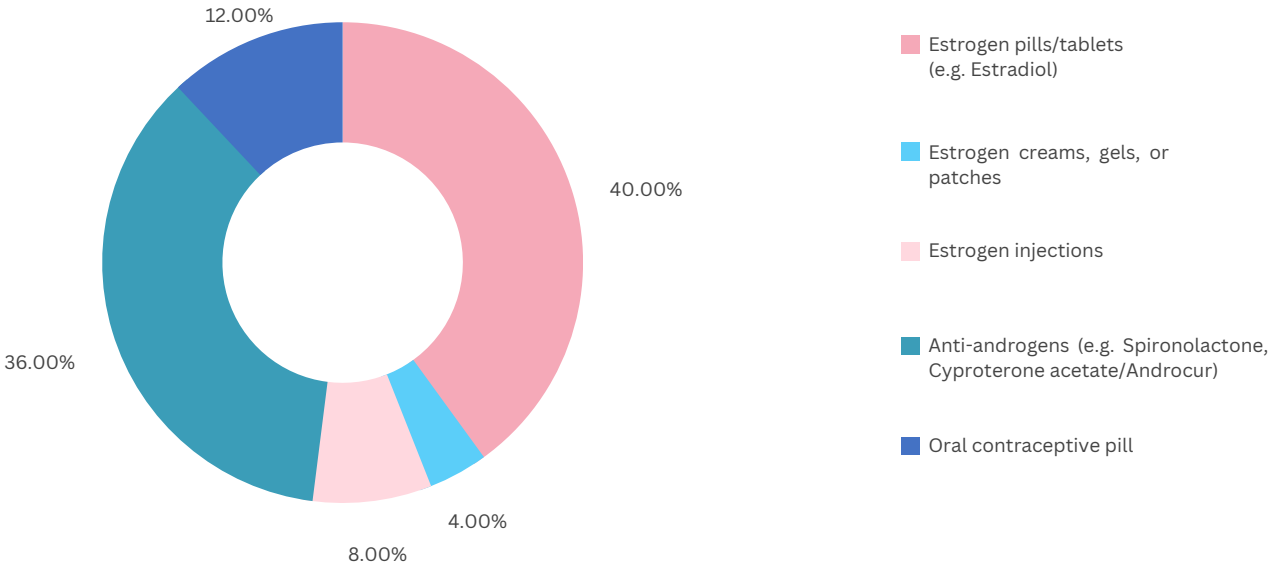
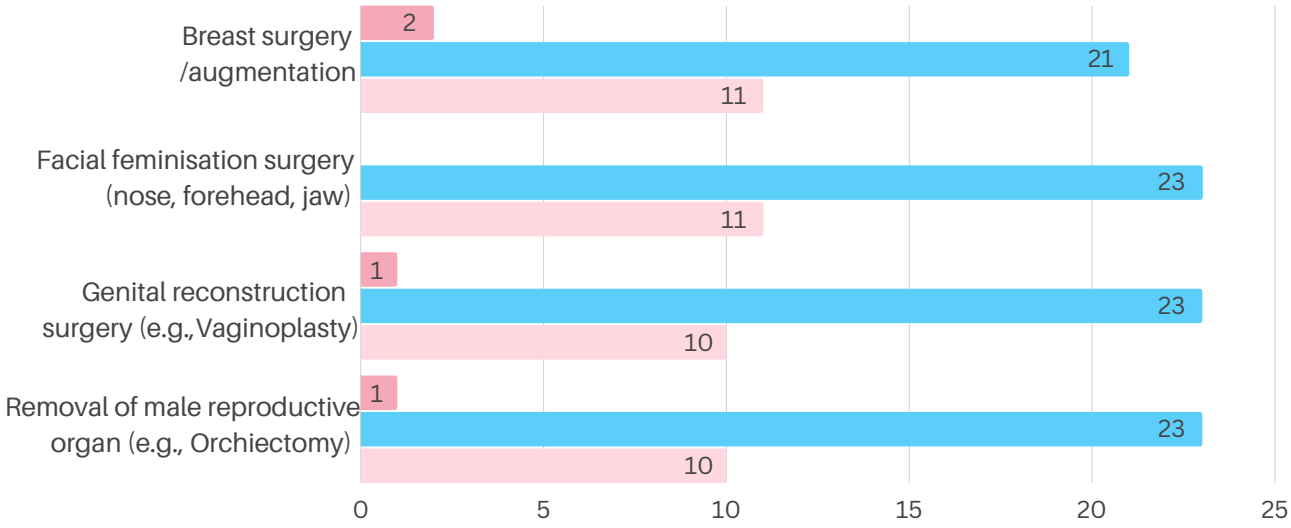
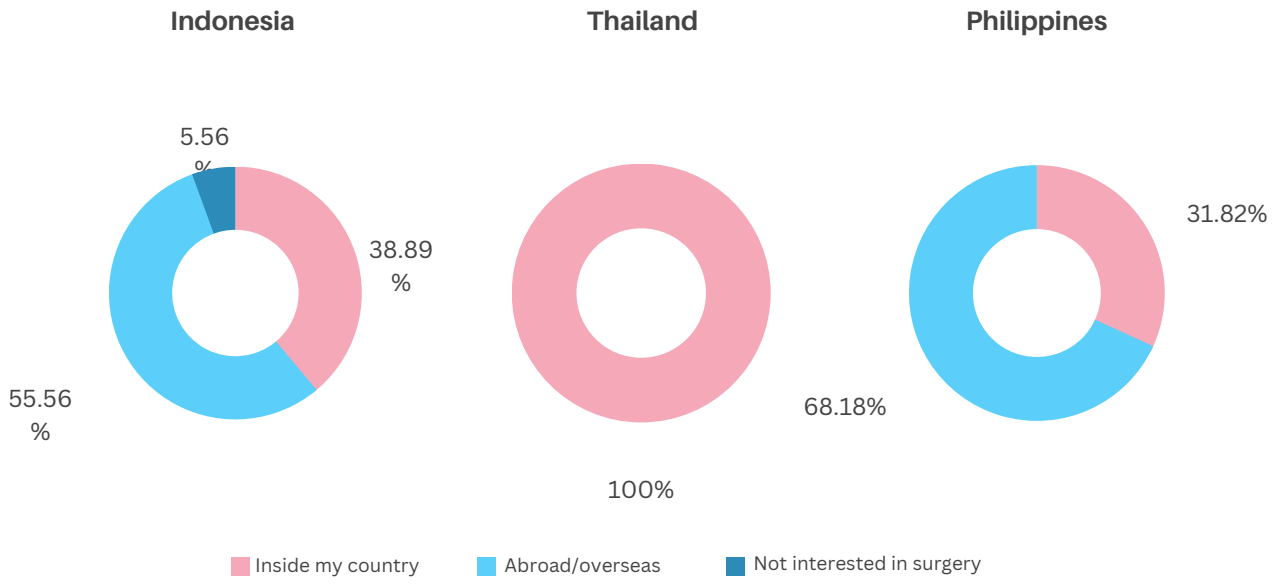


Figure 22. Types of surgeries for AMAB individuals



A slightly greater number of respondents who desired surgeries reported that they would prefer to have them overseas (54.69%; n=35). Country-level analysis revealed that a majority of respondents from Indonesia (n=20) and the Philippines (n=15) preferred to access surgeries overseas, whereas all respondents from the Thai sample (n=6) reported that they would prefer to access surgeries in their own country.

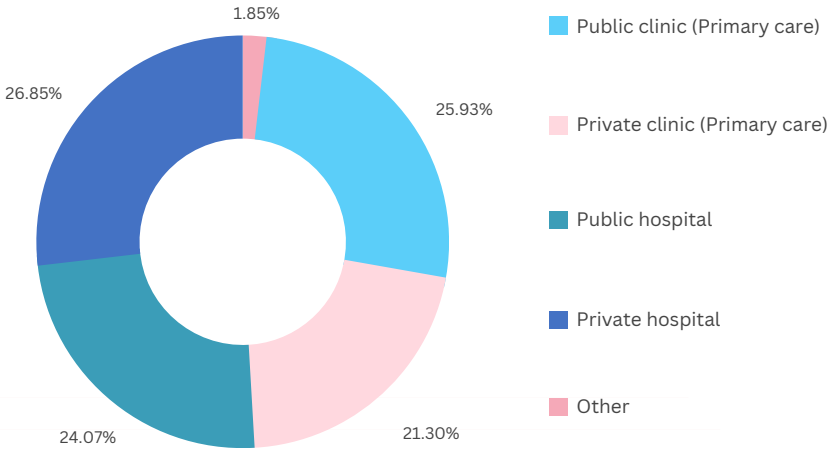
Figure 23. Destination for surgeries based on country-level analysis



Healthcare access of transgender youth

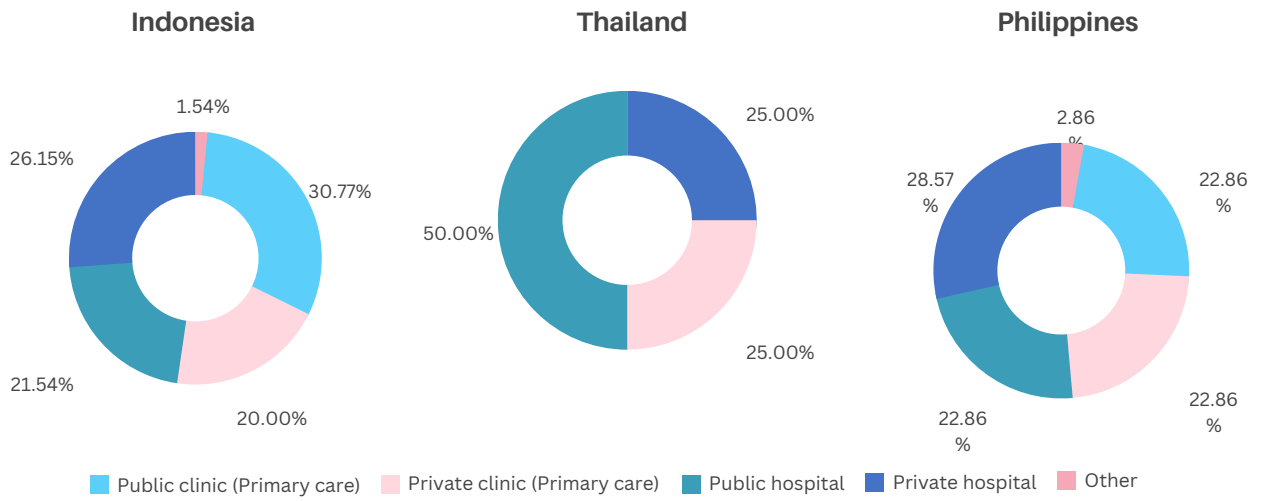
Around 26.85% of responses (n=29) listed private hospitals as the main type of healthcare facilities that they visited, followed by a close margin with public primary care clinics (25.93%; n=28), public hospitals (24.07%; n=26), and private clinics (21.30%; n=23). Two respondents listed NGO-based mental health support groups and psychology bureau as the type of healthcare facilities that they visited.

Figure 24. Type of healthcare facilities accessed



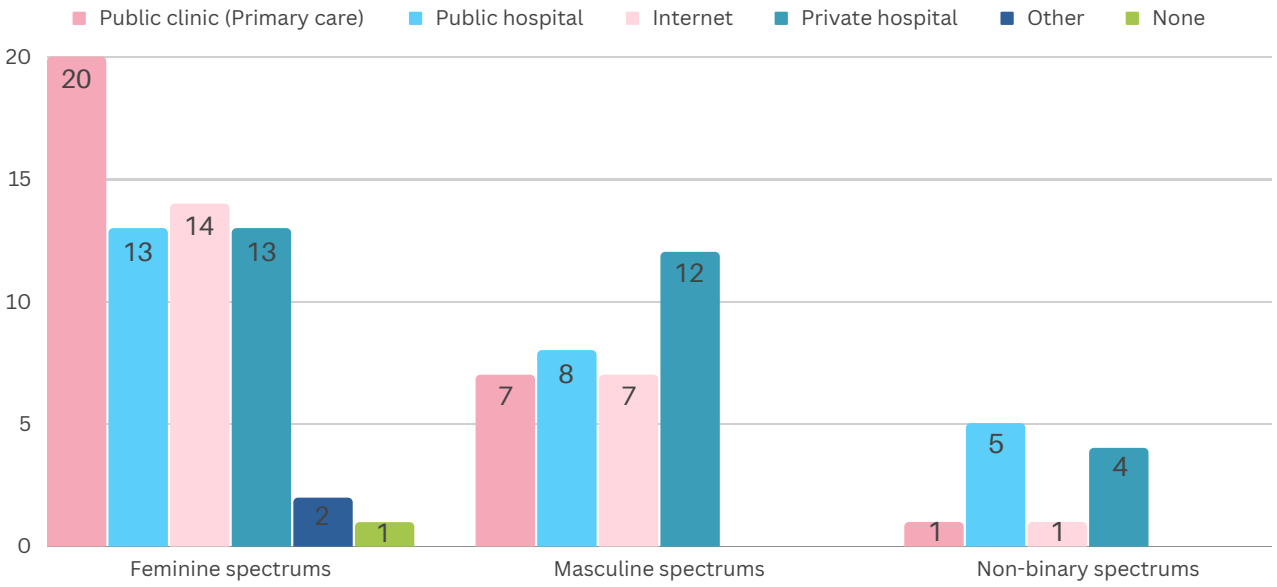
Through a country-level analysis, we found that the results were quite balanced, with around half of all total responses from Indonesia, Thailand, and the Philippines still accessing both public and private health facilities.

Figure 25. Type of healthcare facilities accessed based on country



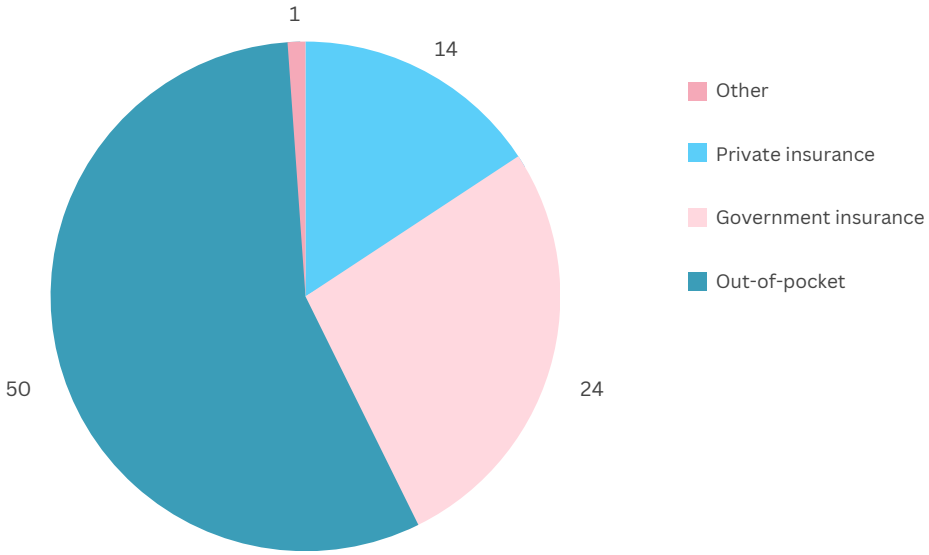
Around 55.88% trans masculine respondents reportedly accessed private health facilities (n=19), while a slightly greater percentage of trans feminine and non-binary respondents preferred accessing public health facilities, at 57.14% (n=33) and 54.54% (n=6) respectively.

Figure 26. Type of healthcare facilities accessed based on gender identity spectrums



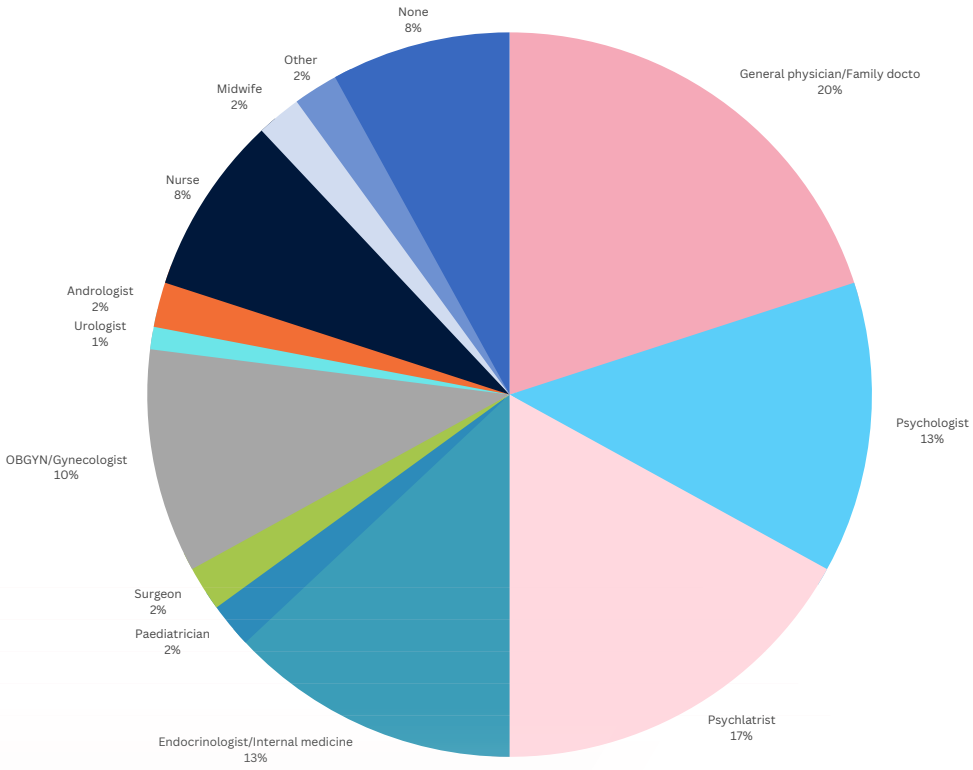
The results also aligned with previous studies (APTN, 2020, 2021a), and found that out-of-pocket expenditure remained the primary health financing method for trans individuals in accessing health services, with 56.17% responses (n=50), continued with government (n=24) and private insurance (n=14); this is well reflected in both overall and country-level analysis, as well as on gender identity basis. One response listed peer financial support to cover health costs.

Figure 27. Health financing methods



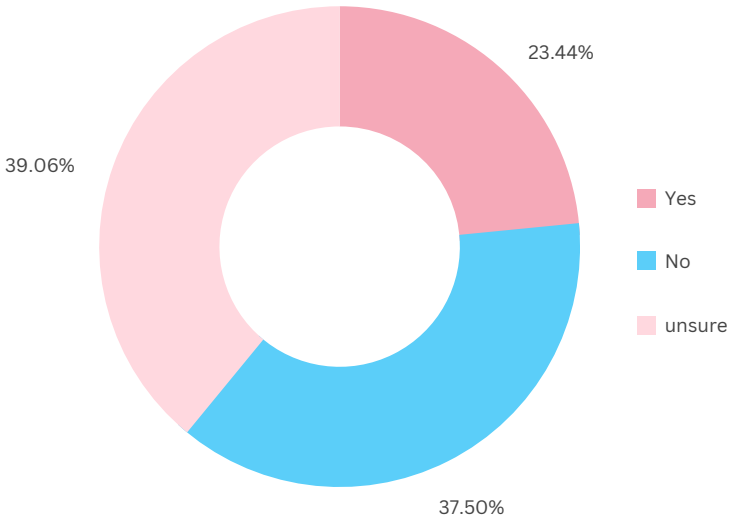
The top five healthcare providers visited for transitioning were general physicians/family doctors (20%; n=24), psychiatrists (17%; n=20), psychologists (13%; n=15), endocrinologists/internal medicine (13%; n=15), and obgyns/gynecologists (10%; n=12). Two respondents listed one hematologist and one sexologist.

Figure 28. Health providers visited related to transition



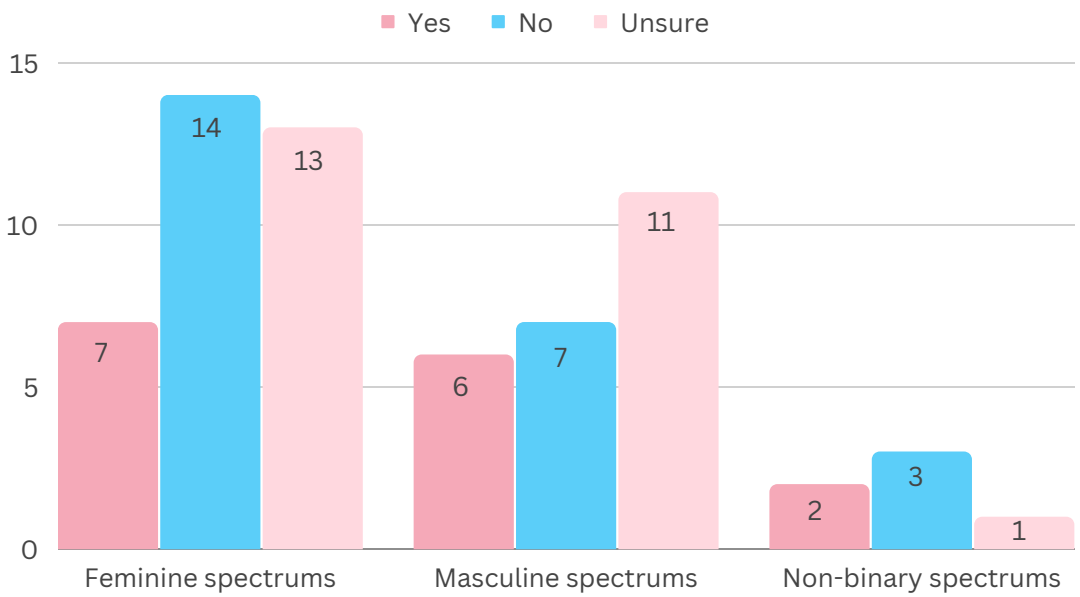
However, when asked to express their opinion on whether the healthcare provider they visited regularly offered appropriate transgender health services, most respondents still doubted that their providers were providing them with appropriate transgender health services (39.06%; "unsure" and 37.50%; "no"). Due to data limitations, especially for Thailand, we could not conclude if this data reflects on country by country.

Figure 29. Opinions whether the current healthcare providers offered proper transgender health services for trans youth



Those who identified with feminine categories were more likely to respond with the answer "no" (41.17%; n=14) and "unsure" (38.23%; n=13) when it came to opinions on healthcare providers offering proper transgender care. The response "unsure" was the highest for respondents who identified as masculine categories (45.83%; n=11), while more than half of those who identified in the non-binary categories responded "no" and "unsure" about their healthcare providers (n=4). Through a country-level analysis, there was a higher percentage of "no" and "unsure" responses combined, coming from Indonesia (88%; n=32), Thailand (83.33%; n=12), and the Philippines (54.54%; n=5).

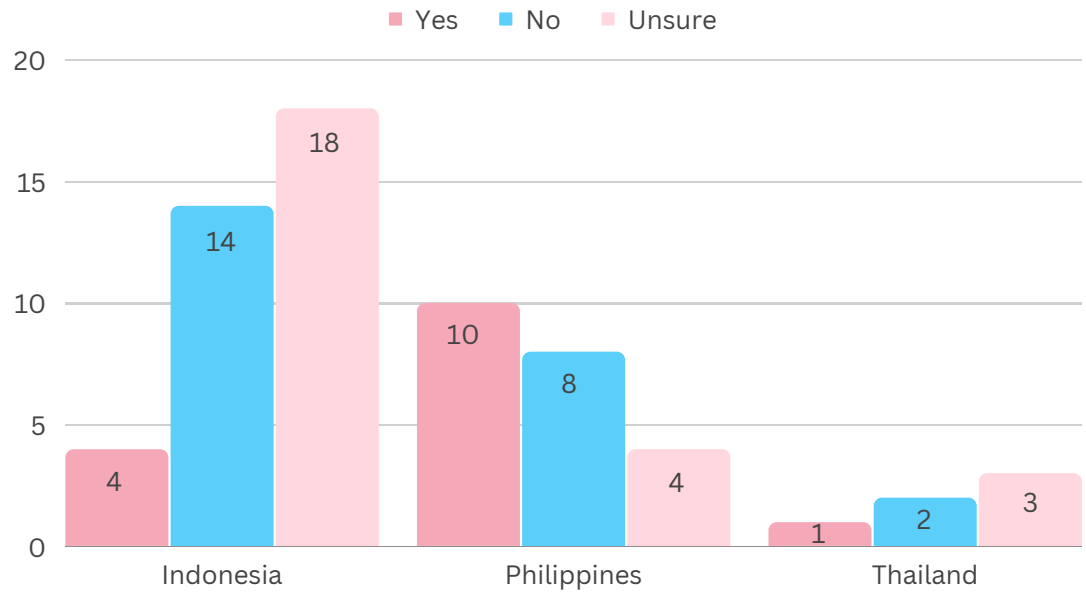
Figure 30. Opinions on whether their current healthcare providers offered proper transgender health services based on gender identity spectrums



"I need to identify as a binary trans person (when I am not) to access affordable services." - 22 y.o. non-binary trans individual, Thailand

"A doctor found out that I'm autistic, so he didn't trust my judgment to undergo the HRT despite the fact that I'm 29 and working full time." - 29 y.o. non-binary trans individual, Thailand

Figure 31. Opinions on whether their current healthcare providers offered proper transgender health services based on country

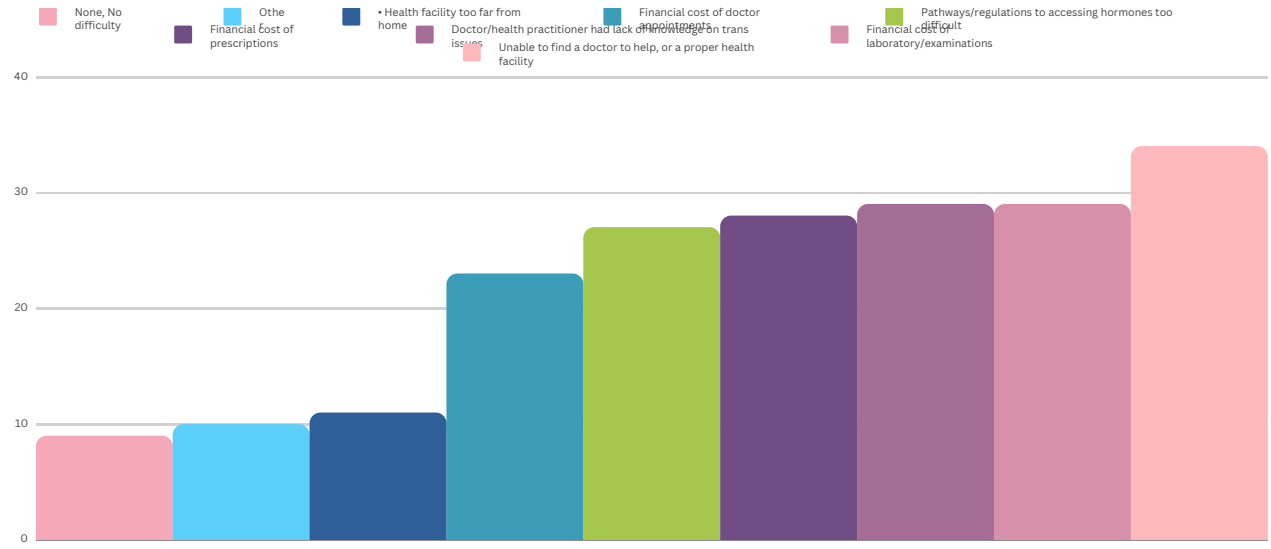


The study identified multiple barriers in receiving gender-affirming care. The most common challenge in obtaining hormonal treatment and other gender-affirming services was an inability to find a suitable doctor or healthcare facility (17%), followed by financial cost of laboratory and other examinations (14.50%), doctors/health practitioners lack knowledge on trans issues (14.50%), the financial cost of prescription drugs (14%), pathways/regulations too difficult (13.50%), and financial cost of doctors' appointments (11.50%). The bottom two barriers identified were distance to health facilities (5.50%) and other barriers listed (5%), mostly related to family acceptance and personal barriers, such as anxiety and zero experience in accessing care. Additionally, there were some responses related to the uncomfortable experiences in accessing care (n=4), such as:

"I'm not sure about the one who can advise me and I am still afraid to lose my current job if I choose this." - 26 y.o. trans masculine individual, Indonesia

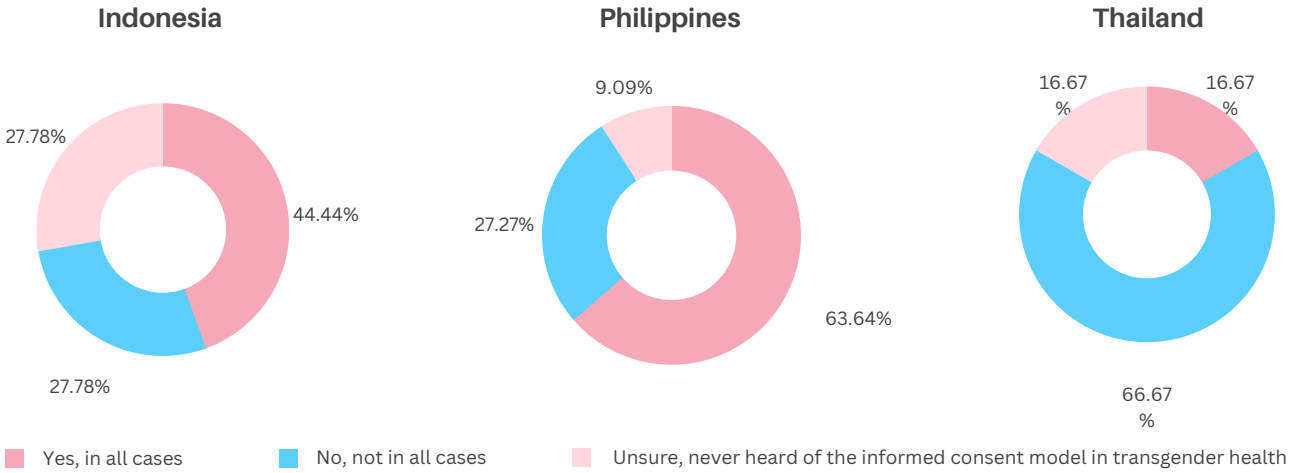
"(Being) misgendered and disconnected." - 28 y.o. trans feminine individual, Philippines

Figure 32. Difficulties accessing hormonal treatment and other gender-affirming services



The results of this survey suggest that understanding of the role of an informed consent model is not widespread. Almost half of the respondents believed that they should undertake a mandatory, formal mental health assessment before starting hormonal therapy (48.44%; n=31), while others responded, "no, not in all cases" (31.25%; n=20) and "unsure" (20.31%; n=13). Interestingly, Indonesia (44.44%) and the Philippines (63.64%) have a higher percentage of responses saying that they would need a mandatory formal mental health assessment before starting hormonal therapy, compared to Thailand. The highest percentage of those who responded "unsure" was from Indonesia (27.78%).

Figure 33. Trans youth perspectives on the informed consent model based on country

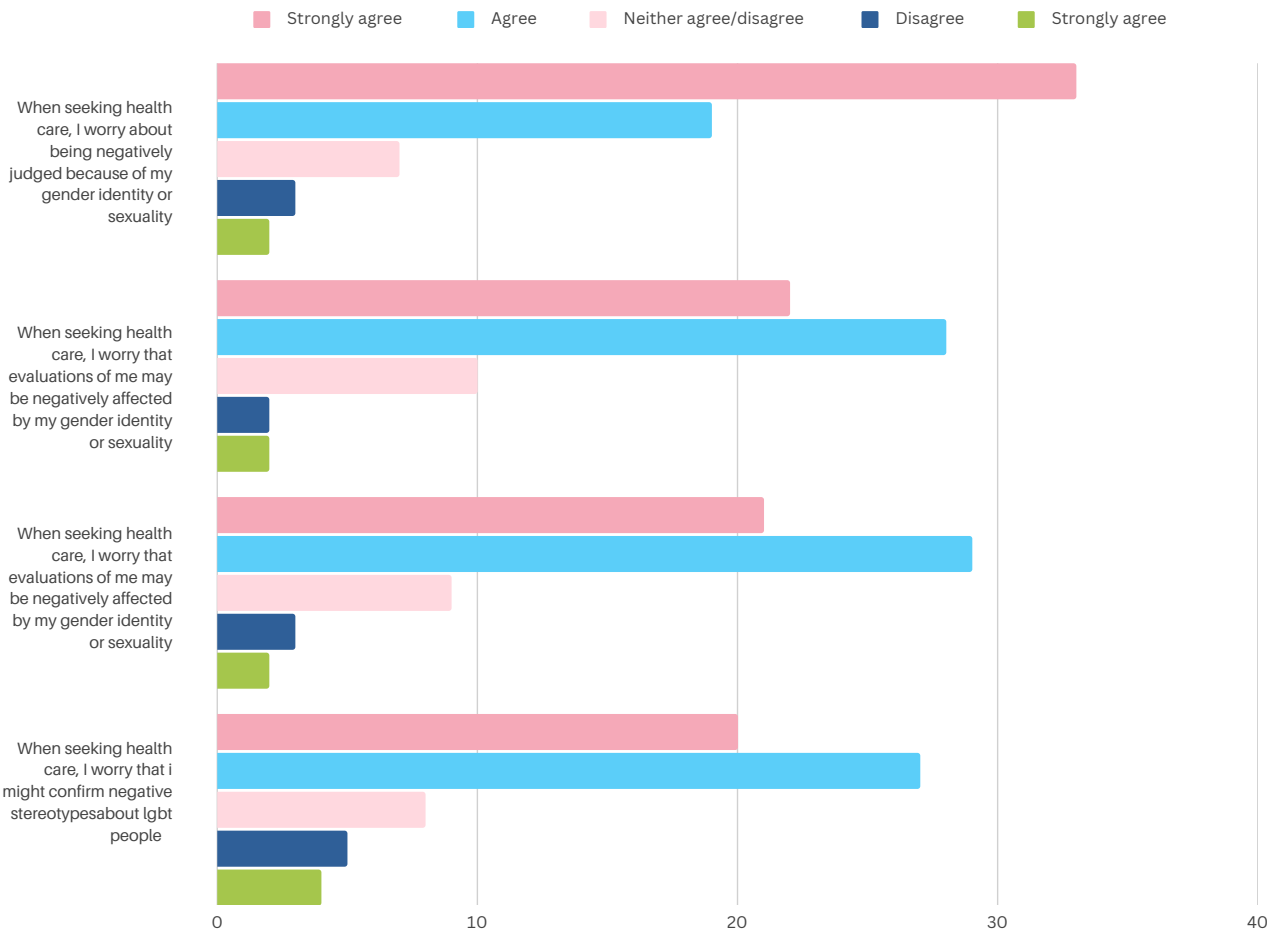


2 A model of gender affirming care that allows transgender individuals and their healthcare providers to initiate hormonal therapy without making mental health provider's authorization mandatory (Coleman et al., 2022; ISSM, 2021; Strahan, 2020).

Discrimination in healthcare experienced by transgender youth

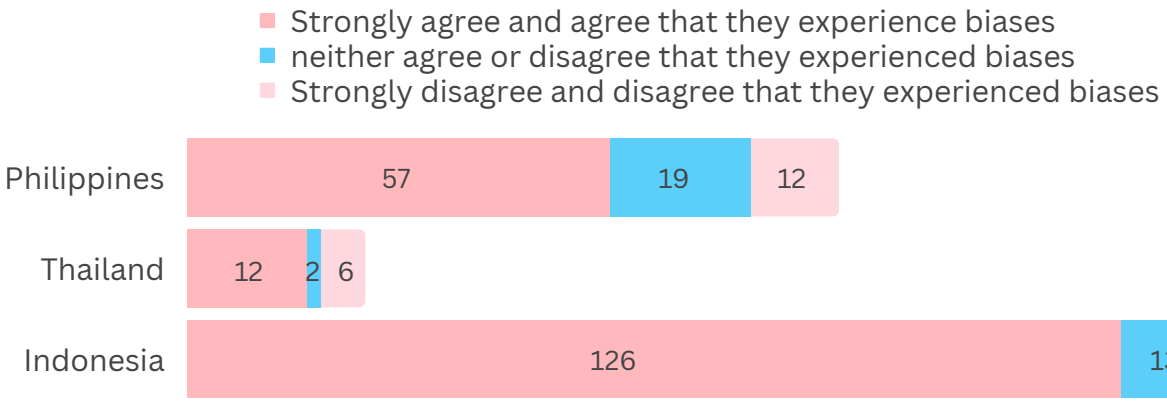
The survey showed a staggering number of responses that suggested concerns on bias and discrimination when accessing healthcare. Around 81.3% of respondents reported that they "agree to strongly agree" of being negatively judged due to their gender identity or sexuality (n=52), continued by 78.1% respondents who were strongly concerned that their health evaluations (n=50) and diagnoses (n=50) might be negatively be affected by their gender identity or sexuality, and that 73.4% were "agree to strongly agree" that they might confirm negative stereotypes about LGBT people (n=47).

Figure 34. Concerns and biases when accessing healthcare



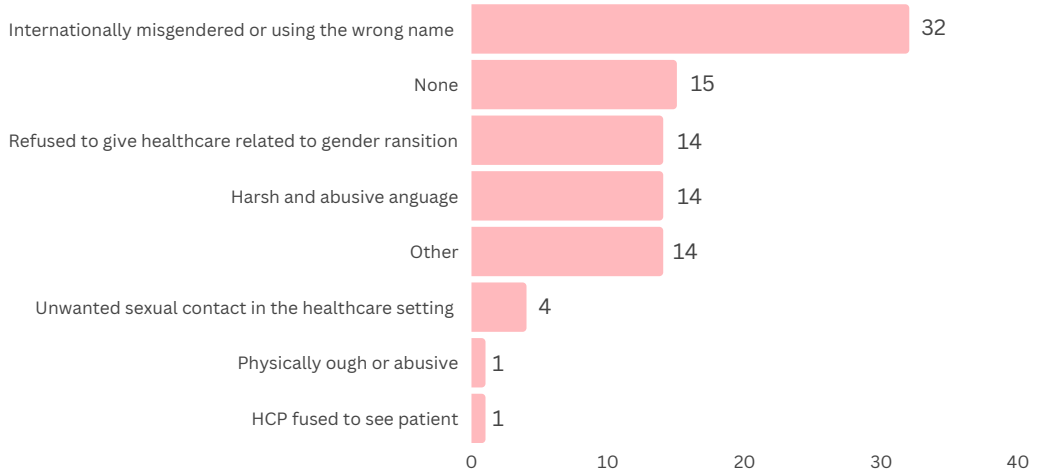
Country-level analyses revealed similar levels of responses from Indonesia, Thailand, and the Philippines. In each country most responded with "agree and strongly agree" that they had experienced negative judgments based on their gender identity or sexuality; Indonesian respondents (87.5%) were more likely to report that they received biases when seeking healthcare (n=126), continued with 66.66% from Thailand (n=16) and 64.77% from the Philippines (n=57). Additionally, respondents from Thailand (25%) were more likely to respond with "disagree and strongly disagree" if they experienced biases in healthcare (n=6), compared to counterparts in the Philippines (13.63%) and Indonesia (3.47%). This might serve as one explanation for why transgender youth, especially in Indonesia and the Philippines, opt to seek information and treatment on a DIY or peer basis.

Figure 35. Concerns and biases when accessing healthcare based on country



The study captured the high levels of discrimination that trans youth experience when accessing healthcare. The most common experiences of discrimination included misgendering and the intentional use of a wrong name (33.68%; n=32), refusal to provide transition-related healthcare (14.74%; n=14), the use of harsh and abusive language (14.74%; n=14), and other types of abuse (14.74%; n=14). Concerningly, respondents also reported instances of unwanted sexual contact (4.21%; n=4) and physical abuse (1.05%; n=1) when accessing services.

Figure 36. Types of abuse experienced related to one's gender identity



As a mixed method survey, the study captured a number of written responses from trans youth sharing their story navigating a discriminatory healthcare environment. Among types of abuse described in comments (14.74%; n=14), available as a free text field in the survey, some comments were related to a lack of gender and cultural sensitivity, i.e.

- "(Being) soft spoken, but neglecting my identity,"
- "No empathy,"
- "Asking unrelated, invasive, and intrusive questions,"
- "Deliberately asked for my ID card,"
- "Being intensively asked about my 'real' gender,"
- "Getting lectured about my identity,"
- "Insensitive about my gender."

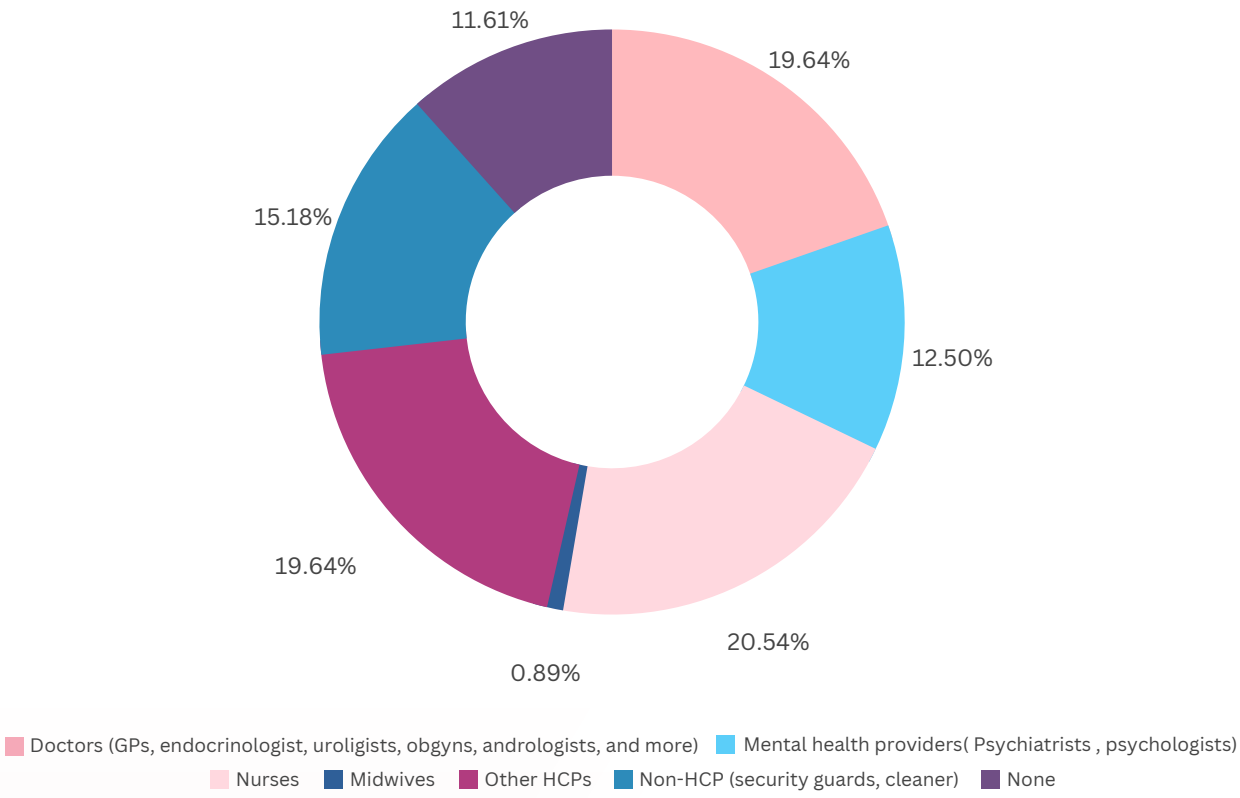
Some were even afraid to come out to their healthcare providers, "I don't want to come out to my HCPs", or "Never transitioned, because I am too afraid that I might receive abusive behavior if I transitioned." As respondents reported in their own words:

> *"I experienced an incident while accompanying my partner as a caregiver, where an officer asked for my identification and made fun of me. This made me feel uneasy as it occurred twice. As a result, I have been avoiding healthcare services except for COVID-19 tests, which are required for certain activities." - 29 y.o. trans masculine individual, Indonesia*

> *"Maybe not explicitly, but there have been times when people apologize to me for using masculine pronouns when they realize I'm AFAB (assigned female at birth). I don't really see the importance of correcting it, partly because I am afraid, and partly because that's the name on my insurance and identity card..." - 26 y.o. trans masculine individual, Indonesia*

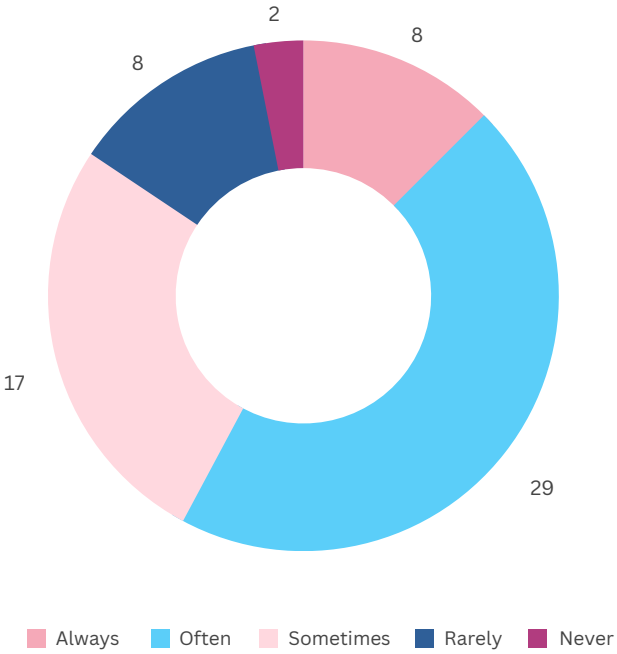
When asked about the types of healthcare providers that made them feel uncomfortable/unwelcomed, trans youth responded to nurses (20.54%), doctors (19.64%), other HCPs (19.64%), non-HCPs (15.18%), mental health providers (12.50%), and midwives (0.89%). Only 13 responded that no health providers made them feel uncomfortable (11.61%).

Figure 37. Type of healthcare providers that made you feel uncomfortable/unwelcomed



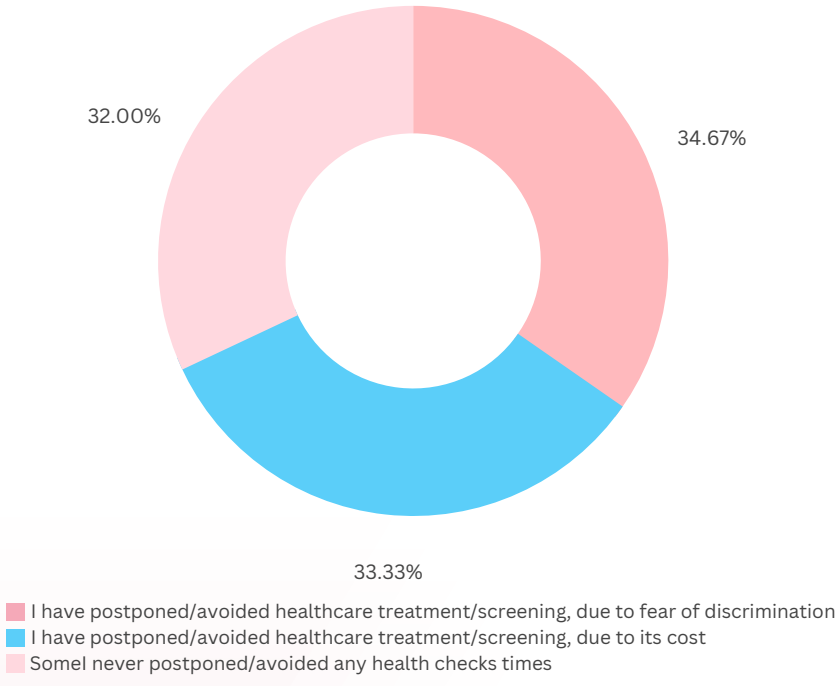
The frequency of unpleasant, discriminatory, and abusive experiences in the healthcare settings was varied. Most respondents answered sometimes (45.31%), and continued with rarely (26.56%), often (12.50%), never (12.50%), and always (3.13%). In total, only 12.5% of respondents said they never had an unpleasant experience in a healthcare setting (n=8).

Figure 38. Frequency of any unpleasant, discriminative, and abusive experience in the healthcare settings



Correspondingly, a large proportion of respondents (68%) reported experiences of having postponed or avoided healthcare treatment and/or screening due to its cost and/or fear of discrimination (n=51).

Figure 39. Trans youth's experience in postponing or avoiding healthcare



The study found similar results in the country-level analysis and segregation based on gender identity categories. Around 70.46% of respondents from Indonesia, 66.66% from Thailand, and 60% from the Philippines, as well as 67.50% from the feminine categories (n=27), 70.37% from the masculine categories (n=19), and 62.50% from non-binary categories (n=5) reported postponing or avoiding care for the reasons listed above. Those who made less than US$ 50 per month had the highest number of responses on postponing or avoiding care (n=21).

Figure 40. Trans youth experience postponing or avoiding healthcare based on country

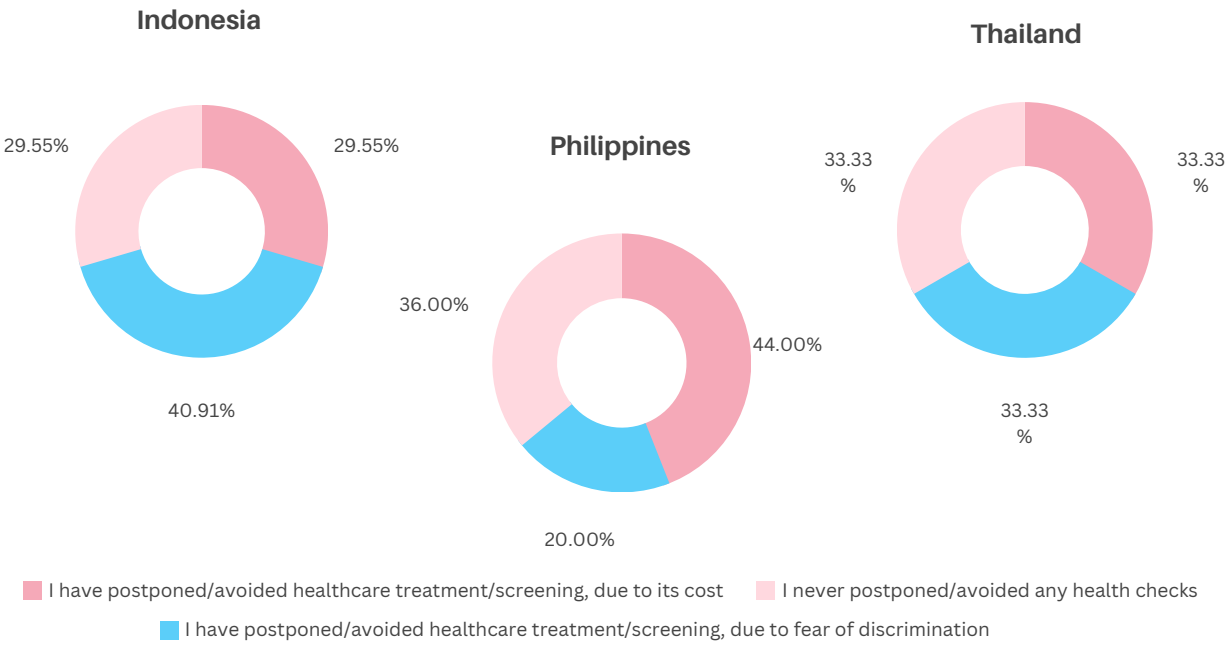
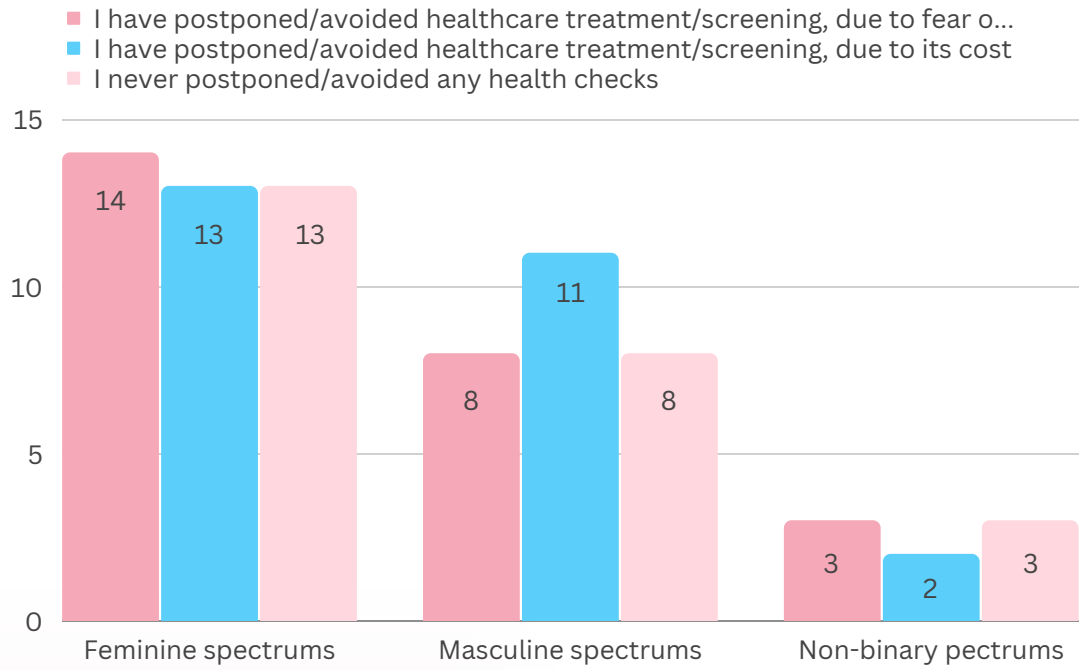


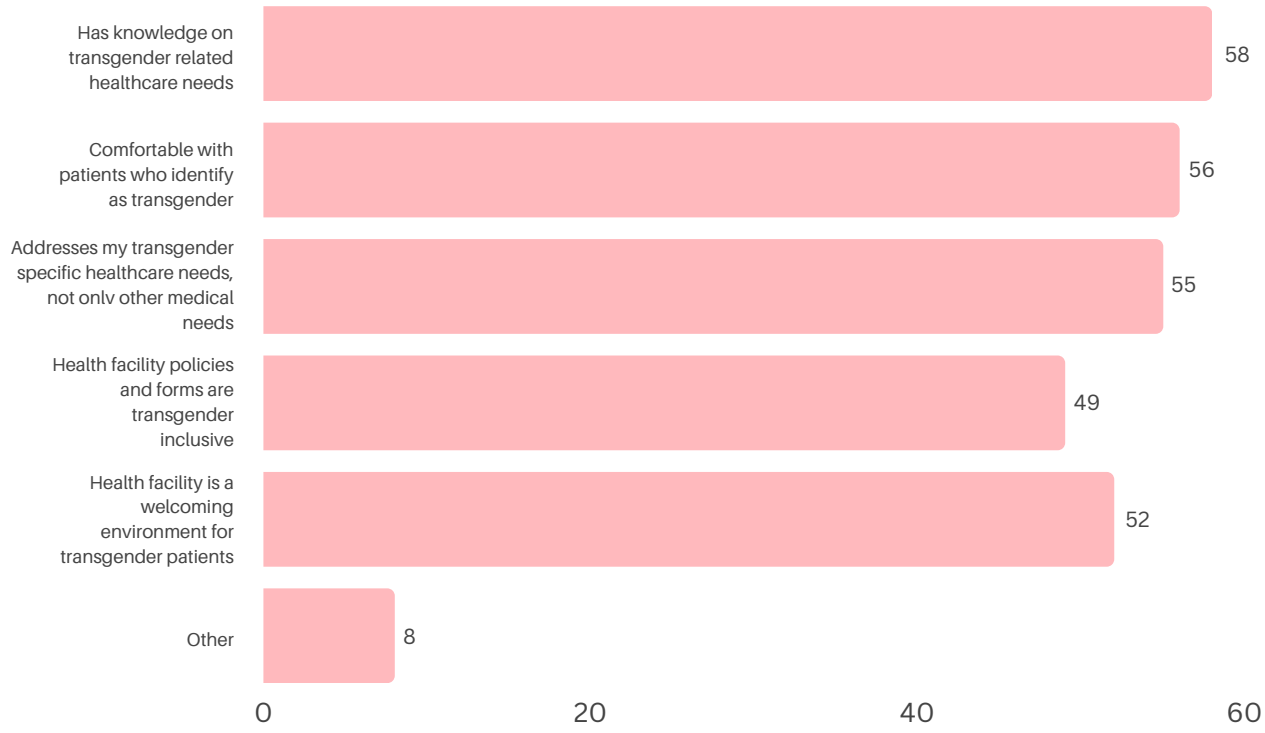
Figure 41. Trans youth experience postponing or avoiding healthcare based on gender identity spectrums



Health resources, community priorities, an expectations of transgender youth

Transgender youth reported seeking to find healthcare providers with several qualities, including those with a knowledge of transgender-related healthcare needs (20.86%), being comfortable with patients who identify as transgender (20.14%), addressing transgender-specific healthcare needs (19.78%), not only other medical needs, as well as health facility that is welcoming for transgender patients (18.71%) and health facility policies and forms that are transgender-inclusive (17.63%). Additionally, those who gave other answers (2.88%), wrote some interesting responses: "Actually also down to earth and connects to community concerns", "Affordable and not gatekeeping", "Friendly and non-discriminatory services", "Understand gender diversity", and "Understand neurodiverse people too".

Figure 42. Qualities trans youth want to see in a healthcare provider



The data showed a proportional prioritization of healthcare and funding for trans youth. The establishment of a gender clinic claimed the top priority (12.56%), continued with access to universal health coverage (11.87%), counseling and mental health services (10.96%), trans-related health research (10.96%), education about gender diversity (10.73%), and trans advocacy groups (10.27%). Without reducing the importance, the bottom four priorities were referral networks (8.45%), better healthcare professional training (7.99%), support groups (7.99%), and access to general services (7.76%). In the other section (0.46%), some respondents listed:

"(The need for) trans healthcare for disabled and chronically ill individuals" - 22 yo non-binary trans individual, Thailand

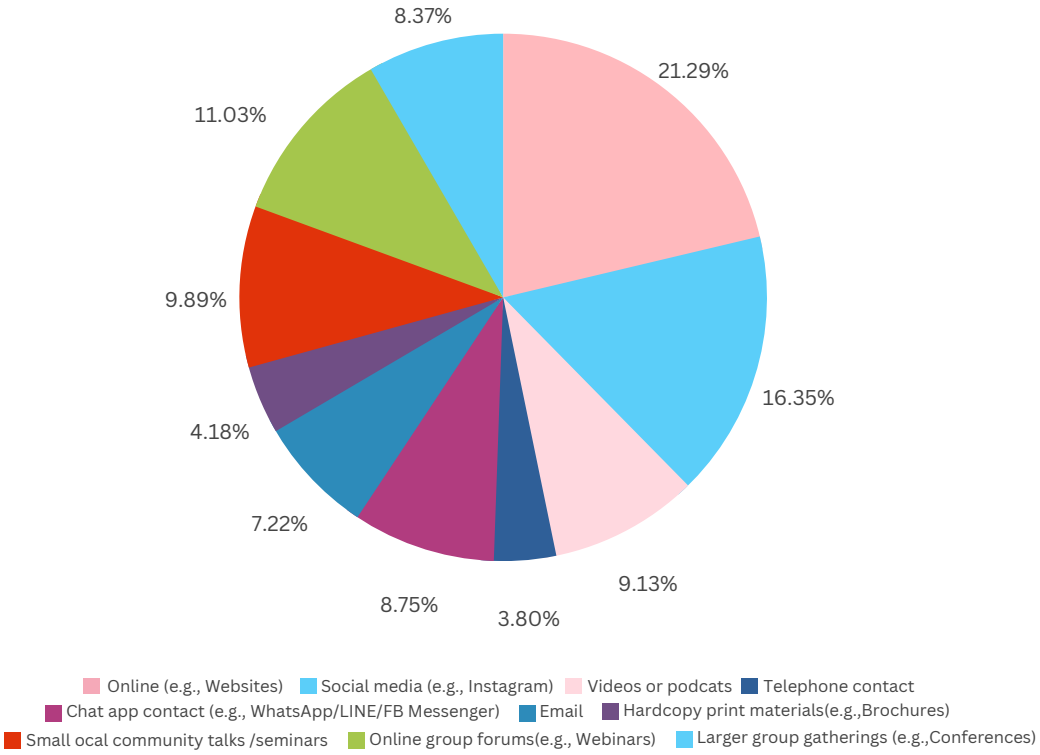
"A community/collective care that is culturally competent and able to treat us as people." - 28 trans feminine individual, Philippines

Table 6. Priorities for transgender healthcare and funding

Field		Choice Count
Gender clinics: An all inclusive/one stop facility for gender-affirming care	12.56%	55
Access to universal health insurance	11.87%	52
Counseling, psychology, and psychiatric services	11.87%	52
Trans or gender-related medical research	10.96%	48
Education about gender diversity (e.g., Community or schools)	10.73%	47
Trans advocacy groups	10.27%	45
Referral network of doctors and health practitioners for trans health	8.45%	37
Better training for doctors and other healthcare professionals	7.99%	35
Support groups	7.99%	35
Access to general health services (e.g., Local clinic/GP)	7.76%	34
Other	0.46%	2

With respect to the medium of delivering healthcare, mixed online (e.g., telehealth) and offline (e.g., in person, at the clinic or hospital) healthcare delivery remained favorable for trans youth who responded to this survey (57.81%; n=37), continued with offline (34.38%; n=22) and online consultation (7.81%; n=5). The top five preferred methods of delivering trans health information delivery were online (21.29%; n=56), social media (16.35%; n=43), online group forums (11.03%; n=29), small local community talks or seminars (9.89%; n=26), and videos or podcasts (9.13%; n=24). Additionally, 26% of responses reported that Instagram is their most used social media platform (n=50), followed by Youtube (21.81%; n=41), Facebook (18.62%; n=35), Twitter (16.49%; n=31), TikTok (12.7%; n=24), and others (3.72%; n=7). Those who picked others reported Discord (n=3), Reddit (n=2), Pinterest (n=1), and "do not use social media." This information can be used to consider strategies for delivering relevant healthcare information to transgender youth.

Figure 43. Preferred methods of information

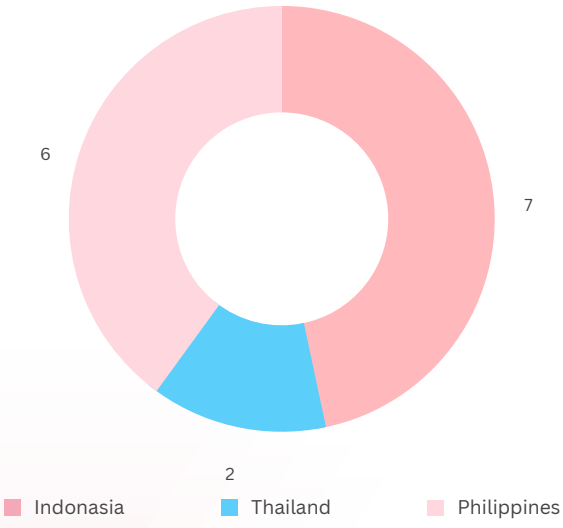


Responses from healthcare providers

Demographics of transgender youth

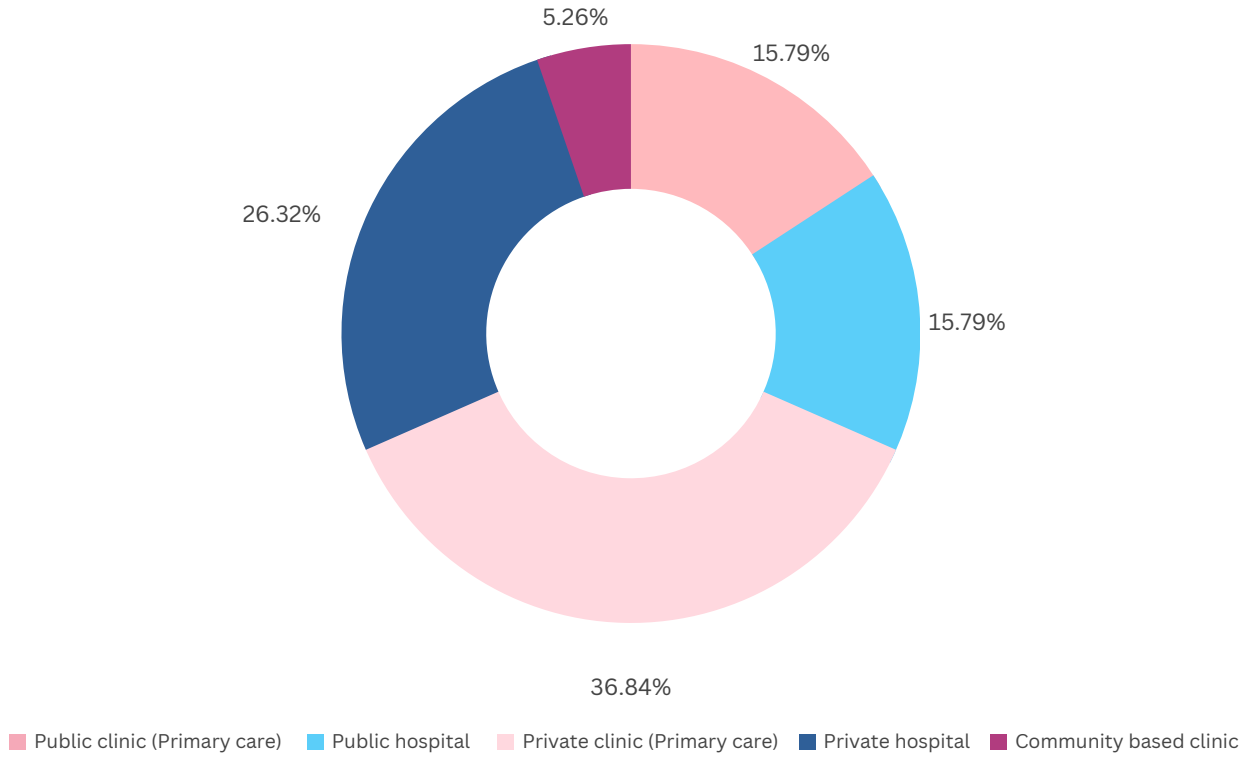
From the total of 25 health providers who responded to the survey there were a total of 15 complete responses that we drew on for analysis. Most responses came from Indonesia (n=7), second, the Philippines (n=6), and the smallest from Thailand (n=2). HCPs mostly resided in large cities, namely Greater Jakarta (n=5), Bangkok Metropolitan Region (n=2), and Greater Manila (n=6). There were two providers from East Nusa Tenggara, Indonesia.

Figure 44. Providers' country of residence



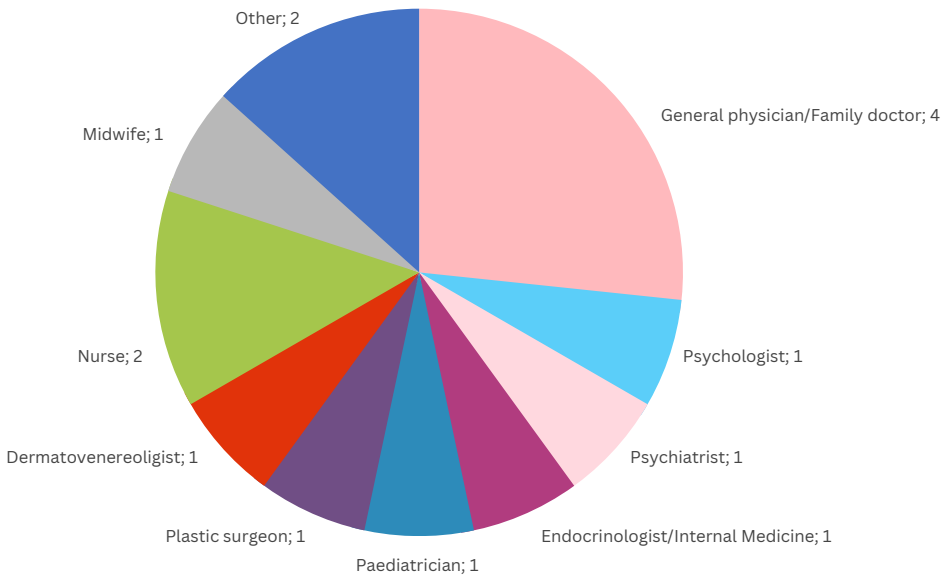
The healthcare providers who responded to the survey came from the age range of 28-64 years old, predominantly male assigned at birth (n=11). Around ten respondents identified with feminine categories (4 trans women; 4 women; 1 waria; 1 bakla; none identify as Ying Kham Phet), four respondents identified as men (none identify as a trans man, trans pria, tomboy, and Chye Kham Phet), and one respondent preferred not to disclose their gender identity. Additionally, around seven respondents described their sexuality as straight/heterosexual, six as same-gender loving, one as bisexual, and one as "other." Most with current partnership status of being single; never married (n=11), continued with married; with a domestic partner (n=2), and partnered, but not living together (n=2). Most respondents worked in private healthcare facilities, either in a clinic or hospital (n=12), followed by respondents who worked in public settings (n=6), and community-based clinics (n=1).

Figure 45. Providers' place of practice



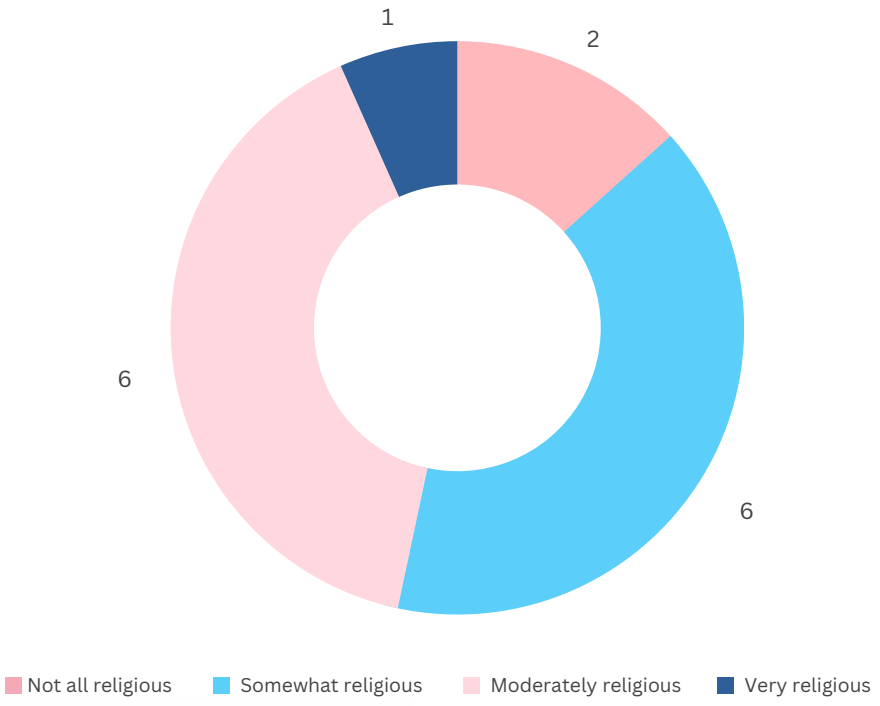
Health professionals who responded came from various branches of health, including general practice (n=4), psychology (n=1), psychiatry (n=1), endocrinology/internal medicine (n=1), plastic surgery (n=1), pediatrics(n=1), dermatovenerology (n=1), nursing (n=2), midwivery (n=1), and community health (n=2).

Figure 46. Type of specialties



When it comes to religion, healthcare professionals identified as Christian (n=7), Agnostic (n=3), Catholic (n=2), Buddhist (n=2), and Moslem (n=1). Among all providers, around 80% identified as somewhat (n=6) and moderately religious (n=6) combined. One identifies as very religious and two as not religious.

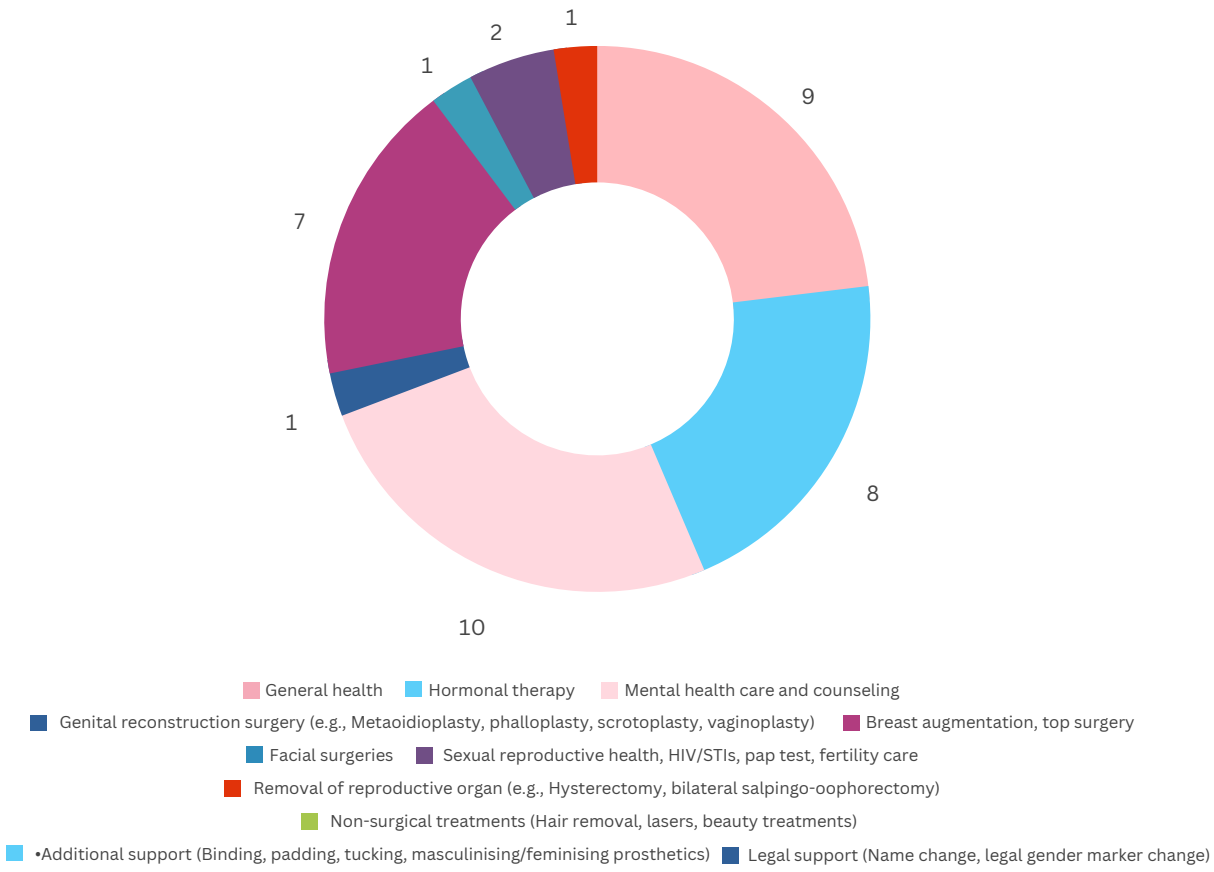
Figure 47. Provider's religious identification



Personal and clinical exposure to transgender patients

All respondents have cared for transgender patients in the last 12 months and have known transgender people outside of their practice. Services provided by healthcare professionals were varied, from general health (n=9) to hormonal therapy (n=8), mental health (n=10), sexual reproductive health (n=8), genital surgery (n=1), non-surgical beauty treatment (n=1), to legal support (n=1).

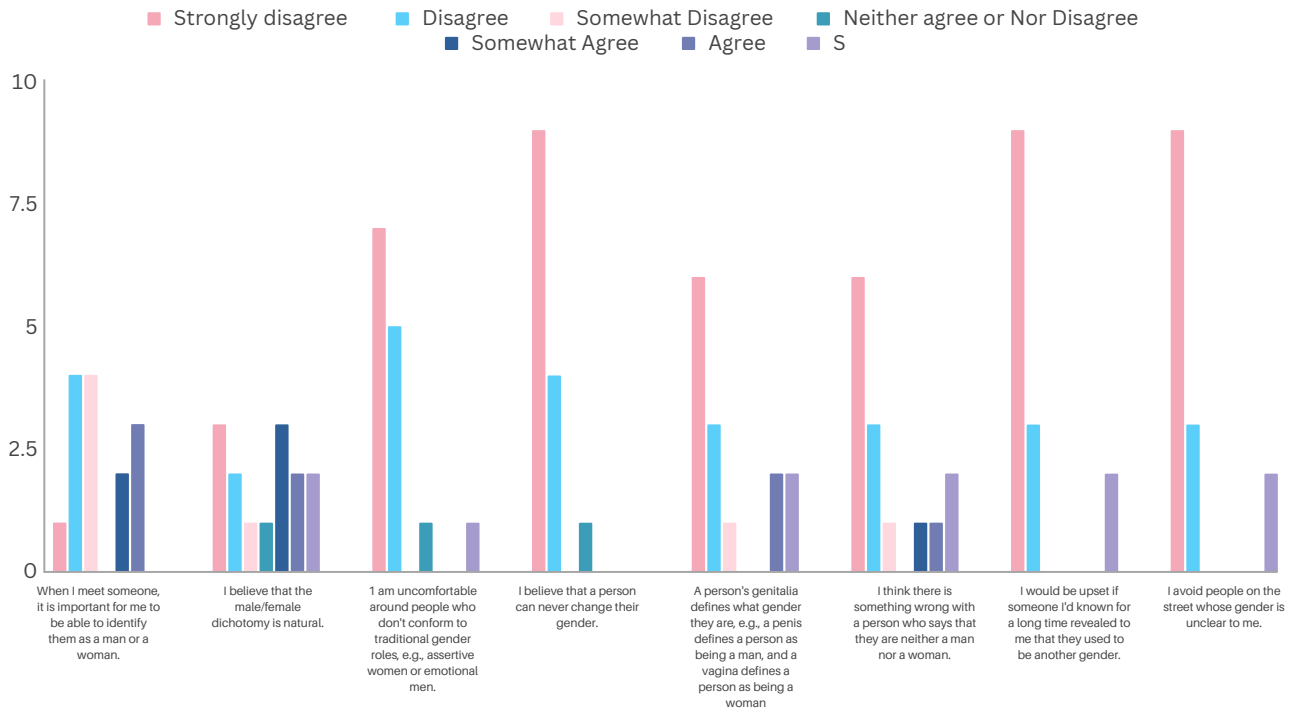
Figure 48. Services provided by healthcare providers



This research measured the gender attitudes scale (transphobia scale) to explore the negative attitudes of healthcare professionals in relation to the gender identity of their patients. Respondents answered on a seven-point Likert scale (1 = strongly disagree; 7 = strongly agree). A transphobia score was calculated as a mean score for eight answered questions (range 1–7), with higher scores indicating a greater degree of transphobia. However, due to data limitation, comparative analysis could not be measured. On average, all respondents scored 2.73. Per country analysis revealed that Indonesia has the highest average of scores (2.91), followed by the Philippines (2.8) and Thailand (2). Interestingly, conflicting attitudes on gender sufaced from 13 responses.

- *35.71% somewhat, agree, and strongly agree on "When I meet someone, it is important for me to be able to identify them as a man or a woman."*
- *50% to somewhat, agree, and strongly agree on "I believe that the male/female dichotomy is natural."*
- *7.14% strongly agree on "I am uncomfortable around people who don't conform to traditional gender roles, e.g., assertive women or emotional men."*
- *Only one neutral response on "I believe that a person can never change their gender." The rest disagree (28.57%) and strongly disagree (64.28%).*
- *28.57% agree and strongly agree on "A person's genitalia defines what gender they are, e.g., a penis defines a person as being a man, and a vagina defines a person as being a woman."*
- *28.57% somewhat, agree, and strongly agree on "I think there is something wrong with a person who says that they are neither a man nor a woman."*
- *14.28% strongly agree on "I would be upset if someone I'd known for a long time revealed to me that they used to be another gender."*
- *14.28% strongly agree on "I avoid people on the street whose gender is unclear to me."*

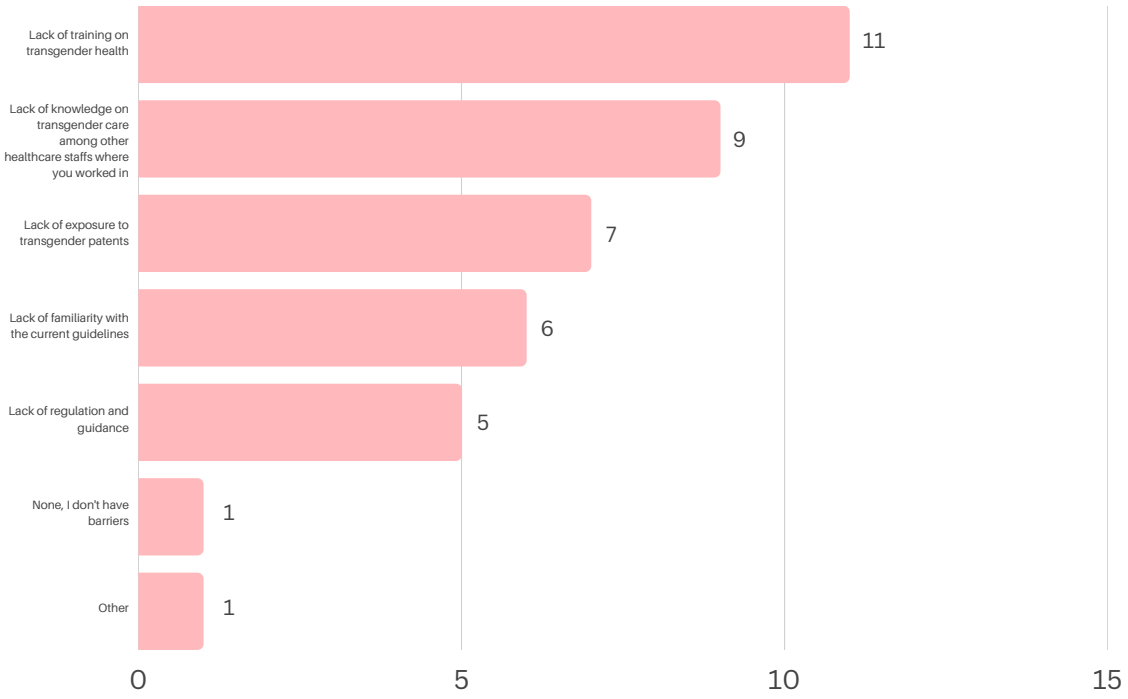
Figure 49. Healthcare providers' attitudes about gender



Perceived barriers in treating transgender patients

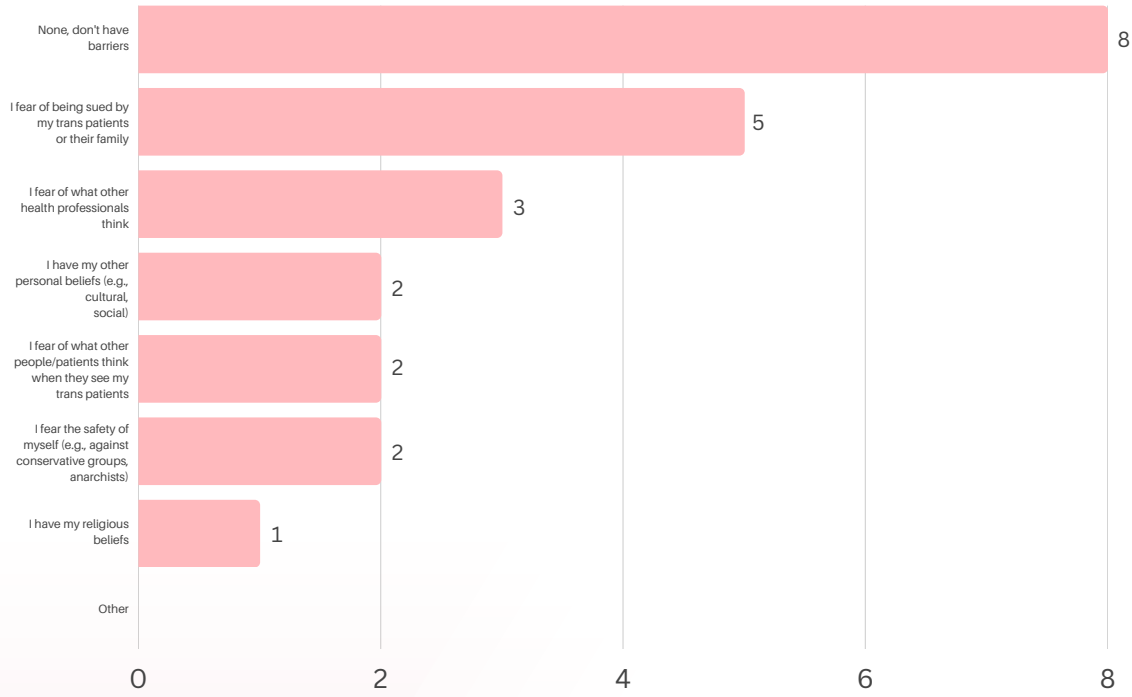
Around 27.50% of healthcare professionals (n=11) responded that lack of training on transgender health remained a primary professional barrier for them in treating trans patients, continued with the lack of knowledge among other healthcare staff they worked with (22.50%; n=9), lack of exposure to trans patients (17.50%; n=7), lack of familiarity with the current guidelines (15%; n=6), lack of regulation or guidance (12.50%; n=5); one listed barriers from the health systems. In contrast, only one responded that they do not have professional barriers to providing transgender health.

Figure 50. Professional barriers in treating transgender patients



With respect to social barriers, although 34.78% of respondents recorded that they have no barriers (n=8), the fear of being sued was one of the identified barriers for healthcare professionals providing care for their transgender patients (n=5), followed by the fear of what other professionals might think (n=3), other cultural/social/personal beliefs (n=2), fear of what other people or patients think (n=2), fear of personal safety (n=2), and religious beliefs (n=1).

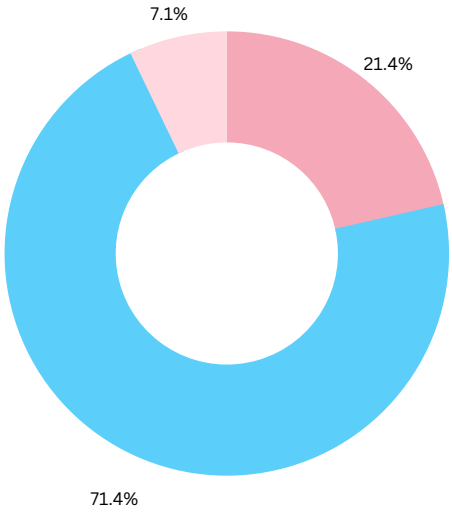
Figure 51. Social barriers in treating transgender patients



Capability and willingness to provide transgender healthcare

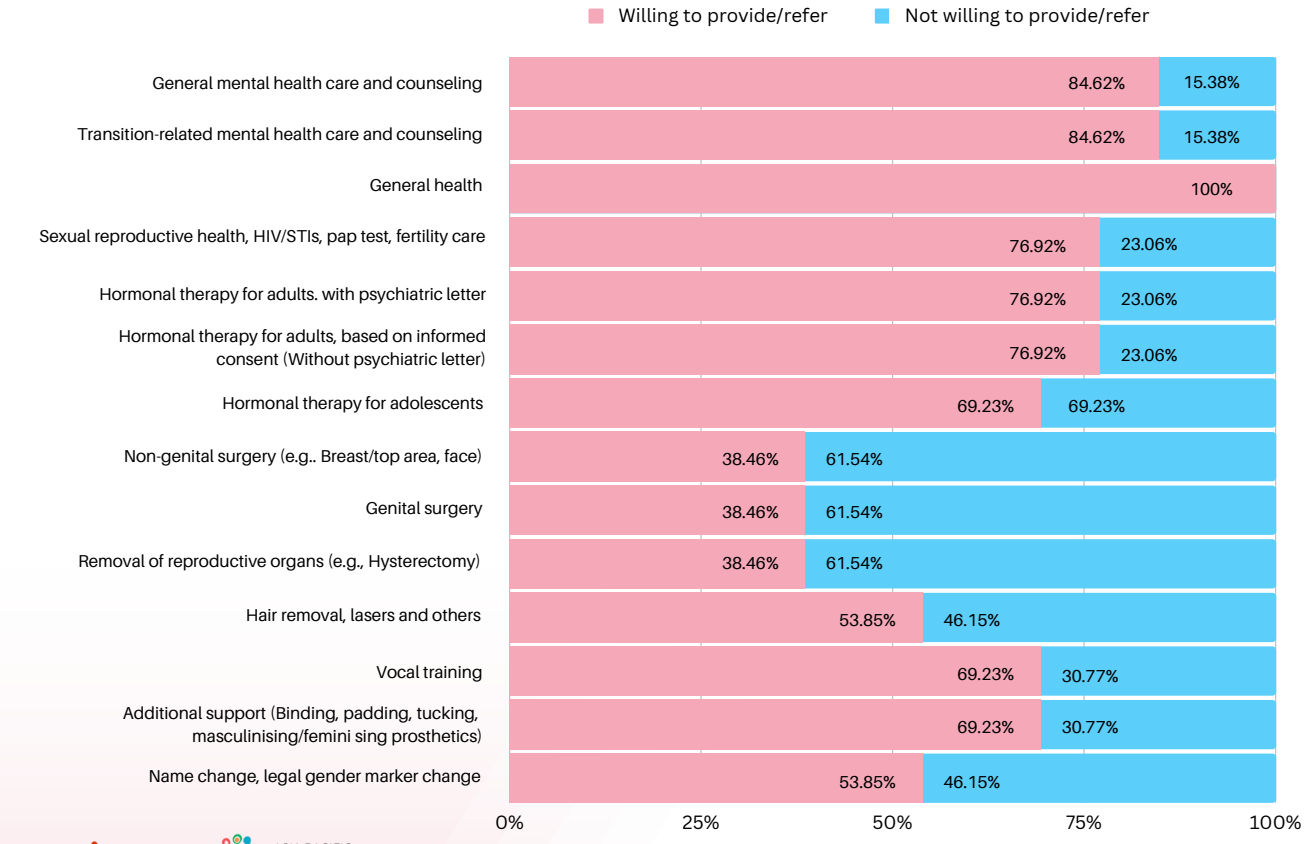
Most healthcare providers had learned about transgender health via informal training, such as self-directed learning, research, and learning from the community (n=10). In contrast, only few learned through formal training, such as medical school, nursing school, residency, and continuing professional development (n=3). One respondent listed that they never learned about transgender health before, either formally or informally.

Figure 52. Providers' experience learning about transgender health before



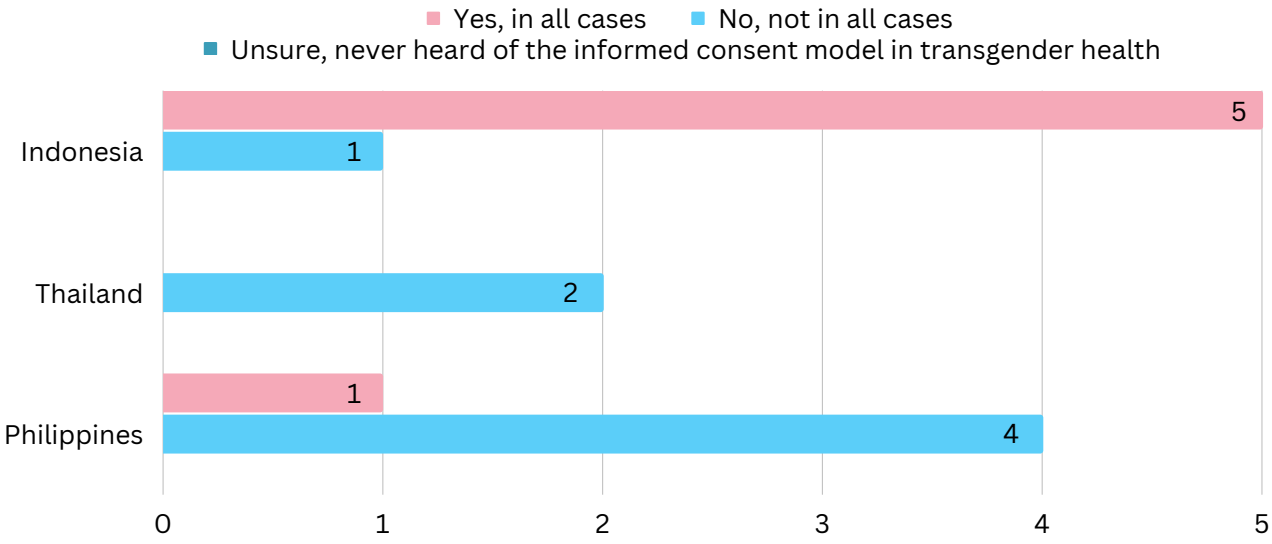
All healthcare providers responded that they were capable of providing routine care for transgender patients. However, when asked about the type of health services they were willing to provide or refer for their transgender patients, we received conflicting answers. All health providers agree to provide or refer on general health, but the willingness decreases when it comes to hormonal therapy (especially for adolescents), additional support (such as binding, prosthetics), legal support, and surgery-related concerns (genital and non-genital surgeries). Furthermore, if given a choice, one responded they would prefer not to treat trans patients.

Figure 53. Type of health services healthcare providers were willing to provide or refer for transgender patients



Regarding the informed consent model, all healthcare providers from Thailand (n=2) responded to "no, not in all cases" when asked about formal and mandatory mental health evaluations prior to initiating hormonal therapy, while 83.33% of practitioners from Indonesia (n=5) and 20% from the Philippines (n=1) still thought that it is mandatory. In total, 46.15% of healthcare providers responded "yes, in all cases" (n=6) and 53.85% responded "no, not in all cases" (n=7).

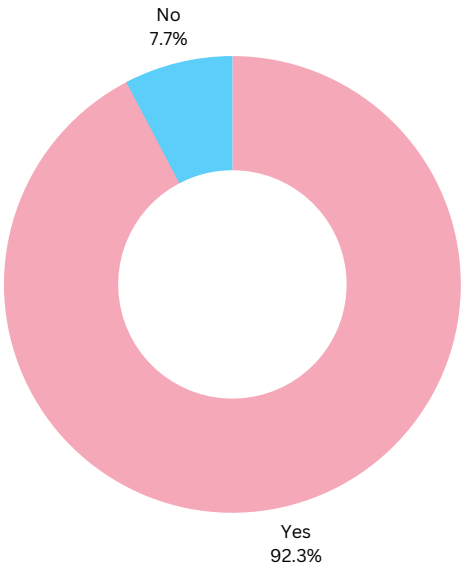
Figure 54. Healthcare providers' perspectives on the informed consent model based on country



Healthcare provider's preference on education

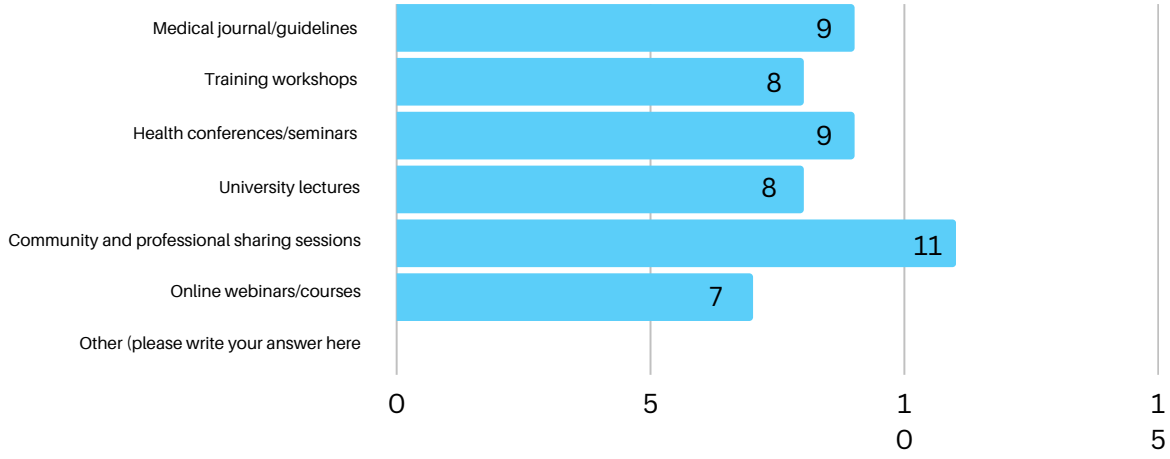
Most respondents agree that transgender health and related information should be taught in medical and other health professional schools (n=12).

Figure 55. Providers' perspectives on transgender health and related information being taught in medical and health professional schools



Several methods of preference in receiving transgender health information were varied, including community and professional sharing sessions (n=11), continued with medical guidelines (n=9), health conferences or seminars (n=9), training workshops (n=8), university lectures (n=8), and online webinars or courses (n=7).

Figure 56. Providers' preferences in receiving transgender health information

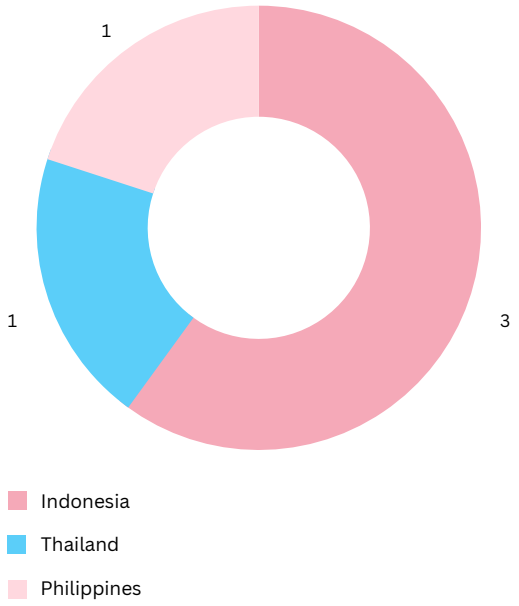


Responses from parents, legal guardians, and family members with transgender youth

Demographics of parents, legal guardians, and family members with their transgender youth

This survey managed to capture five respondents sharing their experience navigating the healthcare system for their transgender youth (18-30 years old). Out of 8 respondents answered, five fully answered the survey questions substantially. Three respondents came from Indonesia (Bali, West Java, Jakarta), one from Thailand (Chiang Mai), and one from the Philippines (Batangas).

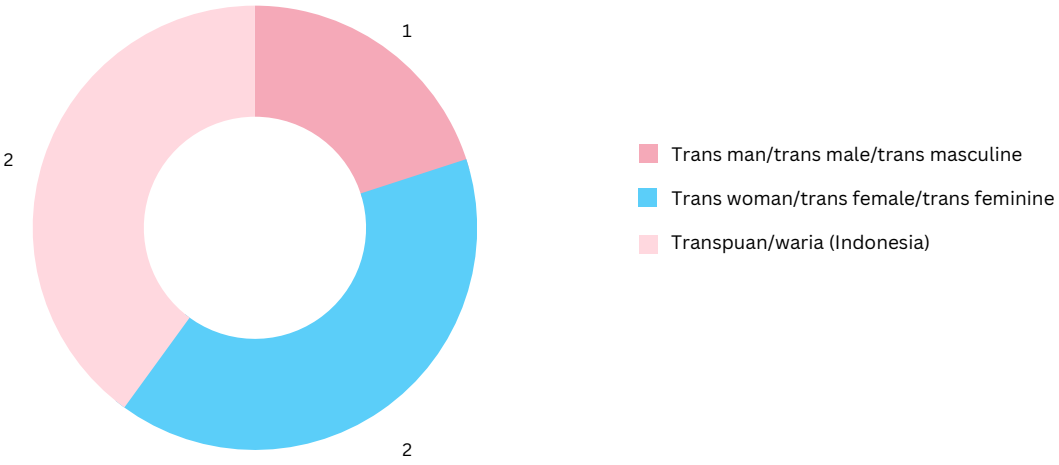
Figure 57. Parents, legal guardians, and family members' country of residence



With the age range of 21-56 years old, most of the legal guardians were assigned female at birth and identified as female (4:1). Two respondents were parents, one sibling, one aunt/uncle, and one friend as legal guardians. Three respondents were married, one was single (never married) and one preferred not to say. In terms of sexuality, three identified as straight, one as bisexual/pansexual, and one prefer not to disclose. Three of the respondents had university or tertiary qualifications, one with a high school education, and one with a vocational apprenticeship. In terms of work, one was employed on a full-time basis, one on a part-time or casual basis, one on an informal basis, one doing home duties full-time, and one was a student. Two respondents make more than > US$750, two made around US$ 300-450, and one made around US$50-150.

Trans youth in respondent's families were reported to identify and start living as their gender at the age bracket of 7-24 years old (age 7, 13, 16, 20, and 24 years old). Mostly were assigned male at birth (4 out of 5), with four identified in the feminine spectrum and one in the masculine spectrum. There were several spectrums of sexuality reported, with each being same-gender loving, straight, bisexual/pansexual, not sure, and not known.

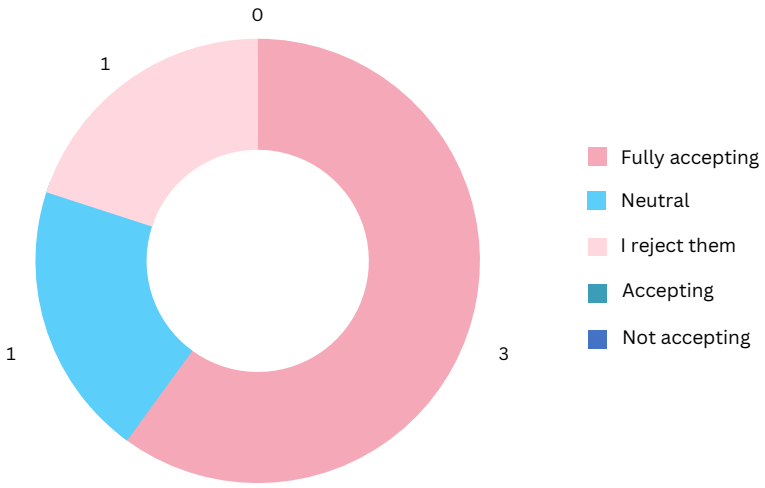
Figure 58. Gender identities of trans youth, listed by parents/legal guardians/family members



Parental and family acceptance, support, and attitude around gender

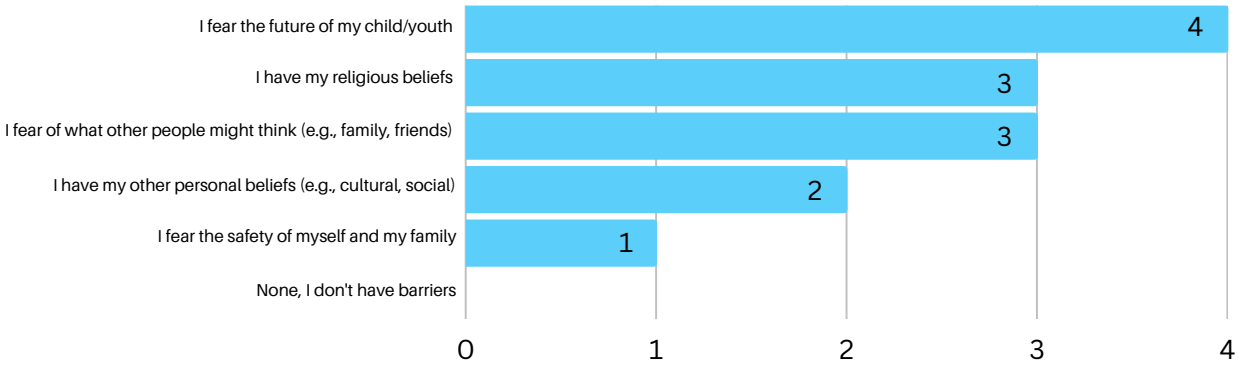
In terms of acceptance, three respondents were fully accepting, one was neutral, and one rejected the identity of their youth. Evidence showed that parental and family support could serve as protective factors for transgender and gender-diverse individuals against low self-esteem, desire to leave home, and even homelessness (Seibel et al., 2018). Furthermore, parental support is associated with higher quality of life and better health conditions (Simons et al., 2013).

Figure 59. Acceptance towards trans youth



"Fear for my child's future" remained the top barrier for respondents to fully accept their transgender youth (n=4), continued with religious beliefs (n=3), fear of what other people might think (n=3), personal beliefs (n=2), and fear of personal and family's safety (n=1).

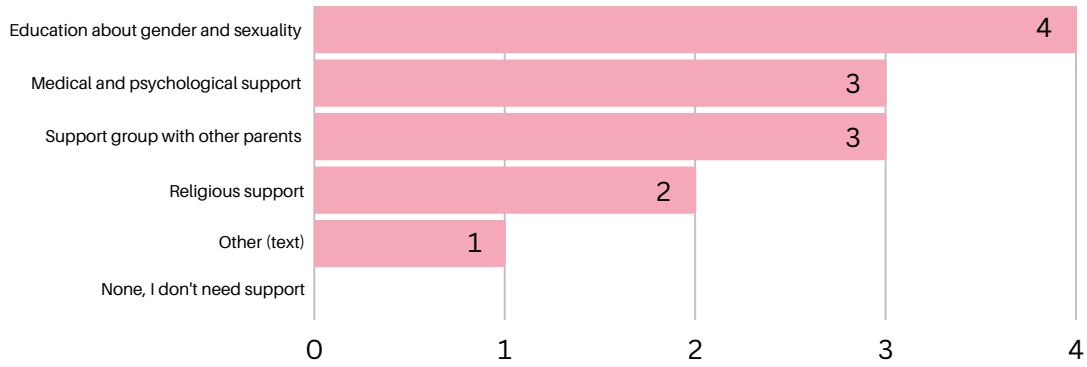
Figure 60. Parental barriers to fully accept my trans youth



To better understand and support their trans youth, our respondents revealed the importance of education around gender and sexuality (n=4), medical and psychological support (n=3), support groups with other parents (n=3), and religious support (n=2). One person responded with:

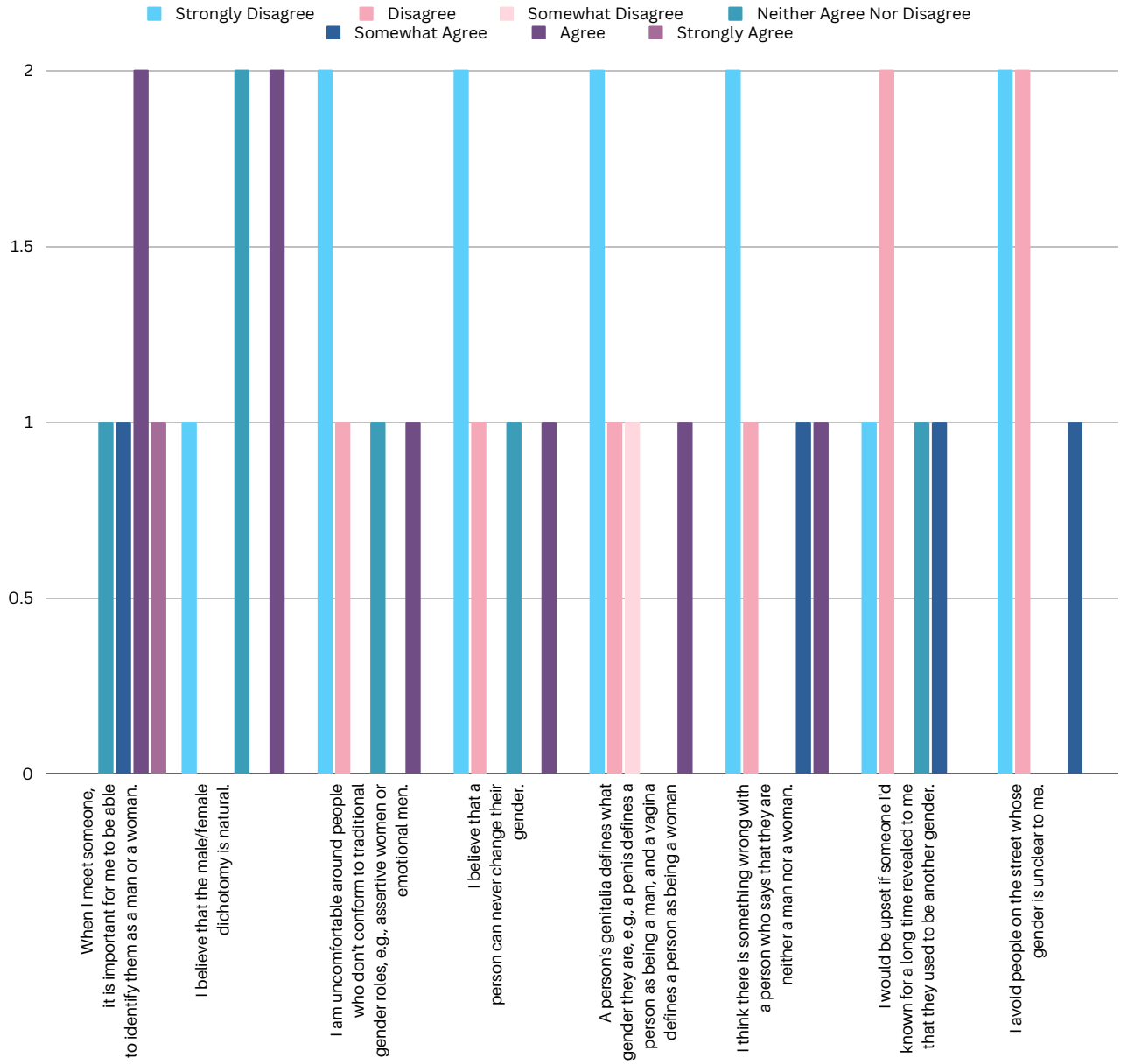
> *"Educational support (is important). It is very common that trans persons in Indonesia, left the school very early because they've been bullied horribly." - 21 yo woman (legal guardian), Indonesia*

Figure 61. Types of support that parents needed to better understand and support trans youth



Regarding attitudes toward gender diversity, parents, legal guardians, and family members who responded to this survey generally have conflicting values in dealing with gender-diverse individuals. The gender attitudes scale revealed 3.25 as the average score, with the highest score being 5.

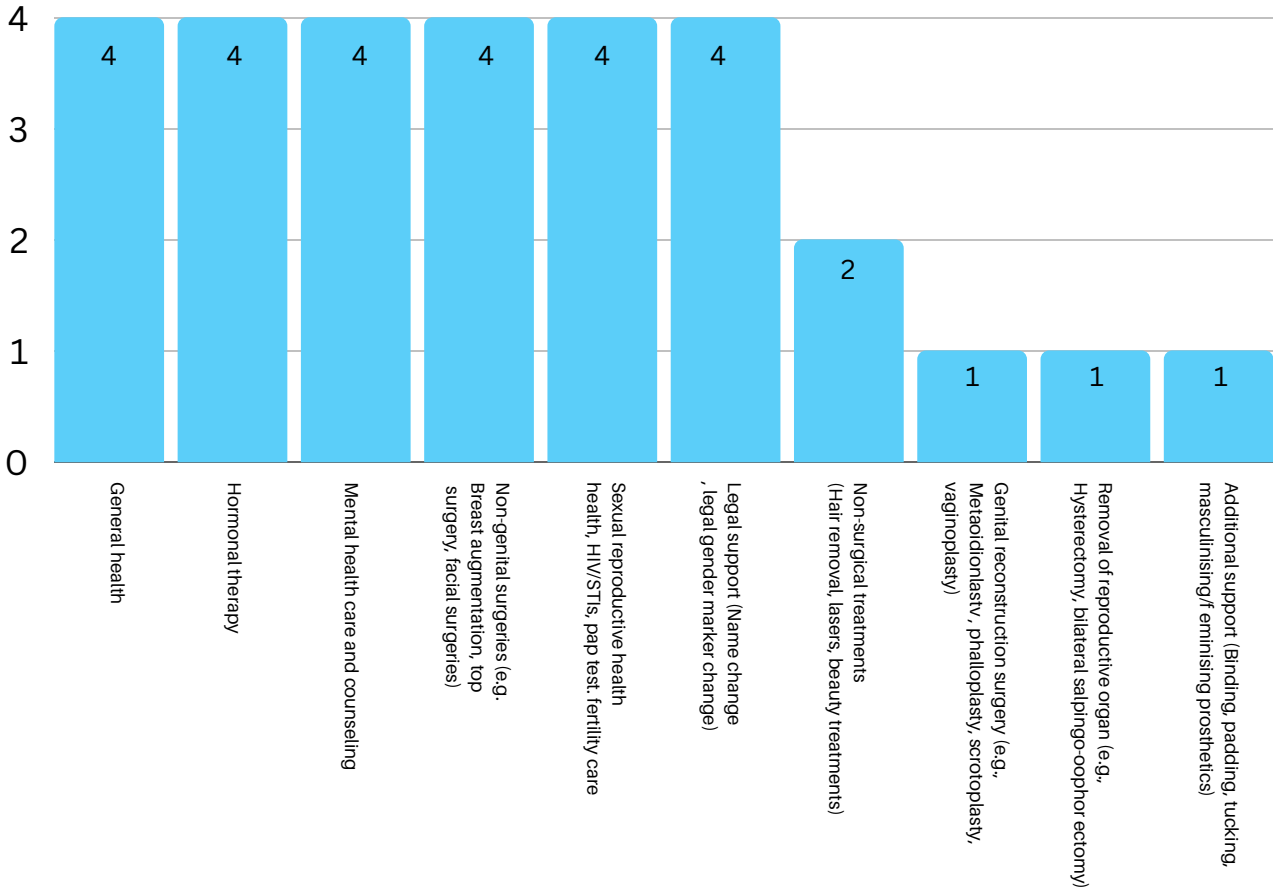
Figure 62. Parental attitudes about gender



Parental and family perspectives around transition

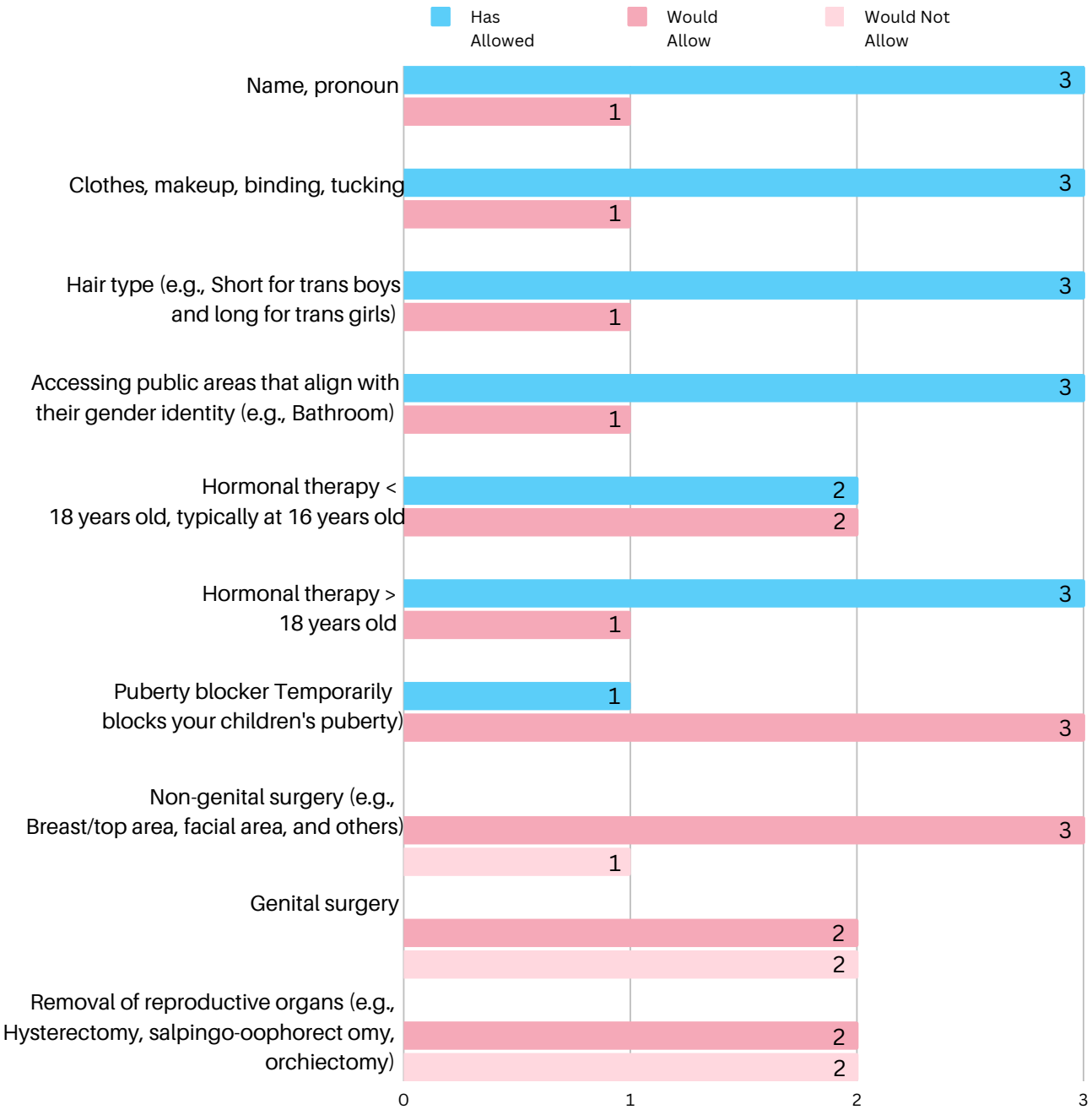
All recorded responses revealed that all respondents preferred to have medical supervision when their child or youth is transitioning (n=4). When asked about the appropriate age for someone to begin their transition, two respondents thought that there was no specific age for a child to transition, all depending on their journey, and two others responded with the age of 17 and 25, respectively. When asked about the kind of support that their youth needed, all responding respondents answered on the importance of general health, hormonal therapy, mental health, non-genital surgeries (breast or top surgery, face), sexual reproductive health, and legal support to change the legal name and/or gender marker (n=4, each). The least chosen answers were non-surgical beauty treatments, genital reconstruction, removal of reproductive organs, and additional support such as binding and tucking.

Figure 63. Types of care that trans youth need during their transition based on their parents, guardians, or family members



Moreover, in regards to the type of transition that one would allow their trans youth to have were the use of names, pronouns, clothes, hair, and public spaces that aligned with their gender identity. Three out of four recorded responses have allowed hormonal therapy for those older than 18 years old, compared to two responses for those under 18 years old. Around three respondents would allow the use of puberty blockers, with one already did. There seemed to be a higher response for those who "would not allow" surgery-related interventions (genital and non-genital surgery, removal of reproductive organs), compared to other gender-affirming practices.

Figure 64. Types of transition that parents, guardians, or family members would allow



Healthcare access for parents, legal guardians, and family members with transgender youth

Public hospitals remained the top type of healthcare facilities accessed by youth and their families (40%; n=4), continued with other types of healthcare facilities, such as public hospitals (n=2), public clinics (n=2), and private clinics (n=2). Most respondents accessed healthcare using out-of-pocket expenditure (80%; n=4), and only one responded on the use of government insurance.

Figure 65. Types of healthcare facilities accessed by youth and their family

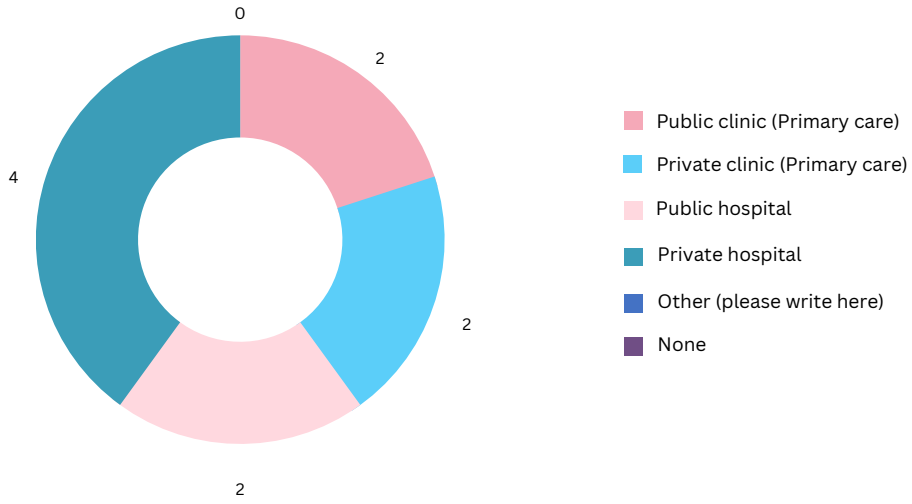
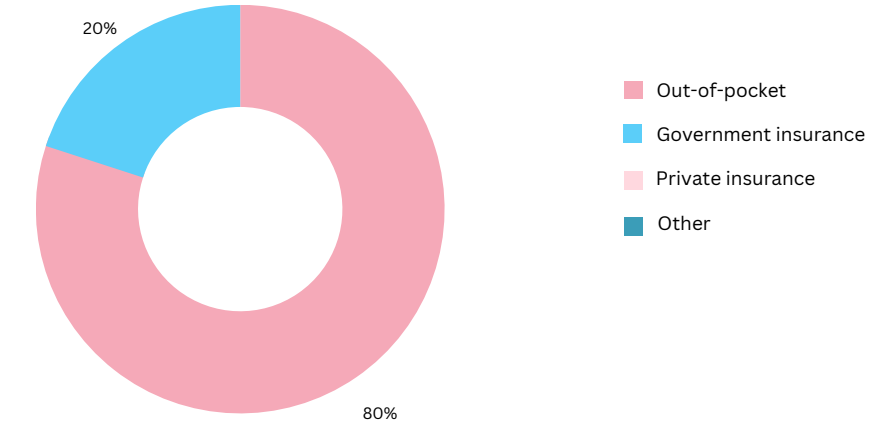
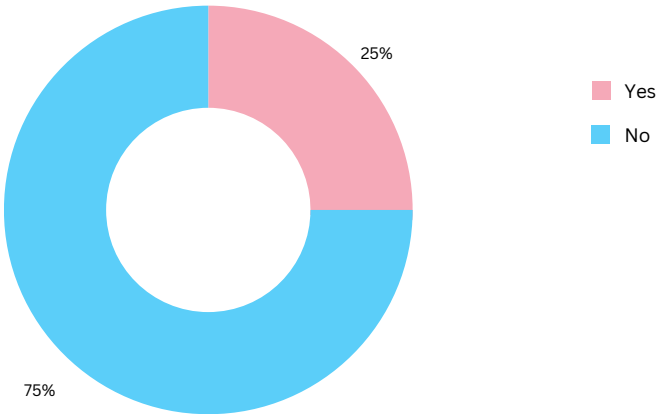


Figure 66. Type of payment coverage accessed by youth and their family



The type of healthcare providers seen were quite varied, each from general physicians or family doctors, psychologists, psychiatrists, obgyns, and midwives. However, when asked about whether they felt that their current healthcare provider provides them with proper transgender care, only one out of four respondents said "yes."

Figure 67. Opinions on whether the current healthcare providers offered proper transgender health services for parents, legal guardians, and family members of trans youth



All recorded responses (n=4) believed that mental health evaluations should be mandatory and formal prior to starting hormonal therapy. Parents, legal guardians, and family members of trans youth would expect their providers to have knowledge of transgender health (n=4), be comfortable interacting with trans patients (n=4), be able to address transgender-specific healthcare needs (n=3), and working in health facilities that were trans-inclusive (policies, forms) (n=4) and welcoming (n=3). Furthermore, the top three hardships in accessing gender-affirming services were the inability to find doctors to help or any proper health facilities (n=2), the financial cost of laboratory and other examinations (n=2), and pathways/regulations to accessing hormones too difficult (n=2).

Figure 68. Qualities parents, legal guardians, and family members want to see in a healthcare provider

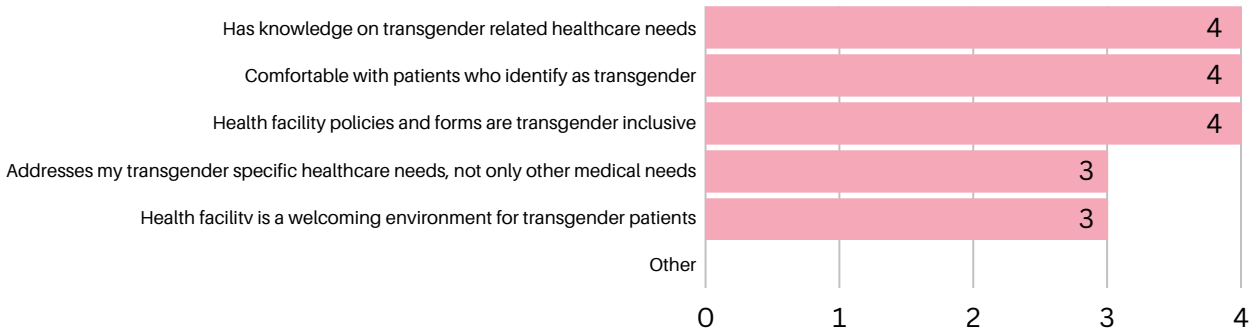
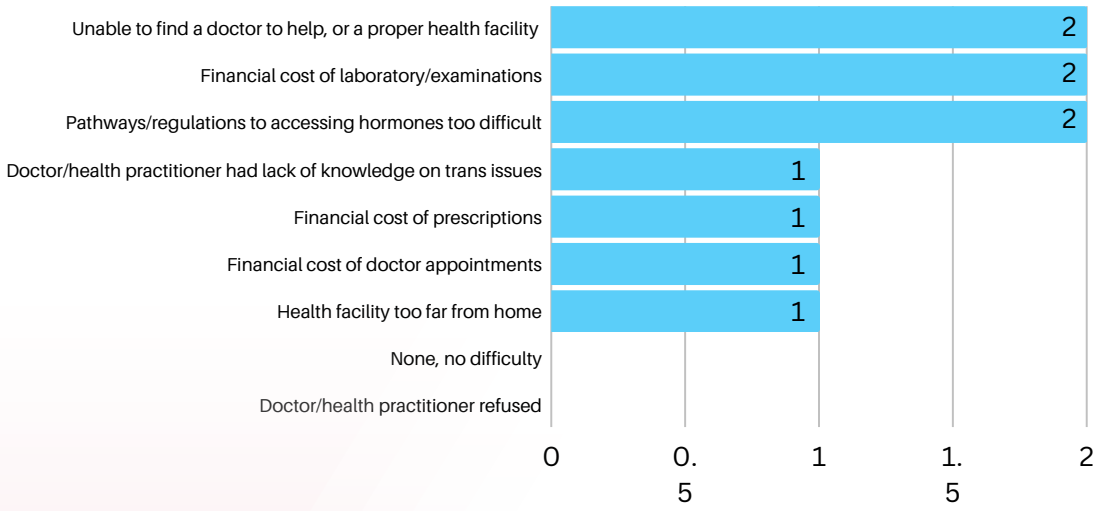


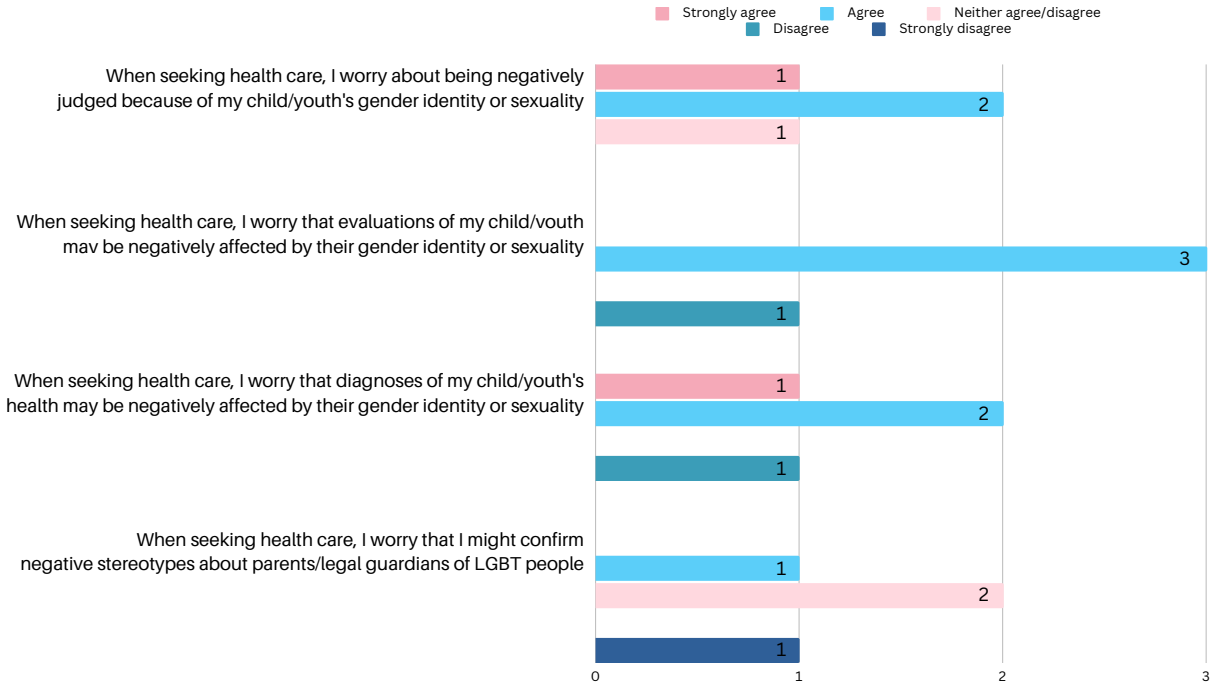
Figure 69. Difficulties of parents, legal guardians, and family members in accessing gender-affirming services



Discrimination and abuse in healthcare, experienced by parents, legal guardians, and family members' of transgender youth

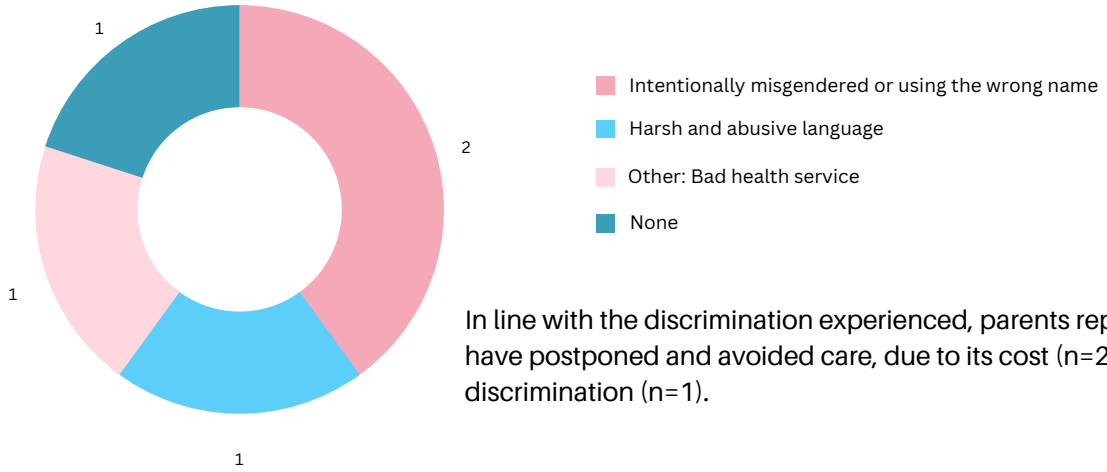
There was a varying level of concerns and biases when accessing healthcare, with some responding that they were worried about being negatively judged by healthcare providers (n=3), amplifying the stereotypes due to the identity of their transgender child or youth (n=1), and whether such identities affected medical diagnoses (n=3) and evaluations (n=3). In general, two recorded responses stated that they had doctors who made them feel uncomfortable or unwelcome in the healthcare settings, and one responded on non-healthcare providers. The frequency of any discriminative experiences were "sometimes" (n=3) and "rarely" (n=1).

Figure 70. Parents, legal guardians, and family members' concerns when accessing healthcare



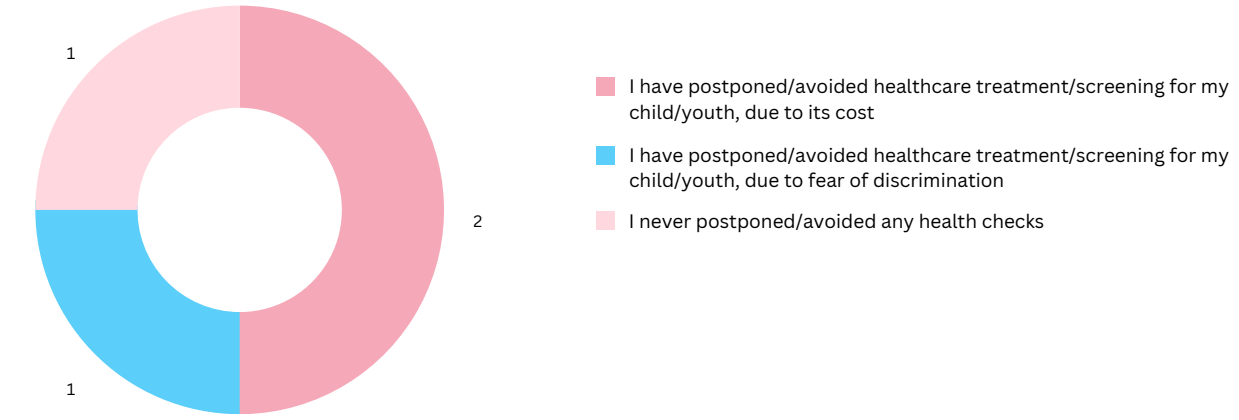
The study explored the types of abuse experienced by trans youth and their parents, legal guardians, and family members. Some themes popped out, including the intentional use of the wrong name or being misgendered (n=2), harsh and abusive language (n=1). One response listed, "bad health service" as their answer. One respondent listed that they do not experience any form of abuse (n=1).

Figure 71. Types of abuse experienced by trans youth and their parents, legal guardians, or family members



In line with the discrimination experienced, parents reported that they have postponed and avoided care, due to its cost (n=2) and fear of discrimination (n=1).

Figure 72. Parents, legal guardians, and family members' experience in postponing or avoiding healthcare



Parents, legal guardians, and family members' access to health resources and their priorities for funding

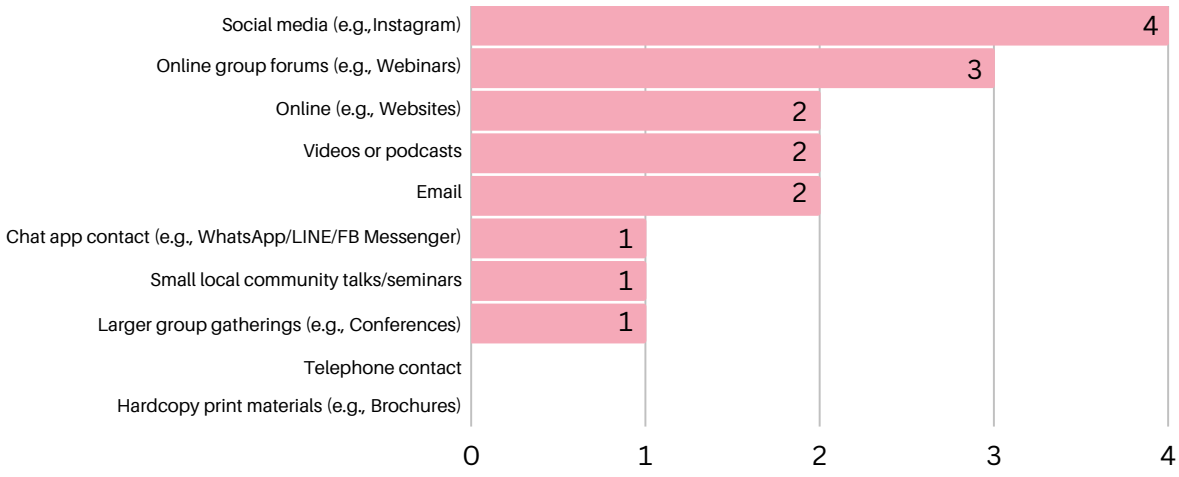
Most parents and legal guardians would expect to have access to universal health coverage, which also includes transgender health (n=4), continued by other no less important priorities, such as mental health services (n=3), education about gender diversity (n=3), referral network (n=2), better training of healthcare professionals (n=2), trans-related health research (n=2), support groups (n=2), and trans advocacy groups (n=2). The bottom priorities were access to general health services (n=1) and gender clinics (n=1). Three respondents expected both online and offline care, while one preferred offline or in-clinic consultation.

Table 7. Parents, legal guardians, and family members' top priorities for healthcare and funding

#	Field	Choice Count	
1	Access to universal health insurance	18.18%	4
2	Access to general health services (e.g., Local clinic/GP)	4.55%	1
3	Gender clinics: An all-inclusive/one-stop facility for gender-affirming care	4.55%	1
4	Referral network of doctors and health practitioners for trans health	9.09%	2
5	Counseling, psychology, and psychiatric services	13.64%	3
6	Better training for doctors and other healthcare professionals	9.09%	2
7	Education about gender diversity (e.g., Community or schools)	13.64%	3
8	Trans or gender-related medical research	9.09%	2
9	Support groups	9.09%	2
10	Trans advocacy groups	9.09%	2
11	Other	0.00%	0

Most parents, family members, and legal guardians would prefer online deliveries as the primary methods of receiving transgender health information, such as social media (n=4), online groups (n=3), websites (n=2), videos/podcasts (n=2), emails (n=2), chat application (n=1), while some do prefer local seminars (n=1), or large group gatherings (n=1). Most respondents were using Instagram (n=4), continued with Facebook (n=2) and TikTok (n=1).

Figure 73. Parents, legal guardians, and family members' favored methods of receiving health information



Discussion and analysis

Considering cultural context

There is significant variation between countries in Southeast Asia on many categories used, including the understanding of gender, social, legal, and cultural context, as well as medical practitioners' knowledge, presence of transgender health guidelines, and the community's experience of discrimination, relationship, and trust in healthcare providers (APTN, 2020, 2021a; Chiam et al., 2020; UNDP & APTN, 2017). While the small number of results made it hard to generalize, Thailand, in particular, is likely to be a distinct context relative to Indonesia and the Philippines, with lower rates of discrimination and greater availability of medical experts (in metropolitan areas). For example, the speculation that Thailand is a destination for gender-affirming care from other nations in Southeast Asia is reflected in country-level results, which revealed that a majority of respondents from Indonesia (n=20) and the Philippines (n=15) preferred to access surgeries overseas, whereas all respondents from the Thai sample (n=6) reported that they would prefer to access surgeries in their own country. While researchers did not ask where they would like to go for surgeries, existing research suggests that Thailand is a popular destination for medical tourism for transgender populations (Gale, 2015; Tan, 2022). Any future approach must take into account distinct country contexts or regulatory environments when developing any guidelines or training modules, with a strong potential to explore the dynamics of overseas travel for gender-affirming care.

Understanding health challenges of transgender

The majority of respondents rated their overall health as good or very good, but they also reported experiencing physical and mental health issues in the past 30 days that interfered with their daily activities; with youth experiencing an average of 6.10 days with physical illness and 11.17 days with mental health issues in the past month, that adds up to a total of around 8.45 days during which they faced physical or mental health challenges that hindered their activities, including self-care, work, or recreation. A high percentage of respondents had been diagnosed with a mental health condition (71%; n=28), with depression (n=21) and anxiety (n=20) being the most common. This report also found a small number of respondents using drugs to get high (n=6), and some were reportedly smoking (n=13) and drinking (n=30) while on hormonal therapy, even though it is not recommended (Coleman et al., 2022). Some analyses have noted the increased mortality among trans and gender-diverse populations, in comparison with their cisgender counterparts (Jackson et al., 2023; Wise, 2021), as well as physical and mental health challenges burden faced by this population throughout the life course (Seelman, Young, et al., 2017; Su et al., 2016). Overall, the findings emphasize the need for larger research to map the overall physical and mental health conditions of trans individuals in the Asia Pacific region, especially on its relation with minority stress and health impacts (Pellicane & Ciesla, 2022).

Context on hormones and gender-affirming care: A "harm reduction" approach

More than half of the trans youth respondents (59.38%; n=38) reported undergoing hormonal therapy, with an average age starting at 21 years old and the youngest at age 14. The majority of respondents who were not currently undergoing hormonal therapy expressed their intention to do so in the future (69.23%; n=18). However, less than half of the respondents were doing hormonal therapy with medical supervision (42.11%; n=16). Some noticeable differences include: 1) a higher number of trans youth in Indonesia and the Philippines underwent hormonal therapy without medical supervision compared to those in Thailand (13 and 12 respondents from Indonesia and the Philippines vs. one from Thailand), 2) trans-masculine-identified respondents were more likely to seek medical supervision during hormonal therapy compared to those in the trans feminine categories, and 3) while only a small percentage of respondents (17.65%; n=12) received information on hormonal therapy from healthcare providers, trans feminine individuals were more likely to seek information from peers and the internet compared to those in the trans masculine spectrum. This result is in line with previous studies conducted by APTN, indicating the importance of a more grounded approach in transgender healthcare and the need to explore the health-seeking behaviors and experiences between trans feminine and trans masculine individuals in accessing healthcare (APTN, 2021a).

In this sense, healthcare providers were not the primary source of information on hormonal therapy for most trans youth respondents, as they relied on peers, support groups, and the internet. On the other hand, there is a danger in self-medicating for transgender youth who seek to live their lives authentically, which might lead to adverse health effects or even death (ASEAN SOGIE Caucus, 2016; Idrus, 2013; Ivanka Custodio, 2019). Therefore, such premises should be taken into account while delivering transgender healthcare.

The results of the study revealed high levels of well-being among respondents, as well as skillful negotiation in challenging environments to access trans health. The findings that respondents were accessing hormonal treatment without medical supervision suggested that transgender youth were already finding relevant information on their own, or through peer networks. Following our proposed harm reduction approach, the correct information on safe hormonal use and other forms of gender-affirming care should be distributed via peer-led pathways, relevant to each country's context, in addition to the available healthcare system delivery models (APTN, 2020; Hiransuthikul et al., 2022; Samuel, 2021; van Griensven et al., 2021). This means that approaches to transgender health should be broadened to encompass a more holistic understanding of health and its socio-behavioral aspects, moving beyond the narrative of gatekeeping and stigma, into the basis of consent and empowerment. Furthermore, there is a need to develop proper social and behavior change communication (SBCC) strategies, especially for those who choose to medically transition by themselves. This includes designing specific interventions (online or offline), establishing intended audiences, setting behavioral communication objectives, and determining consistent messages, materials, and activities (UNICEF, 2023).

A challenge of cost and the need for universal health coverage for transgender health

The data shows that a majority of respondents pay for transgender healthcare privately (out-of-pocket), which suggests a structural barrier to access lies in cost, particularly for economically disadvantaged populations. Results for both transgender youth respondents and parents or family members of trans youth were aligned with previous studies (APTN, 2020, 2021a), indicating that out-of-pocket expenditure remained the primary health financing method for trans individuals in accessing health services (56.17%; n=50). On the other hand, universal health coverage is also placed as one of the highest priorities of needs for trans individuals (n=52). This is well reflected in both overall and country-level analysis, as well as on gender identity basis. Future research should work on investigating the dynamics of universal health coverage, gender equality, and social protection (UN Women, 2020), that transcend beyond the narrative of financial protection, but also on service and population coverage, and how it applies in gender-affirming care and other health services for trans youth and adults (Macdonald et al., 2022).

Furthermore, around 55.88% of trans masculine respondents reportedly accessed private health facilities (n=19), while a slightly greater percentage of trans feminine and non-binary respondents preferred accessing public health facilities, at 57.14% (n=33) and 54.54% (n=6) respectively. This might indicate some financial and access inequalities across gender identity spectrums (APTN, 2021a), although larger data and investigations are required. On a broader scope for what counts as trans healthcare, there is a need to extend gender-affirming care to a range of different needs of care, including general care, mental health, and more. With that being said, healthcare inclusion for trans individuals should be guaranteed using a human rights-based approach to health; it should be available, accessible, acceptable, and held to the highest attainable quality.

Addressing discrimination faced by transgender youth

Transgender youth do experience concerns when accessing care, with the worry of being negatively judged due to their gender identity or sexuality (n=52), worry that their health evaluations (n=50) and diagnoses (n=50) might be negatively be affected by their gender identity or sexuality, and that they might confirm negative stereotypes about LGBT people (n=47). The study further captured several notions that discrimination in the healthcare settings still persisted, with the most common being the intentional use of a wrong name or misgendering (33.68%; n=32), refusal to provide transition-related healthcare (14.74%; n=14), and the use of harsh and abusive language (14.74%; n=14). Four trans youth respondents also reported instances of unwanted sexual contact and one reported experiencing physical abuse. Parents, legal guardians, and family members also reported several abuse incidents, such as the intentional use of the wrong name (n=2) and the use of harsh language (n=1).

Although beyond the scope of this study, prior research showed a significant association between delaying healthcare (due to fear of discrimination) and worse general and mental health conditions among transgender people (Seelman, Colón-Diaz, et al., 2017). Furthermore, the 2015 U.S. Transgender Survey revealed that 22.8% of respondents avoided healthcare due to anticipated discrimination; other risk factors include living in poverty and visual nonconformity, or being recognized as transgender by others (Kcomt et al., 2020). Further studies in the Southeast Asia region should investigate the specific reasons why transgender people postpone and delay access to healthcare, as well as the importance of transforming the healthcare environment and workforce to be more inclusive.

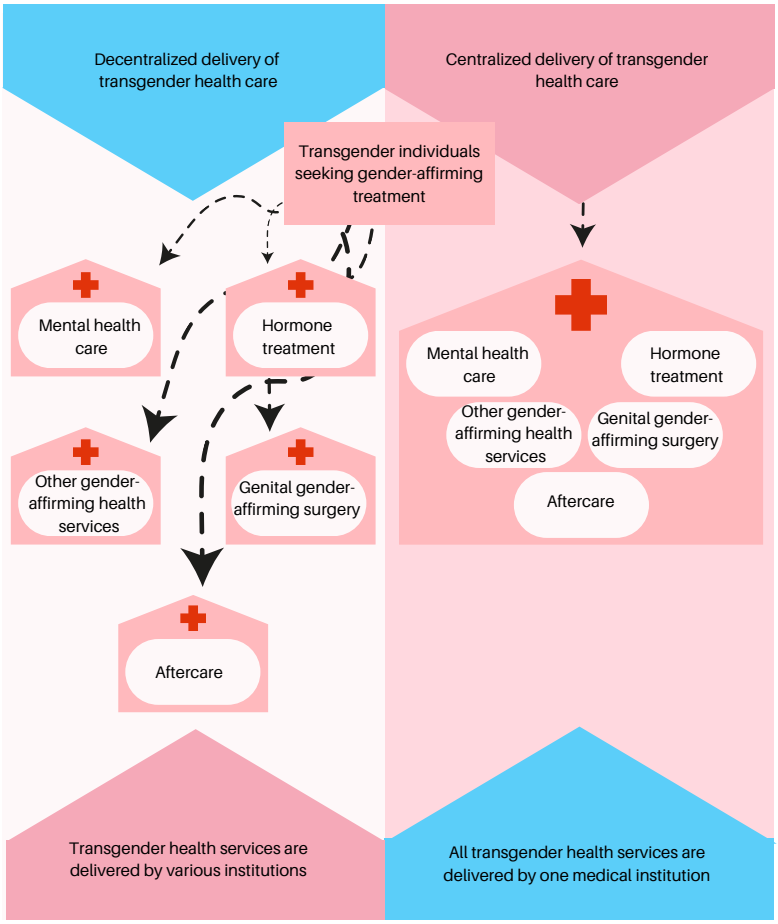
Transgender healthcare needs to not only be available, but also acceptable, accessible, and attained with the highest quality

When asked whether respondents felt that their current healthcare provider provides them with proper transgender care, most respondents answered with "no" and "unsure." This raised the question of quality and acceptability of care, on top of availability and accessibility. Rigorous efforts in improving healthcare quality for trans and gender non-conforming patients (and their families) should be implemented through a multifaceted and community-engaged approach, which includes the component of a transgender advocacy program, community advisory board, and transgender health clinic. Furthermore, key measures to monitor and evaluate all assessments and interventions should be a priority (Boyd et al., 2022; Ding et al., 2020).

In terms of funding priorities, transgender youth respondents prioritized the establishment of a gender clinic as the top priority (12.56%; n=55). In general, there are two types of service delivery models for transgender healthcare: a decentralized and a centralized delivery approach. These models vary between countries and healthcare systems. Recent evidence has shown that both service delivery models have certain advantages and disadvantages depending on the context. The study suggests moving beyond a focus on healthcare availability, for example, whether through a specialized gender unit in a teaching university hospital (as a centralized delivery mode), or referral networks of clinics to cater to transgender health, but rather on extending the focus to the delivery of quality care to improve health outcomes. The data from this study suggests the following question as an important starting point for evaluation of impact: "Does this health service delivery model affect the clinical outcome of transgender patients (e.g., quality of life)?" Proven approaches that facilitate the delivery of quality care include the involvement of transgender people in healthcare deliveries, interaction with community organizations, professional exchange between health providers and caregivers, as well as the availability of health insurance (Koehler et al., 2021). Such efforts should be considered while delivering care for transgender people.

Kevin Marian, courtesy of APTN

Figure 74. Centralized and decentralized delivery of transgender health (Koehler et al., 2021)



Understanding the needs of healthcare providers

There were high levels of reported hormone use without medical supervision. This result can be read with data on varying levels of discrimination reported by transgender youth respondents, combined with the lack of training, knowledge, and welcoming environment from healthcare providers and the healthcare system as a whole. This was reflected as one of the reasons for youth doing hormones without medical supervision, and how it lies in the structural barrier to access quality care. Therefore, teaching healthcare practitioners and other providers about transgender health should not only focus on the knowledge aspect but also on gender and cultural sensitivity. Recent evidence showed that knowledge factors alone, such as the increasing hours of education, might not be sufficient to improve providers' competence in caring for trans individuals. Broader efforts to address transphobia in society and medical education were required to build a welcoming environment and address systemic discrimination (Stroumsa et al., 2019).

These gender transformative approaches include addressing internal biases against different gender identities (masculine vs. feminine spectrums), sexualities (heteronormative vs. non-heteronormative), age (adult vs. youth), types of care provided (surgical vs. non-surgical), and other factors. A majority of respondents had learned about providing transgender healthcare based on their own initiative (n=10). But at the same time, a lack of guidance for healthcare providers in some countries might make it difficult for them to safely provide quality, accessible, acceptable healthcare for trans youth. Some professional barriers listed by healthcare providers in treating transgender patients include the lack of training on transgender health (n=11), lack of knowledge about transgender care among other healthcare staff (n=9), lack of exposure to transgender patients (n=7), lack of familiarity with current guidelines (n=6), and lack of regulation or guidance (n=5). Additionally, some respondents shared social barriers in delivering transgender healthcare, including the fear of being sued (n=5), fear of what other professionals might think (n=3), other cultural/social/personal beliefs (n=2), fear of what other people or patients think (n=2), fear of personal safety (n=2), and religious beliefs (n=1).

Education for healthcare providers must take into account country-specific guidelines, lived experiences, and engagement with professional organizations, accreditation bodies, and training providers. The study showed that there is a need to educate the health workforce as a whole, in both formal and non-formal deliveries, and not only for those who work professionally in delivering health services (e.g., doctors, nurses, midwives), but also those in supporting roles (e.g., security guards, cleaners, laboratorians, and others). The report acknowledged that cultural competency and understanding of intersectionality in the care of LGBTIQ+ patients should be one of top priorities (Bass & Nagy, 2023). Several methods of preference in receiving transgender health information were varied, including community and professional sharing sessions (n=11), continued with medical guidelines (n=9), health conferences/seminars (n=9), training workshops (n=8), university lectures (n=8), and online webinars/courses (n=7). Some great examples for training materials and guidelines were the APTN's "Towards Transformative Healthcare: Asia Pacific Trans Health and Rights Module," (APTN, 2021c) and WPATH's "Stantards of Care Version 8." (Coleman et al., 2022)

Understanding the needs of parents and family members

In terms of acceptance, three respondents were fully accepting, one was neutral, and one rejected the identity of their youth. "Fear for my child's future" remained the top barrier for respondents to fully accept their transgender youth (n=4), continued with religious beliefs (n=3), fear of what other people might think (n=3), personal beliefs (n=2), and fear of personal and family's safety (n=1). When a child transitions, it is a "transition" for their parents and families as well (Dierckx et al., 2016). It is clear from the study that most parents were worried about their child's future after transition, which might potentially impact their level of acceptance. Evidence showed that parental and family support could serve as protective factors for transgender and gender-diverse individuals against low self-esteem, desire to leave home, and even homelessness (Seibel et al., 2018). Parental support is also associated with higher quality of life and better health conditions (Simons et al., 2013). Navigating forward, these aspects cannot be neglected in terms of putting parental acceptance as the primary advocacy agenda. Future research should work on identifying the effects of parental and family support for transgender individuals, as well as navigating factors that influence parental acceptance, such as peer support, information, and quality of the family relationship (Morgan et al., 2022). The toll of advocacy should not only be in the hands of trans communities, but a total collaboration between the communities, parents, and family members, as well as their healthcare providers.

Healthcare delivery and information sharing for healthcare providers, transgender youth, and their families

The survey conducted revealed that a combination of online and offline healthcare delivery was favored by the majority of respondents (57.81%; n=37). Online platforms, social media, online group forums, local community talks or seminars, and videos or podcasts were identified as the top preferred methods for receiving trans health information. Transgender youth, their families, and healthcare providers could definitely benefit from sharing online and peer-supported information about educational materials around gender diversity, gender-affirming care, and accessible providers or health facilities in their area. One good example was provided by TransHub, ACON (ACON, 2023). Instagram emerged as the most widely used social media platform, followed by YouTube, Facebook, Twitter, and TikTok. Parents, legal guardians, and family members also expressed a preference for online methods of receiving transgender health information. To note, all information should be evidence-based, up-to-date, and relevant to preferred communication delivery methods, and adhere to the standards of care (Coleman et al., 2022).

Limitations

The study had a major limitation regarding the short time frame given for conducting the situational analysis in three different countries. Although the data collection and analysis phase was extended, this constraint had implications for various aspects of the study. Due to limited time, there was insufficient opportunity to design and test survey translations, as well as to access extensive networks to ensure an even distribution of the survey in each country. As a result, the responses to the survey were unevenly distributed, with a larger number of transgender youth respondents from Indonesia (n=36), followed by the Philippines (n=22), and a significantly smaller number from Thailand (n=6). This uneven distribution was primarily due to the researchers' networks and presence in Indonesia. Despite efforts to reach a broader audience, language, and network limitations hindered substantial participation from the Thailand context. Additionally, due to time constraints, only the respondents who completed the survey were included in the final data analysis.

With larger data, this research could progress beyond a descriptive analysis of the current situation to a more analytical study, investigating the connections between various factors that either facilitate or hinder the inclusion of transgender youth in healthcare. For example, due to data limitations, it was not possible to fully conclude whether or not there is a correlation between countries of origin and gender identities with a perception of whether healthcare practitioners were providing them with proper care or not. However, further studies (and particularly, qualitative studies, involving interviews and focus groups) should focus specifically on experiences of healthcare according to gender identity, geographical location, and other sociodemographic factors.

Despite these limitations, the study's mixed-method/qualitative design helped address the skewed number of participants across countries and the relatively small sample size. The research serves as a robust situational analysis of transgender youth's access to healthcare in the three countries and provides a crucial foundation for future, more comprehensive research. It highlights the need for qualitative and quantitative studies focusing on the specific impacts of national policies and regulations (or their absence), exploring social and behavioral patterns, and understanding the dimensions of universal health coverage for transgender individuals. Additionally, empowering the community and providing education to healthcare providers, transgender youth, and families are essential aspects that warrant further investigation. It is recommended to conduct research specific to each country, considering their significant differences and the importance of linguistic and cultural expertise in studying each setting.

Future research

With the interest of time and the number of respondents, the study managed to provide new insights into the topic of transgender youth inclusion in healthcare. Moving forward, it is suggested to explore future research with:

1. Larger funding, time, and sampling

Given increased funding and longer duration, this preliminary research has the potential to be expanded in order to gather more extensive quantitative and qualitative data from larger sample sizes in countries such as Indonesia, Thailand, the Philippines, and others. With a larger dataset, this research could progress beyond a descriptive analysis of the current situation to a more analytical study, investigating the connections between various factors that either facilitate or hinder the inclusion of transgender youth in healthcare. This expanded research would take into account the perspectives of healthcare providers, youth, and their families.

2. Online and offline data collection

A limitation of this survey was that it was only online, and therefore we could not access communities that were not linked via online recruitment methods (social media), including the more marginalized populations (e.g., younger, economically disadvantaged, geographically remote, refugee populations, and more). Future research will need to incorporate local community-based organizations in each country to collect offline surveys, interviews, and observations.

3. Disaggregated data for transgender health

Depending on the context of future research, disaggregated data based on gender identity spectrums, education, employment, income, geographical areas (city vs. rural), and other sociodemographic factors can be used as denominating factors in exploring the healthcare access and delivery of transgender youth.

4. Social and behavioral patterns and communication strategies of transgender youth inclusion in healthcare

There is a need to explore the social behavioral patterns of transgender youth accessing care; those doing hormonal therapy without medical supervision, the need of overseas travel for care, and more. Our findings suggest that a combination of the lack of availability of quality services, cost, and other social challenges might contribute to such a reality. In the future, to support the harm reduction approach, a strong social and behavior change communication (SBCC) strategy research is also required to design specific interventions for this population.

5. Universal health dimensions covering transgender healthcare

The current narrative is that cost and out-of-pocket payment became one of the main barriers for trans youth and their families to access proper care. The availability of universal health coverage should extend beyond the narrative of financial protection, but also on service and population coverage. Further research should navigate how this applies to gender-affirming care and other general health services for trans individuals.

6. Not only availability, but also quality, accessibility, and acceptance of transgender health services

While availability is already a challenge, current healthcare delivery models do not provide enough insights into the quality of services available in each country. Future research should work on capturing these elements, even better if created as a part of proper monitoring and evaluation process.

7. Population under 18 years old

There is a dire need to engage with transgender youth under the age of 18. While the legal risk might be daunting for researchers, we argue on the importance of working with healthcare providers, particularly those who provide transgender health for youth and their families, as well as support groups for parents to better capture the need of this population. Another strategy is to provide assent for children and youth under 18.

8. Exploring the needs of parents, legal guardians, and family members in supporting their youth

With a number of positive outcomes from parental and family support, further research should investigate factors that influence parental support for their youth, either through education, peer support, and quality relationships.

Renz Narciso courtesy of TMPH

Recommendations

1. Aligning transgender healthcare with the country and cultural context: Supporting participatory approach in developing healthcare policies, guidelines, and research

- The report recommends the development of trans-inclusive health policies and clinical pathways in countries where these are not in place.
- The results revealed that this requires a commitment from various stakeholders, including the government, healthcare providers, community organizations, and other key stakeholders involved in supporting the health and well-being of transgender youth.
- Any policies, decisions, and research designated to trans youth should only be made using a participatory approach, extending the involvement of the community members and experts from planning through to implementation, using an evidence-based approach.
- While beyond the scope of this analysis, specific consideration should be given to those under 18 years old, on how to navigate a system that can provide respectful care to one's needs, alongside their families.

2. Amplifying the importance of universal health coverage, social security, and a human rights-based approach to transgender health

- Universal health coverage was placed as one of the highest priorities which would meet the needs of transgender individuals in accessing healthcare. Data shows that a majority of respondents pay for transgender healthcare privately (out-of-pocket). This suggests a structural barrier to access lies in cost, particularly for economically disadvantaged populations.
- On a wider scope, it is recommended to extend beyond gender-affirming care to a range of different needs of care, including general care, mental health, social security, and other needs. With that being said, healthcare inclusion for trans individuals should be guaranteed using a human rights-based approach to health.

3. Preparing the health workforce to provide proper care for transgender people

- There were high levels of reported hormone use without medical supervision. This result can be read with data on varying levels of discrimination reported by transgender youth respondents, combined with the lack of training, knowledge, and welcoming environment from healthcare providers and the healthcare system as a whole.
- Teaching healthcare practitioners and other providers about transgender health should not only focus on the knowledge aspect but also on gender and cultural sensitivity. This gender transformative approach includes addressing internal biases against different gender identities (masculine vs. feminine spectrums), sexualities (heteronormative vs. non-heteronormative), age (adult vs. youth), types of care provided (surgical vs. non-surgical), and other factors.
- it is recommended that proper guidance for healthcare providers, for them to safely provide quality, accessible, acceptable healthcare for trans youth. Education for healthcare providers must take into account country-specific guidelines, lived experiences, and engagement with professional organizations, accreditation bodies, and training providers.
- the study showed that there is a need to educate the health workforce as a whole, not only those who work professionally in delivering health services (e.g., doctors, nurses, midwives), but also those in supporting roles (e.g., security guards, cleaners, laboratorians, and others).

4. The right to correct transgender health information: A harm reduction approach on the basis of consent and empowerment

- A harm reduction approach meaning that the information on safe hormonal use and other forms of gender-affirming care could be delivered via peer-led pathways, adding community participation as the core element, in addition to the existing healthcare system delivery models on transgender health in each country.
- The purpose is to reduce the danger of self-medicating, especially among transgender youth, by taking into account the barriers to care and relevant health-seeking behaviors in the community.
- Transgender health should move beyond the narrative of gatekeeping and stigma, into the basis of consent and empowerment, which could benefit transgender youth, their families, and healthcare providers, using evidence-based, up-to-date, and relevant information and preferred communication delivery methods (online, offline).

5. Establishment of quality care, designed by and for the transgender communities

- Either through centralized or decentralized healthcare delivery; gender clinics, hospitals, or referrals, the most important aspect is to focus on delivering quality care and proper health services for the transgender population.
- Transgender youth and their families should receive care in a safe, welcoming, and discrimination-free environment. This includes an approach based on an integrated service delivery model, including, but not limited to, general health, mental health, gender-affirming services, surgical care, legal services, and other types of necessary support.
- In order to improve the quality and acceptability of care, it is important to amplify community engagement efforts, by involving transgender people in healthcare deliveries, providing professional exchange between health providers and caregivers, and adding the component of transgender advocacy programs, community advisory boards, and health insurance.

6. The need to support parents, legal guardians, and family members of trans youth

- Parental acceptance could serve as a key protective factor for transgender individuals against adverse health outcomes, and even homelessness, hence, should be catalyzed.
- It is clear from our study that most parents were worried about their child's future after transition, which might potentially impact their level of acceptance. Parents, legal guardians, and family members of trans youth should receive support in navigating the transition journey as well, either through peer support for parents with transgender children, information and education sharing for caregivers, or improving the quality of family relationships.
- The toll of advocacy should not only be in the hands of trans communities, but a total collaboration between the communities, parents, and family members, as well as their healthcare providers.

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