RESEARCH REPORT 2019

QUALITY THROUGH INCLUSION

Evaluation of Health Training and Advocacy by the Community in Indonesia

GWL-INA

pph
PUSAT PENELITIAN HIV AIDS
UNIKA ATMA JAYA

RESEARCH REPORT

QUALITY THROUGH INCLUSION:

Evaluation of Health Training and Advocacy by the Community in Indonesia

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EXECUTIVE SUMMARY

Background

Perkumpulan Gaya Warna Lentera Indonesia (GWL-INA) as a collaborating partner of COC, has been working with service providers and stakeholders in the health sector, implementing a number of health care improvement activities for the LGBTI population. The activities range from training certain service providers, to working with the Ministry of Health on health policy evaluation, to providing specific services. GWL-Ina also participated in a high-level stakeholder meeting that aimed to increase the awareness and knowledge of national health policymakers about LGBTI-specific health issues. Some of these efforts already documented as individual case studies, but up to now, there has not been a systematic evaluation about the impact of health training, education and policy advocacy on the actual health service delivery. Therefore, The HIV/AIDS Research Centre (ARC) of Atma Jaya Catholic University, in collaboration with GWL-INA and COC Nederland, conducted a study to evaluate the extent of influence, and the outcome, a local LGBTI Organisation has on health service delivery and policy in Indonesia. The study was conducted in three cities, i.e. Jakarta, Pekanbaru, and Manado using a combination of quantitative and qualitative methods.

This evaluation study aims to evaluate the impact of organisational-based participation in health policy development at three levels; first, at the level of individual members of the community who are also users of health care; second, at the level of the organisation itself; and third, at the level of health care providers and policymakers. This allows us to assess the knowledge and attitude toward community participation while simultaneously evaluate the barriers to accessing health service that community participation and advocacy is expected to address. The result will enable us to triangulate our findings to identify problems in community participation practices. At the same time, the study will also be able to see how stakeholders in the health care system, who formulate and establish health policies, perceive the role of community organisations in improving health care for the LGBTI population. Therefore, objectives of the study are:

1. To asess the level of community empowerment, the health-seeking behaviour and experience of LGBT group with respect to stigma and discrimination in health facilities, also the relationship between community empowerment and health-seeking behaviour.
2. To document and describe the various health training and health policy advocacy that LGBT-specific organisations have conducted with a specific focus on the framing, approach and strategy.
3. To evaluate the impact of health-related activities that LGBT organisations have carried out on the knowledge, attitude, and practices of service provider and policymaker

This is a cross-sectional study where information from respondents is gathered at one specific time for comparison and analysis. A mixture of quantitative and qualitative method was used to answer the three research questions. The quantitative component is focused to identify the level of community empowerment, the health-seeking behaviour and barriers that members of LGBT organisation face in accessing health care. Data for this component of the study was collected from 220 LGBT people in three cities through face to face interviews using digital survey

platform. The qualitative component is focused to document the health training and policy advocacy that COC partner organisations have performed, and the impact of those activities on service providers and policymakers. Data tor this component of the study was gathered through semi-structured interviews with representatives from 17 non-governmental organisations/community groups, 8 health care facilities, 3 legal aid institutes, and 1 government agency.

Quantitative data was analyzed using descriptive and inferential statistics. Descriptive statistics was provided in the form of frequency tabulation and diagram, while inferential statistics was done by logistic regression to describe the association between variables. Data from the interview transcripts and field notes were entered into the NVIVO version 12 software package for coding. Thematic analysis was conducted based on an interview guide that has been designed. Data analysis was performed on the specific themes that were identified

Result

1. *Community empowerment and its impact on fulfillment of their health, social and legal rights.*
    a. More than half of respondents (60.4%) fall into the category of less exposure. A similar pattern consistently emerges that gay and transgender groups are more exposed to empowerment activities than lesbian and bisexual groups. It is critical to note that even though gay and transgender have been the focus of HIV outreach programs, almost half of respondents in these two groups still fall into the category of less exposure.
    b. Most respondents with low exposure to empowerment activities cite not getting enough information about violence, discriminatory attitude and human rights issues. This indicates that outreach workers have been focusing too heavily on health-related information and have not given sufficient portion to other topics. The majority of respondents (65.3%) in general fall into the category of more exposure to health program, as opposed to other empowerment activities.
    c. Overall, most respondents (81.5%) are in the category of quite and more empowered. Only 18.5% are considered less empowered. This means that respondents are not always confident they can perform the activity in question. In certain dimensions, respondents may in fact feel not confident about the activity, such as regarding the need for PrEP. The majority of respondents (48.6%) were not certain they need PrEP, which may be due to lack of knowledge about PrEP, combined with limited actual access to PrEP. On the other hand, the majority of respondents feel confident to provide advice (91%) and convey their opinion in public (77%), provided those are done within their own circle or community
    d. Significant association between exposure to empowerment activities and level of empowerment ($p < 0.01$) can be observed during the analysis. Individuals who are more exposed to empowerment activities are five times more likely to be more empowered than individuals who are less exposed to empowerment activities.
    e. Further analyses show that level of empowerment is significantly associated with outcome variables such as higher health-seeking behavior, more reporting experience of discrimination, better power relations and more likely to participate in social activities.
    f. It can be concluded that empowerment programs that have been implemented by NGOs successfully empower the LGBT community to access STI, HIV, and general health services and to giving advice and conveying an opinion in public.

2. *The meaning of empowerment and perceived benefit of the program.*
    a. At individual level, being empowered is seen as awareness about their health, starting with the awareness about their rights for health as citizens, and that they can fulfill their needs by utilizing the health services that the state has provided. Empowerment programs, therefore, relates to capacity building, which is defined as development of one's potential in order to be independently to fulfill their needs, without relying exclusively on service providers. The knowledge or skills are then shared with other members of the community who lack the knowledge, and knowledge transfer provides a way for members of minority groups to support one another.
    b. Benefits of the empowerment programs can be seen on more and more community members are taking the initiative to visit a health facility for routine check-up like getting tested for HIV or STI. A small number of individuals still need to be encouraged or accompanied to a health facility, but the majority have done so on their own. Awareness to reduce high-risk sexual behaviour is also better and condom use is increasing along with higher retention in treatment.
    c. The other benefit is perceived as more peer educators are available to reach out to their peers, encourage individuals to get tested, and provide support during the treatment process. Members of various LGBT community also establish a communication forum where individuals can voice their opinion, discuss various issues and network with other groups and academic partners including legal themes.
    d. LGBT community, however, feel that some programs have a strong focus on target, and are then carried out without making effort to truly consider the need of the community.
    e. Some LGBT communities desire to be able to get access to mental health care from a psychologist for example, for emotional problems that they often have. Not all health facilities and NGOs have a SOGIESC and human rights program so some health care providers and community members have not been exposed to these two issues, which may partly cause services to be less-friendly, plus self-stigma among community members who feel they deserve unfair treatment

3. *Community Acceptance to the program*
    a. An essential knowledge to prevent stigma and discrimination is started form from self-stigma that the community frequently holds. Some community members claim that without changes within the LGBT community itself, they will not recognize any stigma and discrimination that they receive from outside the community.
    b. In order to be accepted by communities, the program should provide education about the basic rights of each individual, one of which is the right for health, that the state has to fulfill. On the other hand, the program should be able to improve acceptance of the service providers to the program by giving SOGIESC education to health care providers
    c. Acceptance to the program will increase if the program is able to address the basic need of the LGBT community as citizens which is possession of an identification (ID) card. This works particularly for transgenders. A lot of transgenders do not have an ID card as they do not have a transfer letter from their hometown to their current residence. Assistance is therefore given for transgenders to prepare the required paperwork in order to get an ID card from their current neighborhood.

4. *Program and policy advocacy of LGBT-specific organisations.*
    a. The program is grouped into three categories, namely education, service and advocacy. community empowerment programs that have been implemented to date have mostly focused on service delivery.
    b. Programs that are implemented by service providers do not specifically focus on the LGBT community, since health services are supposed to be inclusive, without discriminating or giving exclusive treatment to any specific group.
    c. Most community empowerment programs seem to focus on MSM and transgenders. NGOs tend to focus on these two groups as the most vulnerable to HIV.
    d. Health care providers focus on the health aspect, so service will be provided without any differentiation based on specific sexual orientation or behavior.
    e. Even though the intention of having the same procedure, and the same waiting room is to not discriminate any patients, this practice actually becomes a matter of debate in the LGBT community. Service providers often receive input that community members feel uncomfortable with such practices and some government officials who were interviewed also said that some health facilities do provide a separate waiting room for LGBT people.
    f. Stigma and discrimination are often impacted by the political situation in Indonesia. During the general election period, there were pressures in various neighborhood to not organize any LGBT-related activities in an open manner. A number of organisations adopted a more concealed approach in promoting and announcing upcoming activities for fear of attack or crackdown during the activity.
    g. Health facility also institutes the same service access procedure for the LGBT community and the general population. Having the same procedure is hoped to eliminate discrimination and have people be aware that the LGBT community has the same right for health.
    h. The less-conducive situation leads community members to make special efforts to secure their safety, including their organisations. Fostering good relationship with people in the neighborhood is one approach that an advocacy and LGBT research institution adopts.
    i. NGOs advocating LGBT discrimination report that this lack of knowledge makes LGBT individuals particularly vulnerable to hate crimes as a result of their gender expression, sexual status or profession that is considered a violation of societal norms. Even though criminalisation did not impact the delivery of health service, it did have an indirect effect on the decreasing number of LGBT who accessing the services.
    j. Community engagement can take a number of forms, such as through a formal discussion like FGD, or routine periodic meetings. FGD can be conducted by an NGO and government institution in order to get information about pressing issues, or to discuss the situation and needs of the community. Informal discussion also occurs on a daily basis in a relaxed setting where community members will feel free and at ease to convey their opinion. NGOs and health facilities also performed client satisfaction survey or provide a suggestion/comment box for community members to give input.

5. *Social Participation*
    a. to actively involve community members in the program, and not make them a target of program achievement. NGOs therefore are starting to invite community members to participate in the program from planning to implementation.

b. Many programs provide training to empower LGBT individuals economically, but the program does not match to the community's needs. Engaging the community can make them more interested in the program since it will be suit with their interest.
c. Community members need capacity strengthening in order to effectively participate in the program implementation.

6. *Barriers to services*
   a. Different LGBT groups do have different access to service due to NGOs giving more attention to certain sub-groups, combined with the political situation in Indonesia. The community is also still dissatisfied about being treated with the same procedure as the general population in health facilities, showing that there is still fear toward discrimination by the public, such that the community feels they need a separate waiting room away from the general population.
   b. The LGBT communities are perceived by NGOs as not committed to the activity and even seem to resist the program. However, some communities feel that they do not enjoy any benefit from the program, instead they are a mere object of achievement of the NGOs.
   c. Problems often come from the media that broadcast inaccurate or insensitive news about sexual minority groups. The media also tend to exaggerate certain issues, creating more pressure to the community.
   d. Constraints also come from the government, creating more and more tasks for NGOs. NGOs who actively work with sex workers believe that government programs have not been appropriately targeted, and government officials are not responsive to the needs that arise during NGO's program implementation.
   e. Problems with the unethical behaviour of law enforcement officers. Legal aid institute staffs still see police officers not processing reports about community members' experience objectively, and focus on the individual's gender instead.
   f. Constraints from health care providers who may seem less friendly or do not use the proper approach in providing service, causing community members to feel uncomfortable.
   g. Inadequate number of field personnel who can serve the community is another constraint. NGO who works with MSM also thinks that the frequent change of health personnel in health facilities affects the relationship between health facility staff and community members.

7. *Best Practices*
   a. A collaborative outreach effort between health care providers and NGO staff has encouraged the community members to independently take initiatives and to access information and services
   b. NGOs help the community to have self-control and protect themselves. At the same time NGOs build relationship with the general population as well as important community figures to gain support to the empowerment program
   c. Networking with a legal aid organisation greatly helps the community manage human rights violations wisely and appropriately. One NGO who works with transgender states that this collaboration allows minority groups to receive assistance at no cost.

8. *Stakeholder's Acceptance to the program*
    a. Program improvement is perceived not limited to the health aspect but also in network and strategic relationship with government institutions. A good relationship with government institutions have increased stakeholder's acceptance to the program and bring about positive changes for LGBT community
    b. There is a concern about the decreasing funds from external donors, so support from the government is needed for private health facilities. In this regard, organisations have to be more proactive in convincing the government to allocate funds and provide support
    c. An organisation needs to have a permit and be registered, which will strengthen its position in implementing a program. A legal status should also enable the respective NGO to access funding from the government or other donors
    d. NGOs also perform advocacy, though only a few NGOs are targeting policy changes at the national and local level

CONCLUSION

1. The majority of LGBT groups, lesbian, gay, bisexual, and transgender can be categorised as empowered, particularly with regards to giving advice and conveying an opinion in public. LGBT people are also relatively empowered to access STI, HIV, and general health services, though the majority are less empowered with regards to use of PrEP. Level of empowerment is significantly associated with outcome variables such as higher health-seeking behavior, more reporting experience of discrimination, better power relations and more likely to participate in social activities. It can be concluded that empowerment programs that have been implemented by NGOs successfully empower the LGBT community to access STI, HIV, and general health services and to giving advice and conveying an opinion in public.
2. Programs implemented by NGOs or CBOs can be grouped into three categories, namely education, service and advocacy. However, service delivery program is the most common implemented by the NGOs and CBOs. The programs tend to focus on MSM and transgenders these groups are categorized as key population in HIV and AIDS control. While programs that are implemented by service providers do not specifically target to LGBT community, since health services are supposed to be inclusive, without discriminating or giving exclusive treatment to any specific group
3. The impact of activities that LGBT organisations have carried out on the knowledge, attitude, and practices of service provider and policymaker can be seen in changes awareness to their health and independently access and utilize the existing HIV/STI services. Lack of empowerment would result in lack of information, and inadequate attention to healthy behaviours that would increase their likelihood of being transmitted by HIV or STI. There is also awareness among the health providers and policy makers that the negative stereotype against the LGBT community have limited the community's opportunity to develop their potential and be more economically productive. The communities unable to increase their skills and undeniably stay working as sex workers. Empowerment is hoped to provide trainings that match the community potential and interest, helping community members to develop their ability.

RECOMMENDATION

Based on the study results, several recommendations are proposed that are hoped to be able to facilitate further community development efforts. Separate recommendations are made for each group: the LGBT community, NGO and service provider.

For the LGBT Community

1. Strengthen psychosocial support for fellow LGBT people through dissemination of positive information about sexual orientation and gender identity, and maximising use of information media.
2. Employ innovative approaches like virtual outreach, and dating application to reach LGBT people while continuing to focus on providing psychosocial support.

For NGOs

1. Program implementation approaches that have been adopted by NGOs seem to not fully involve the LGBT community yet. The feeling of being considered as a target is still there, which makes community members reluctant to participate in program activities. More active engagement with the community will be necessary to eliminate the impression of being a programmatic target.
2. The LGBT community also needs to be involved in programs that focus on socio-economic and legal empowerment so that program activities will match the needs of the community.
3. NGOs can help create an LGBT-friendly environment in health facilities by facilitating frequent interaction between service providers and members of the LGBT community. NGOs and health facilities can establish a mutually-beneficial partnership for provision of health service (refer, support, educate, etc.) and create opportunities for positive interactions between the community and service providers.
4. This study finds that advocacy for fulfillment of the rights of LGBT people is still limited. Yet, it is necessary to consistently advocate to related stakeholders for provision of rights-based services, instead of identity-based services. Throughout the advocacy process and activity, it is critical that NGOs also involve the LGBT community. This will create an opportunity for them to interact with stakeholders and further empower them to defend their rights.
5. Community involvement in program activities can be maximised by employing the peer educator system, and involving the general population through positive and interesting activities. This will also increase people's acceptance of the LGBT community.

For Service Providers

1. Create a mechanism for knowledge transfer and capacity building between health care providers in order to increase their awareness and understanding about rights-based services.
2. Network with the LGBT community in order to provide more effective health services, and create opportunities for frequent interactions between health care providers and the community.

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1. INTRODUCTION

BACKGROUND

In the last two decades, researches on lesbian, gay, bisexual, transgender, and intersex (LGBTI and sexual and gender minorities) have highlighted the substantial health disparities that population in various parts of the world face due to their sexual orientation and gender identity. Even though interest in the health of sexual and gender minority groups has so far been disproportionately focused on sexually-transmitted infections (STIs) – specifically HIV/AIDS – there is however increased awareness of the negative health consequences that stigma, marginalisation and discrimination bring about to these minority groups (Branstorm & van der Star, 2013; Hughes & Sommers, 2015; Institute of Medicine, 2011; Logie, 2012; World Health Organisation, 2013).

A recent report on LGBTI health from the Institute of Medicine says that sexual and gender minorities are at an increased risk of harassment, victimisation, depression and suicide. They also have higher rates of smoking and alcohol abuse than heterosexual people (IOM, 2011). The report further indicates that lesbian and bisexual women seem to be at a high risk of being obese, and suffering from cardiovascular disease and breast cancer. These findings underline the link between stigma, marginalisation, discrimination and health (Hatzenbuehler *et al*., 2014; Meyer, 2003), and further strengthens the idea that sexual orientation is a critical social determinant of health (Logie, 2012).

Most of what is known about the health of sexual and gender minority groups is based on studies that were done in developed countries, mainly the USA. Existing research also tends to focus on male sexual minorities, and disproportionately focuses on HIV and other STIs. For example, a review by Coulter, *et al* (2014) on research grants that the US National Institutes of Health (NIH) awarded between 1989-2011 finds that aside from studies on HIV/AIDS, research on sexual minority health only makes up 0.1% of all the funded studies, and among the 0.1%, the majority of studies focus on gay and bisexual men. The health of lesbian or bisexual women is discussed in only 13.5% of studies.

A similar result is found in a review of MEDLINE-indexed English articles that were published between year 1980-2000. Boehmer (2002) discovers the same low proportion of studies (0.1%) on sexual minority health, and of this low proportion, only 37% of studies have information about lesbian or bisexual women. A lot of articles categorise lesbian, bisexual and transgender people as one group, while each of these populations actually faces different health

risks and have different health outcomes. Lesbian and bisexuals do share a lot of the vulnerabilities, social marginalisation and stigmatisation that transgenders face, but the fundamental differences between sexual orientation (lesbian or bisexual) and gender identity (transgender) result in significantly different health needs. For example, transgenders need access to health care that acknowledge their gender (gender-affirming health care) (Feldmann & Bockting, 2003).

A report by the Executive Board Secretariat of World Health Organisation (2013) states that one primary challenge to improving the health and well-being of sexual and gender minorities is "prejudice that is institutionalised, social pressure and exclusion (even within one's own family), anti-homosexual hatred and violence …" that these minority groups face. The report further describes that to gain a better understanding about the health need of the LGBT community, more demographic data about the population, particularly those who reside in low and middle-income countries is needed…". A recent United Nations report underline that "in all regions, people are experiencing violence and discrimination as a result of their sexual orientation or gender identity. In many cases, being perceived as a homosexual or transgender can position an individual in a risky situation. Violations include – but not limited to – murder, rape and physical assault, torture, arbitrary detention, denial of rights to gather, to express their views and to receive information, also discrimination in employment, health and education" (UN High Commission for Human Rights, 2015).

An increasing number of academic literature reviews highlight the various challenges that LGBTI population face in accessing health service. Overall the identified challenges can be described as follows, **first**, the prejudiced attitude of health care providers that stem from the homophobia and transphobia that is prevalent in the community. Studies point out that LGBTI population receive harassment and verbal insults from health care providers due to their sexual orientation and/or gender identity; in some cases, health providers even refuse to provide care to the LGBTI group (Muller, 2017; Lane *et al* 2011., Smith, 2014; Stevens, 2011).

Second, health care provider has limited knowledge about the health care needs of the LGBTI population. For example, health workers often do not know how to collect sexual history information using gender-neutral terminologies. They also are not familiar with health risks that are specifically related to non-heteronormative gender (Meer & Muller, 2017). As a result, health care providers often are unable to provide quality health care to people from the LGBTI population. **Third**, the specific health care needs of the LGBTI population are often not part of the health policy and health care planning and are therefore not available in public health facility. For example, the Health Department in South Africa does not have a guideline for gender-

affirming health care, causing transgenders to receive health service that is inconsistent with their gender, or at its worst, impossible to provide (Spencer, Meer & Muller, 2017).

In relation to the challenges, a concept termed 'Community Participation' in health service was first introduced at an International Conference on Primary Health Care in 1978. At the conference, delegates developed the Alma-Ata Declaration that identifies key principles in primary health care called 'individual and collective' participation in health care planning and implementation as a right ('Alma-Ata Declaration', 1978). Since then, community participation has been expanded to include sustainability, evaluation and empowerment (Morgan, 2001).

As a result of community participation in health service, health outcomes of community members have improved. Despite decades of pointing out how community participation improves health outcomes, peer-reviewed studies that evaluate the impact of such intervention are still limited. Existing studies demonstrate that community participation has a positive impact on "intermediate" health outcomes, such as improving access and increasing utilisation of health service (Bath and Wakerman, 2015). It is very likely that such improvement results in more rapid prevention and management of diseases, contributing to the overall health of individuals. In the midst of a number of promising findings, there also has been a call to not put too much emphasis on evaluating community participation as a certain input or result, since participation should be included and conceptualised as a framework that 'should accompany all project activities' (Oakley, Bichmann and Rifkin, 1999; Morgan, 2001). Aside from its positive impact on health, community participation has been shown to also promote community development and ensure that the needs of community members are effectively met within the local, cultural and social context of the community (Sule, 2005; Cyril *et al*., 2015).

A recent systematic review by Cyril, *et al* (2015) documents that community engagement is able to improve the health of sexual minorities, within the disadvantaged population groups. Which component of community participation has the most impact is still unknown, but community-based service provider and emphasis on 'collaboration, partnership and empowerment' seems to be associated with positive outcomes (Cyril *et al*., 2015).

The most recent research on participation of sexual and gender minorities in health focuses on the HIV/AIDS epidemic (Molyneux *et al*., 2016; Bauermeister *et al*., 2017; Chang Pico *et al*., 2017). A recent project in the USA by Bauermeister, *et al*. (2017) that looks at community participation among gay and bisexual adolescent males, men who have sex with men (MSM) and transgender women, documents several best practices on community participation. **First**, knowledge and input of the community has to be treated as valid, and of the same value as 'public health data and/or empirical data'; **Second**, community members have to be involved

'frequently since the start of the program' in order to build support; **Third**, the method of engaging the community needs to vary in scale and scope; and **Fourth**, a community dialogue is useful to clarify the roles of different community members in decision-making (Bauermeister *et al*., 2017).

Molyneux, *et al*. (2016) also promotes participation of sexual minority groups in the earliest possible stage of research and program planning. This is because community members who are seen to participate in the program may risk discrimination or some unsafe scenarios. At the same time, involvement and participation of community members who are less visible should be encouraged (Molyneux *et al*., 2016). This evaluation study proposes to evaluate the impact of organisational-based participation in health policy development at three levels; **first**, at the level of individual members of the community who are also users of health care; **second**, at the level of the organisation itself; and **third**, at the level of health care providers and policymakers. This allows us to assess the knowledge and attitude toward community participation while simultaneously evaluate the barriers to accessing health service that community participation and advocacy is expected to address. The result will enable us to triangulate our findings to identify problems in community participation practices. At the same time, we will also be able to see how stakeholders in the health care system, who formulate and establish health policies, perceive the role of community organisations in improving health care for the LGBTI population.

In Indonesia, *Perkumpulan Gaya Warna Lentera Indonesia* (GWL-INA) as a collaborating partner of COC, has been working with service providers and stakeholders in the health sector, implementing a number of health care improvement activities for the LGBTI population. The activities range from training certain service providers, to working with the Ministry of Health on health policy evaluation, to providing specific services. COC Nederland, and several partner organisations also participated in a high-level stakeholder meeting that aimed to increase the awareness and knowledge of national health policymakers about LGBTI-specific health issues.

Several of the efforts that have been performed are already documented as individual case studies, but up to now, there has not been a systematic evaluation about the impact of health training, education and policy advocacy on the actual health service delivery. Therefore, The HIV/AIDS Research Centre (ARC) of Atma Jaya Catholic University, in collaboration with GWL-INA and COC Nederland, conducted a study to evaluate the extent of influence, and the outcome, a local LGBTI Organisation has on health service delivery and policy in Indonesia. The study was conducted in three cities, i.e. Jakarta, Pekanbaru, and Manado using a combination of quantitative and qualitative methods.

OBJECTIVE

The study had the following objectives:

1. Assess the level of community empowerment, the health-seeking behaviour and experience of LGBT group with respect to stigma and discrimination in health facilities, also the relationship between community empowerment and health-seeking behaviour.
2. Document and describe the various health training and health policy advocacy that LGBT-specific organisations have conducted with a specific focus on the framing, approach and strategy.
3. Evaluate the impact of health-related activities that LGBT organisations have carried out on the knowledge, attitude, and practices of service provider and policymaker.

METHODOLOGY

Study Design

This is a cross-sectional study where information from respondents is gathered at one specific time for comparison and analysis. A mixture of quantitative and qualitative method was used to answer three research questions. The **quantitative component** focused on the first objective to identify the level of community empowerment, the health-seeking behaviour and barriers that members of LGBT organisation face in accessing health care. Data for this component of the study was collected from members of a partner organisation (GWL-INA) through a structured survey.

The **qualitative component** focused on the second and third objective of the study, which is to document the health training and policy advocacy that COC partner organisations have performed, and the impact of those activities on service providers and policymakers. Data tor this component of the study was gathered through semi-structured interviews with representatives of the organisation, health care providers and health policymakers.

Location

The study was conducted in three cities, Jakarta, Pekanbaru, and Manado. These sites were selected based on ease of access to target communities, and geographic representation of the western, central and eastern regions of Indonesia.

Population and Samples

Based on the study objectives, the target population was divided into two studies.

Quantitative Study

As part of the **first objective**, this study focused on community empowerment, health-seeking behaviour and barriers to accessing health care that members of LGBT organisations experience. The study's target population was the LGBT community in Indonesia.

Overall the study collected data from **220 LGBT people** in three cities (120 in Jakarta, 50 in Pekanbaru, and 50 in Manado). The selection criteria of respondents include age, sexual orientation and gender identity as follows.

- All respondents are adults: are at least 18 years old.
- All respondents identify themselves as belonging to a sexual and/or gender minority group

Considering the fact that LGBT population tends to be hidden and is not easily identified, sampling was performed using a **purposive, cross-sectional community venue-based sampling** and **snowball sampling technique.**

Respondent Characteristics

The total respondents who participated in the quantitative data collection was 222 people. Each respondent was asked to describe their gender identity, sexual orientation and sexual behaviour. Each respondent's response for the three aspects was combined and used as a basis for categorising the respondents into four groups, i.e. lesbian, gay, transgender, and bisexual.

Table 1

Demographic Characteristics of Respondents

Variables	Lesbian (n=48)	Gay (n=59)	Transgender (n=47)	Bisexsual (n=68)	Total (n=222)
Sex					
Female	100	0	36.2	2.9	30.2
Male	0	100	63.8	97.1	69.8
Age group					
18-24 years	27.1	32.2	31.9	27.9	29.7
25-30	33.3	35.6	46.8	38.2	38.3
31-40	29.2	22.0	14.9	20.6	21.6
>40	10.4	10.2	6.4	13.3	10.4
Education					
Elementary School or equivalent	6.3	3.4	4.3	4.4	4.5
Junior High School or equivalent	18.8	6.8	25.5	4.4	12.6
High School or equivalent	64.6	69.5	59.6	50.0	60.4
Higher Education	10.4	20.3	10.6	41.2	22.5
Income					
< 1 million rupiahs	20.8	10.2	10.6	10.3	12.6
1 million – 2.5 million	29.2	32.2	27.7	19.1	26.6
2.5 million – 5 million	43.8	49.2	57.4	55.9	51.8
5 million – 10 million	6.3	8.5	4.3	14.7	9.0
Residence					
Same as home town	66.7	45.8	44.7	39.7	48.2
Different from home town	33.3	54.2	55.3	60.3	51.8

Table 1 summarises the characteristics of the study respondents. In general, there was a lot of variability as well as some common characteristics in certain sub-groups of respondents. Most of the respondents (68%) are young, between 18-30 years old and most (60.4%) have at least a high school diploma. Some respondents also obtain higher education, mostly bisexuals (41.2%) and gays (20.3%). In terms of income in the last 30 days, the majority of respondents (51.8%) received Rp. 2.5 - 5 million, and around 40% had income below Rp. 2.5 million. Analysis found a positive and significant correlation between income level and educational level ($p<0.01$). Around half of respondents (51.5%) were also living in a city that is different from their hometown, indicating a high level of mobility among respondents.

Qualitative

The **second and third objective** of the study were to describe the health training and policy advocacy that LGBT organisations have performed, and evaluate the impact of those activities on service providers and policymakers. The study population for this part of the study was LGBT organisations in Indonesia, including health care providers who are familiar with LGBT issues.

Poerwandari (2013) explains that sample size in qualitative research cannot be firmly determined in the initial stage of a study. The conceptual understanding that develops during data collection guides researchers to find new relevant samples or respondents that will provide additional data. Researchers are therefore likely to add more respondents until they reach a saturation point, where additional respondents will not provide any new information. For this part of the study sampling was done using a **strategic convenience snowball sampling** technique that is expected to generate few interviews, but rich in information.

Respondent Characteristics

In total the study interviewed 29 respondents in 3 cities, Jakarta, Manado, and Pekanbaru. Respondents represent 17 non-governmental organisations/community groups, 8 health care facilities, 3 legal aid institutes, and 1 government agency. In order to gather programmatic information and understand the perception of service providers, interviews were performed with individuals who are knowledgeable about their organisation's program. Among the NGOs/community groups, respondents were 10 Directors, 4 Program Managers/Coordinators, and 3 Program Supervisors/Implementors. Among the service providers, respondents included 5 Directors/Persons in Charge, 2 Program Managers, 3 Doctors and 2 legal aid personnel.

Data Analysis

Quantitative

Data was analyzed using descriptive and inferential statistics. Descriptive statistics was provided in the form of frequency tabulation and diagram, while inferential statistics was done by logistic regression to describe the association between variables. Statistics calculation was done using the quantitative software SPSS version 22.

Categorisation

To interpret the score from a number of variables, categorisation was performed using statistical measurement (hypothetical mean). Widhiarso (2010) explains that categorisation with this method is performed by calculating the interval between each category using the following formula:

$$\text{Interval} = \frac{\text{Maximum Score in the Scale} - \text{Minimum Score in the Scale}}{\text{Number of Groups/Categories}}$$

The categorisation result will be explained in more detail in the discussion about each respective variable.

Qualitative

Data from the interview transcripts and field notes were entered into the NVIVO version 12 software package for coding. Thematic analysis was conducted based on an interview guide that has been designed. Data analysis was performed on the specific themes that were identified.

ETHICAL CONSIDERATION

This study secured a number of approvals prior to data collection to ensure that ethical procedures are upheld throughout the study. **First**, approval was obtained from the Ethical Committee of Atma Jaya Catholic University Number 0442/III/LPPM-PM.10.05/04/2018. **Second**, two approvals were obtained from the Ministry of Home Affairs; for the National level through Approval Number 440.02/1128/DV, and for the local levels through approval from Jakarta Investment and One-Stop Integrated Service Agency (*Badan Penanaman Modal dan Pelayanan Terpadu Satu Pintu DKI Jakarta*) Number 830/AF.1/31/-1.862.9/2018. Written informed consent was obtained from each informant prior to data collection.

To ensure complete understanding and smooth data collection, materials on research ethics were also incorporated into the enumerator training materials. Written informed consent

was obtained from each respondent before questionnaire completion and interview. The study was implemented with an emphasis on two key ethical issues, i.e. confidentiality of respondent's identity and respondent's comfort when faced with sensitive questions, like one about experience of discriminatory practices, or sexual relationships.

Considering the study characteristic and procedure, the risks and benefits of participating in this study are as follows:

1. The participants are not at risk of experiencing physical harm.
2. Interviews are tied with the professional identity of participants and the risk for emotional discomfort is minimal.
3. All informants are interviewed in their professional capacity.

2. STUDY FINDINGS

1. SEXUALITY CHARACTERISTICS

This part describes the sexuality characteristics of respondents, grouped into three aspects 1) gender identity; 2) sexual orientation and behaviour; 3) partner's identity. The information is summarised in the table below:

Table 2

Sexuality Characteristics of Respondents

Variables	Lesbian (n=48)	Gay (n=59)	Transgender (n=47)	Bisexual (n=68)	Total (n=222)
Gender Identity					
Female	100	0	31.9	2.9	29.3
Male	0	100	27.7	97.1	62.2
Trans-woman	0	0	31.9	0	6.8
Trans-man	0	0	8.5	0	1.8
Sexual Orientation					
Lesbian	100	0	27.7	0	27.5
Gay	0	98.3	44.7	0	35.6
Bisexual	0	0	8.5	100	32.4
Heterosexual	0	1.7	19.1	0	4.5
Sexual Behaviour[a]					
Male	0	86.4	63.8	22.0	43.2
Female	64.6	0	29.8	1.5	20.7
Male & Female	35.4	11.9	6.4	76.5	35.6
Never had sex	0	1.7	0	0	0.5
Has a Partner					
Yes	64.6	54.2	63.8	48.5	56.8
No	35.4	45.8	36.2	51.5	43.2
Relationship Status[b]					
Married	6.5 (2)	3.1 (1)	0	33.3 (11)	11.1 (14)
Cohabitating	58.0 (18)	68.8 (22)	70.0 (21)	51.5 (17)	61.9 (78)
No Commitment	35.5 (11)	28.1 (9)	30.0 (9)	15.2 (5)	27.0 (34)

Note: [a]Respondents were asked who they have ever had sex with. [b]The question was only asked to respondents who have a partner

Gender Identity

The concept of gender identity has some fundamental differences from the concept of sex. While sex is associated more with physical characteristics (having a penis or a vagina), gender identity is identified more with an individual's psychological aspect that is shaped through their internal experience. Gender identity has evolved into a spectrum of gender where individuals are not exclusively categorised as masculine or feminine.

In relation to gender identity, Table 2 shows that respondents who are in the transgender group have more variable gender identity than the other groups. About 1/3 of transgender respondents identity themselves as female or male, which suggests that they have not fully acknowledged themselves as trans-people. Considering that the majority of respondents are young adults, it is very likely that they are still in the process of self-discovery and identity

formation such that they choose to identify with the binary concept of gender that is more acceptable in the society.

Sexual Orientation and Behaviour

Similar to sex and gender identity, this study also specifically distinguishes the concept of sexual orientation from sexual behaviour. While sexual orientation is related more with the psychological aspect, i.e. an attraction to a certain sex, sexual behaviour is based on a respondent's actual sexual experience. It is very likely that respondent's sexual orientation may not align with their sexual behaviour.

Table 2 shows that the sexual orientation of almost all of the lesbian, gay, or bisexual respondents align with the way they identify themselves. On the other hand, transgender respondents have more variation in their sexual orientation, which is influenced by their sex and gender identity.

Table 2 also shows an interesting finding with regards to sexual behaviour, which does not always align with respondent's sexual orientation. For example, some gay respondents do have sex with women, and some lesbians still have sex with men. This can be influenced by factors such as a job or an economic situation that sometimes causes one to not have control about their sexual partner. Almost all study respondents have had sexual intercourse that, when done without protection, can potentially lead to some health risk. It is therefore relevant for this study to also gather information about respondents' health status.

Partner Identity

More than half of respondents (56.8%) have a steady partner with varying relationship status, most commonly cohabitation. This may be caused by various factors from structural barriers that do not recognize same-sex marriage, to more fundamental issues that relate to identification (ID) card's possession. Employment is another factor why respondents choose to have a steady partner without formal ties. This situation however indicates that respondents are likely to have sex with various partners, emphasizing the importance to gain more information about respondents' health status, including their HIV status.

2. HEALTH STATUS

This part describes the respondents' health status viewed from four aspects: 1) disease status; 2) HIV status; 3) pregnancy status; 4) health-seeking behaviour. Information on these four aspects is summarised in Table 3 and 4.

Table 3

Health Status Characteristics

Health Status	Lesbian (n=48)	Gay (n=59)	Transgender (n=47)	Bisexual (n=68)	Total (n=222)
Has chronic illness					
Yes	2.1	11.9	17.0	0	7.2
No	97.9	88.1	83.0	100.0	92.8
HIV Status[a]					
HIV +	6.7 (1)	20.4 (11)	13.9 (5)	3.6 (2)	11.8 (19)
HIV -	80.0 (12)	51.9 (28)	58.3 (21)	66.1 (37)	60.9 (98)
Refuse to disclose	13.3 (2)	27.8 (15)	27.8 (10)	30.4 (17)	27.3 (44)
Pregnancy Status (last 12 months)[b]					
Has been pregnant	12.5 (6)	-	0	0	9.0 (6)
Never been pregnant	87.5 (42)	-	100.0 (17)	100.0 (2)	91.0 (61)
Pregnancy Outcome[c]					
Continue to delivery	66.7 (4)	-	-	-	66.7 (4)
Spontaneous miscarriage	33.3 (2)	-	-	-	33.3 (2)

Note: [a]Only asked to respondents who know their HIV status. [b]Only asked to female respondents. [c]Only asked to respondents who were pregnant in the last 12 months.

Disease Status

The majority of respondents were not suffering from chronic illnesses (TB, heart disease, etc.) that require routine visits to a health care facility (see Table 3). One factor that may cause this is age, since most respondents are still quite young, though that does not mean they are not exposed to any health risks. Sexual behaviour is one risk factor that should be investigated as it ties with HIV status, which is discussed in the next section,

HIV Status

Complementing the information in the previous section, among the 72.5% respondents who know their HIV status, the majority (60.9%) report their status as HIV negative. Among the 11.8% respondents who are HIV+, the largest percentage was found among gay (20.4%), and transgender (13.9%), while the rest refused to disclose their HIV status (27.3%).

Pregnancy Status

Almost all female respondents report as not being pregnant in the last 12 months (91.0%), while among the 9% who were pregnant, some did continue the pregnancy to term and delivered the baby. No respondents decided to purposefully end their pregnancy.

Health-Seeking Behaviour

The health-seeking behaviour of respondents was assessed from three aspects, the frequency of accessing health care, any routine access to health care and any participation in

HIV test (see Table 5). Interpretation of responses to this health-seeking behaviour variable is divided into two categories, i.e. “never access health care” and “have accessed health care”. A respondent who has never accessed a health service or has never undergone HIV testing is categorised as “never access health care”, while a respondent who says yes to any of the three aspects is categorised as “has accessed health care”.

Table 4

General Health-Seeking Behaviour

Health-Seeking Behaviour	Lesbian (n=48)	Gay (n=59)	Transgender (n=47)	Bisexual (n=68)	Total (n=222)
Never access health care	14.6	0	4.3	7.4	6.3
Have accessed health care	85.4	100.0	95.7	92.6	93.7

In general, Table 4 demonstrates that the majority of respondents (93.7%) have accessed health care, but only 31.3% undergo routine health check-up (see Table 5). This indicates that respondents seek health care when they experience symptoms, and health service is seen as a way to obtain cure and not as a preventive step. A number of factors like economic situation and access to health service may inhibit health-seeking behaviour, and it then becomes important to assess respondents’ access to health service.

Table 5 shows that the majority of respondents (72.5%) know their HIV status. A striking result is seen among the lesbian, where only 31.3% know their HIV status. This reflects a situation that is far below the 90-90-90 target that has been set by UNAIDS for year 2020, meaning that there are still a lot of LGBT individuals who are not yet reached, and do not yet know their HIV status. HIV is therefore still a health risk among the LGBT group that requires proper attention and response. This situation also indicates that health promotion efforts that are directed to hidden populations are still highly dependent on outreach programs.

Table 5

Characteristics of Health-Seeking Behaviour

Characteristics	Lesbian (n=48)	Gay (n=59)	Transgender (n=47)	Bisexual (n=68)	Total (n=222)
Frequency Accessing Care (last 12 months)					
Once	22.9	15.3	12.8	23.5	18.9
2-5 times	52.1	49.2	55.3	54.4	52.7
> 5 times	10.4	35.6	27.7	14.7	22.1
Did not access care	14.6	0	4.3	7.4	6.3
If did not access care, why?[a]					
Did not feel sick	85.7 (6)	-	100.0 (2)	100.0 (5)	92.9 (13)
Did not need health care	14.3 (1)	-	0	0	7.1 (1)
Access health care routinely?[b]					
Yes	25.0	42.4	29.8	26.5	31.1
No	75.0	57.6	70.2	73.5	68.9
Know your HIV status?					
Yes	31.3	91.5	76.6	82.4	72.5
No	68.8	8.5	23.4	17.6	27.5

Note: [a]Only asked to respondents who did not access health care in the last 12 months. [b]Routine check up such as blood pressure measurement, cancer screening, etc.

3. ACCESS TO HEALTH INFORMATION AND SERVICE

This section describes respondents' access to health-related information and health service, including their experience with discrimination. The study also looked at how the general population perceives and accepts LGBT people, the power relations that are prevalent in the community, and respondents' participation in social activities.

Source of Health Information

Table 6 shows that the first source of health information that respondents rely on is their friends (74.3%), followed by internet & social media (70.7%). This is evidence for NGOs to optimise peer-based empowerment activities and intensify the role of social media in information dissemination. It should be noted that very few respondents (6.3%) receive their information from health care facilities, which means that health facilities should broaden their focus, so as to not only provide curative services, but to also focus on health education efforts.

Table 6

Source of Health Information

Information Source	Lesbian (n=48)	Gay (n=59)	Transgender (n=47)	Bisexual (n=68)	Total (n=222)
Friends	68.8	69.5	76.6	80.9	74.3
NGO	29.2	69.5	61.7	50.0	53.2
Internet & social media	66.7	71.2	63.8	79.4	70.7
Support group	8.3	22.0	10.6	17.6	15.3
Electronic & printed media (TV, radio, newspaper, brochure)	6.3	5.1	0	10.3	5.9
Other (health personnel, seminar)	10.4	8.5	2.1	4.4	6.3

Note: The total percentage is not 100% as each respondent may select multiple answers.

Health Facilities and Services that are Accessed

Table 7 shows that respondents' access to health care facilities is generally quite good, though there is always room for access improvement. The majority of respondents go to a primary health facility, namely Puskesmas (Community Health Centre) (77%), followed by public clinic (61.7%) and hospital (55.4%). Based on this finding it is important that health promotion efforts be accompanied with service improvement at Puskesmas as the first line of care for the community. Moreover, to obtain information about existing gaps and opportunities for service improvement, this study also collected information on the type of health service that respondents mostly access, the overall acceptance of LGBT at health facilities, and any discriminatory attitudes that respondents experience at health facilities.

Table 7

Health Facilities that are Accessed

Health Facility	Lesbian (n=48)	Gay (n=59)	Transgender (n=47)	Bisexual (n=68)	Total (n=222)
NGO Clinic	12.5	25.4	21.3	19.1	19.8
General Clinic / General Practitioner's Practice /	60.4	55.9	57.4	70.6	61.7
Hospital	62.5	57.6	55.3	48.5	55.4
Puskesmas / Midwife	72.9	81.4	76.6	76.5	77.0
Specialistic Health Care / Specialist Doctor's Practice	27.1	30.5	19.1	26.5	26.1
Traditional Treatment	10.4	11.9	10.6	13.2	11.7
Supermarket	2.1	13.6	6.4	11.8	9.0

Note: The total percentage is not 100% as each respondent may select multiple answers.

Considering the potential health risk that relates to STI among LGBT groups, it is important to specifically gather information about access to condom. In general respondents obtain condom from various sources, suggesting relatively good access to prevention devices. Table 8 specifically shows that gay and transgender respondents receive condom mostly from NGOs and Puskesmas, while lesbian and bisexual respondents tend to purchase condoms at pharmacies. This confirms the previous finding that gay and transgender have a closer relationship with NGOs and Puskesmas than the lesbian and bisexual groups.

Table 8

Source of Prevention Device or Condom

Source of Condom	Lesbian (n=48)	Gay (n=59)	Transgender (n=47)	Bisexual (n=68)	Total (n=222)
NGO	27.1	72.9	70.2	52.9	56.3
Puskesmas	29.2	52.5	61.7	36.8	44.6
Pharmacy	60.4	37.3	29.8	63.2	48.6
Hospital	4.2	27.1	14.9	10.3	14.4
Supermarket / Shop	33.3	49.2	40.4	61.8	47.7
Friends	27.1	54.2	31.9	48.5	41.9

Note: The total percentage is not 100% as each respondent may select multiple answers.

Table 9 shows that health services that all respondents mostly seek are services that relate to HIV (64.9%) and STI (62.2%). The type of actual service varies among groups. Lesbians, who are women, do not need as many condoms as the other three groups (16.7%), but they do need pap smear (33.3%), while the other three groups who are mostly male, need condom and lubricant.

The majority of respondents also acknowledge that they do receive the service that they need (88.7%) and that they are able to receive service as needed (92.3%). This is actually quite a high number and indicates satisfaction in getting access to services. This finding however does

not include information on service friendliness, and appropriateness, or any discriminatory treatment or behaviours that respondents experience.

Table 9

Health Services that are Accessed

Health Service	Lesbian (n=48)	Gay (n=59)	Transgender (n=47)	Bisexual (n=68)	Total (n=222)
Health Services that are Accessed[a]					
Condom	16.7	76.3	61.7	57.4	54.5
Lubricant	4.2	64.4	40.4	45.6	40.5
Hormonal Contraceptive	10.4	6.8	14.9	0	7.2
STI Service	39.6	76.3	59.6	67.6	62.2
Pap Smear	33.3	0	12.8	1.5	10.4
ARV Therapy	4.2	33.9	25.5	11.8	18.9
HIV Counseling and Test	45.8	67.8	66.0	75.0	64.9
PrEP	2.1	5.1	10.6	1.5	4.5
PEP	0	1.7	4.3	1.5	1.8
Pregnancy Test	8.3	1.7	2.1	1.5	3.2
Pregnancy Care	4.2	1.7	0	0	1.4
Psychological Counseling	14.6	11.9	21.3	11.8	14.4
Other Health Care[b]	22.9	15.3	8.5	14.7	15.3
Was service received?					
Yes	83.3	89.8	87.2	92.6	88.7
No	16.7	10.2	12.8	7.4	11.3
In general, can health care be accessed as needed?					
Yes	83.3	96.6	93.6	94.1	92.3
No	16.7	3.4	6.4	5.9	7.7

Note: [a]The total percentage is not 100% as each respondent may select multiple answers. [b]Other health services include care for fever, cough, common cold, etc.

4. PERCEPTION ABOUT LGBT

Perception about public acceptance

To gather information about this aspect, the study asked about respondents' experience while accessing service at a number of institutions, like health facility, bank, respondent's workplace, public facilities, government offices, as well as during interaction with police / security officers (see Table 11). Responses were then categorised following the procedure outlined on page 8, resulting in the following final category:

Score 6-9 : LGBT people are never treated the same way as other people

Score 10-14 : LGBT people are sometimes treated the same way as other people

Score 15-18 : LGBT people are treated the same way as other people

Table 10 shows that in general the LGBT community still receive some inappropriate treatment at a number of institutions, government offices, private facilities, or within the community. This means that improvement efforts should not focus just on services that are provided in health care facilities, but should include services in other public service institutions as well.

Table 10

Perception about Public Acceptance of LGBT

Perception	Lesbian (n=48)	Gay (n=59)	Transgender (n=47)	Bisexual (n=68)	Total (n=222)
LGBT are never treated the same way as others	4.2	3.4	8.5	7.4	5.9
LGBT are sometimes treated the same way as others	18.8	30.5	40.4	33.8	31.1
LGBT are treated the same way as others	78.0	66.1	51.1	58.8	63.0

Table 11 shows that the LGBT community tend to receive the same treatment as other people in health facilities, indicating that health care facilities do not discriminate their patients and focus on providing inclusive health care. This finding however needs to be supported with actual respondent's experience while accessing health care, as it is possible that respondents do not realize they are experiencing some discrimination.

The perception that LGBT community are treated the same way as other people is lowest in services that involve police/security officers, followed by services in public facilities and at respondents' workplace. This poses a challenge to community empowerment efforts, as it means empowerment is needed not just in the aspect of health, but in economic and legal aspect as well (including the issue of human rights).

Table 11

Perception about Public Acceptance of LGBT at Various Institutions

Institution	Lesbian (n=48)			Gay (n=59)			Transgender (n=47)			Bisexual (n=68)			Total (n=222)		
	1[a]	2[b]	3[c]	1	2	3	1	2	3	1	2	3	1	2	3
Do LGBT people receive appropriate service in or by:															
Health Care Facility	4.2	29.2	66.7	3.4	15.3	81.4	4.3	31.9	63.8	8.8	16.2	75.0	5.4	22.1	72.5
Bank	2.1	12.5	85.4	3.4	10.2	86.4	6.4	19.1	74.5	2.9	8.8	88.2	3.6	12.2	84.2
Workplace	10.4	14.6	75.0	13.6	22.0	64.4	10.6	25.5	63.8	16.2	26.5	57.4	13.1	22.5	64.4
Public Facility	2.1	35.4	62.5	13.6	32.2	54.2	14.9	40.4	44.7	7.4	38.2	54.4	9.5	36.5	54.0
Government Office	6.3	29.2	64.6	8.5	25.4	66.1	12.8	34.0	53.2	11.8	30.9	57.4	9.9	29.7	60.4
police / security officer	10.4	35.4	54.2	22.0	33.9	44.1	27.7	38.3	34.0	23.5	35.3	41.2	21.2	35.6	43.2

Note: [a]LGBT people are never treated the same way as others. [b]LGBT people are sometimes treated the same way as others. [c]LGBT people are treated the same way as others.

Experience with Discrimination

Respondents' experience with discrimination was evaluated based on 6 questions about health provider's behaviour during the respondent's last visit to a health facility (see Table 13). For interpretation, respondents' responses are grouped into two categories, namely "no-discrimination" and "discrimination". If a respondent experiences any one of the six behaviours,

then they are categorised as receiving "discrimination", while if the respondent does not experience any of the behaviours in the six questions, they are considered to receive "no discrimination".

In contrast to the previous information about the perception of public acceptance of LGBT, Table 12 shows that 31.5% of respondents do receive some discriminatory treatment at health facilities. Some respondents (26.1%) have even postponed visits to a health facility out of fear of discrimination. This indicates that some respondents actually are not aware of the discrimination they are experiencing, which strengthens the need to empower LGBT communities not just on issues that relate to health care, but on human rights issues as well so that communities are more perceptive with behaviour and attitudes that potentially violate their rights as citizens.

Table 12

General Experience with Discrimination at Health Facilities

Experience with Discrimination	Lesbian (n=48)	Gay (n=59)	Transgender (n=47)	Bisexual (n=68)	Total (n=222)
No Discrimination	66.7	66.1	51.1	83.8	68.5
Discrimination	33.3	33.9	48.9	16.2	31.5
Have you ever postponed a visit to a health facility out of fear of discrimination based on your sexual orientation, gender identity or sexual behaviour?					
Yes	27.1	18.6	36.2	25.0	26.1
No	72.9	81.4	63.8	75.0	73.9

Table 13 specifically lists the various discriminatory treatment that respondents receive from health care providers. The most common one is giving respondents some religious or morality talk, and gossiping and saying negative things about the respondent. Transgenders also tend to experience such treatment more often than the other three LGBT groups, perhaps because physically transgenders are the easiest to identify. It is therefore reasonable if a lot of transgenders change their appearance even when it does not match their own gender expression.

Table 13

Specific Experience with Discrimination at Health Facilities

Discriminatory Attitude	Lesbian (n=48)		Gay (n=59)		Transgender (n=47)		Bisexual (n=68)		Total (n=222)	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
During your last visit to a health facility, did you experience any of the following as a result of your expression, sexual orientation, gender identity and/or sexual behaviour?										
Health care providers treat you poorly	8.3	91.7	8.5	91.5	21.3	78.7	7.4	92.6	10.8	89.2
You have been denied care by health provider	2.1	97.9	10.2	89.8	10.6	89.4	1.5	98.5	5.9	94.1

You have to wait longer than other patients to get service	14.6	85.4	13.6	86.4	19.1	80.9	4.4	95.6	12.2	87.8
Health care providers gossip or speak negatively about you	14.6	85.4	13.6	86.4	31.9	68.1	2.9	97.1	14.4	85.6
Health care providers disclose your gender expression, sexual orientation, gender identity and/or sexual behaviour, without your consent	2.1	97.9	13.6	86.4	21.3	78.7	2.9	97.1	9.5	90.5
Health care providers talk about religion or morality to you	16.7	83.3	23.7	76.3	29.8	70.2	8.8	91.2	18.9	81.1

5. POWER RELATIONS

Power relation is an individual's ability to negotiate or fight for / defend themselves in order to help other LGBT people. This variable was assessed through respondents' experience negotiating with various parties like police officers, government officials, health providers, the general public, steady partner, commercial partner and casual partner, in order to help other LGBT individuals (see Table 15). The same categorisation procedure outlined on page 8 was used on the responses to generate the following categories:

Score 7-10 : poor power relations

Score 11-14 : better power relations

Table 14 shows that overall more than half of respondents (54.1%) have poor power relations, particularly the lesbian and bisexual groups. This is consistent with previous findings that gay and transgender groups have better power relations than the lesbian and bisexual groups. Gay and transgenders have so far been the focus of outreach program, so this finding indirectly indicates that there is positive correlation between exposure to empowerment activities and power relations. However, the significance of this correlation needs to be confirmed with statistics test.

Table 14

Power Relations in General

Power Relations in General	Lesbian (n=48)	Gay (n=59)	Transgender (n=47)	Bisexual (n=68)	Total (n=222)
Poor	58.3	45.8	34.0	72.1	54.1
Better	41.7	54.2	66.0	27.9	45.9

Table 15 specifically shows that respondents tend to have imbalanced power relations with police officers, government officials, and their commercial sex partner. This can potentially

affect the LGBT's mental and physical health, and therefore needs to be managed properly. Poor power relations between the LGBT groups and the police make LGBT individuals reluctant to report any experiences of violence out of fear of being further criminalised. Failure to address this issue will affect respondents' mental health. Respondents also report imbalanced power relations with their commercial sex partner, and their inability to negotiate condom use can result in unprotected sex or other risky sex behaviours. Ultimately this situation also contributes to an increased transmission of HIV and STIs.

Table 15

Respondents' Power Relations with Various Parties

Party	Lesbian (n=48)		Gay (n=59)		Transgender (n=47)		Bisexual (n=68)		Total (n=222)	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Have you ever negotiated with the following parties or fought for a cause to help other LGBT individuals?										
Police	27.1	72.9	35.6	64.4	48.9	51.1	25.0	75.0	33.3	66.7
Government Staff	27.1	72.9	47.5	52.5	46.8	53.2	25.0	75.0	36.0	64.0
Health Care Provider	52.1	47.9	71.2	28.9	78.7	21.3	48.5	51.5	61.7	38.3
General Public	50.0	50.0	45.8	54.2	63.8	36.2	35.3	64.7	47.3	52.7
Steady Partner	62.5	37.5	54.2	45.8	70.2	29.8	42.6	57.4	55.9	44.1
Commercial Partner	33.3	66.7	42.4	57.6	48.9	51.1	25.0	75.0	36.5	63.5
Casual Partner	58.3	41.7	59.3	40.7	76.6	23.4	50.0	50.0	59.9	40.1

6. SOCIAL PARTICIPATION

Social participation is defined as respondents' experience participating in an LGBT-related forum. Similar to previous findings, gays and transgenders are more involved in such forum than lesbians and bisexuals, as shown in Table 16. However, 38.7% of respondents have never heard about any LGBT forum, which indicates that quite a number of respondents actually do not know about the available resources that can lend them assistance or support.

Table 16

Level of Social Participation in General

Level of Social Participation	Lesbian (n=48)	Gay (n=59)	Transgender (n=47)	Bisexual (n=68)	Total (n=222)
Have never heard of LGBT Forum	56.3	28.8	40.4	33.8	38.7
Have heard of LGBT Forum but did not participate in activities	16.7	15.3	6.4	33.8	19.4
Have heard and have participated in LGBT Forum activities	27.1	55.9	53.2	32.4	41.9

7. EMPOWERMENT

This section describes the degree of exposure that respondents have to empowerment activities and health program, and their level of empowerment. This section also describes how level of exposure correlates with level of empowerment and how level of empowerment links with a number of variables that were discussed in the previous section.

Exposure to Empowerment Activities

Exposure to empowerment activities was assessed through 9 questions about respondent's experience in participating in empowerment activities that LGBT community organisations conducted (see Table 18). Following the procedure outlined on page 8, variables were categorised as follows:

Score 9-13 : Less exposure

Score 14-18 : More exposure

As Table 17 shows, overall, more than half of respondents (60.4%) fall into the category of less exposure. A similar pattern consistently emerges that gay and transgender groups are more exposed to empowerment activities than lesbian and bisexual groups. It is critical to note that even though gay and transgender have been the focus of HIV outreach programs, almost half of respondents in these two groups still fall into the category of less exposure. This indicates that the coverage and effectiveness of outreach programs needs to be expanded and improved. It is therefore important to look into more detail at the different aspects of exposure that require improvement.

Table 17

General Level of Exposure to Empowerment Activities

Level of Exposure	Lesbian (n=48)	Gay (n=59)	Transgender (n=47)	Bisexual (n=68)	Total (n=222)
Less exposure	66.7	55.9	46.8	69.1	60.4
More exposure	33.3	44.1	53.2	30.9	39.6

Table 18 shows that most respondents with low exposure to empowerment activities cite not getting enough information about violence, discriminatory attitude and human rights issues. This indicates that outreach workers have been focusing too heavily on health-related information and have not given sufficient portion to other topics. Program target or success indicators that tend to focus on the health aspect (e.g. number of individuals reached, number of individuals referred, etc.) indirectly influences the quality of outreach activities.

Table 18

Exposure to Specific Empowerment Activities

Type of Activity	Lesbian (n=48)		Gay (n=59)		Transgender (n=47)		Bisexual (n=68)		Total (n=222)	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
In the last 12 months, did you ever										
Request advice or help for non-health related needs from an organisation that works with the LGBT community	37.5	62.5	50.8	49.2	55.3	44.7	48.5	51.5	48.2	51.8
Participate in an event that is organised by an organisation that works with the LGBT community	47.9	52.1	61.0	39.0	68.1	31.9	48.5	51.5	55.9	44.1
Provide information about health and social service to your LGBT friends	62.5	37.5	88.1	11.9	72.3	27.7	73.5	26.5	74.8	25.2
Receive information about human rights from an organisation that works with the LGBT community	41.7	58.3	55.9	44.1	55.3	44.7	50.0	50.0	50,9	49.1
Get involved with an organisation that works with the LGBT community in your city and perform advocacy for a certain issue	27.1	72.9	45.8	54.2	48.9	51.1	33.8	66.2	38.7	61.3
Hear a friend experiencing discrimination or violence at a health facility or other social service facility	31.3	68.7	37.3	62.7	46.8	53.2	33.8	66.2	36.9	63.1
Receive information from an organisation that works with the LGBT community about documenting cases of violence and human rights violation	31.3	68.7	35.6	64.4	42.6	57.4	32.4	67.6	35.1	64.9
Document cases of violence or human rights violation that occur at a health facility or other social service facility	18.8	81.3	25.4	74.6	36.2	63.8	11.8	88.2	22.1	77.9
Accompany a friend who experienced violence or human rights violation at a health facility or other social service facility	25.0	75.0	23.7	76.3	31.9	68.1	16.2	83.8	23.4	76.6

Exposure to Health Program

Respondents' exposure to health programs was assessed through 4 questions regarding respondents' experience with receiving information or being involved in health promotion activities (see Table 20). Following the procedure outlined on page 8, responses were categorised as follows:

Score 4-6 : Less exposure

Score 7-8 : More exposure

Table 19 shows that the majority of respondents (65.3%) in general fall into the category of more exposure. This means that respondents are more exposed to health program, as opposed to other empowerment activities. This supports the finding outlined in the previous section that most respondents are less exposed to information outside the health program. Among the LGBT groups, lesbian is the group with the least exposure to health programs than the other groups.

Table 19

General Level of Exposure to Health Program

Level of Exposure	Lesbian (n=48)	Gay (n=59)	Transgender (n=47)	Bisexual (n=68)	Total (n=222)
Less exposure	64.6	16.9	36.2	27.9	34.7
More exposure	35.4	83.1	63.8	72.1	65.3

Table 20 shows more specifically that the lesser exposure to health programs does not point to any specific type of activity but is quite equal for all health program activities. It is very likely that respondents who acknowledge less exposure to health programs are those who have not been reached by outreach workers.

Table 20

Exposure to Health Program

Type of Activities	Lesbian (n=48)		Gay (n=59)		Transgender (n=47)		Bisexual (n=68)		Total (n=222)	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
In the last 12 months, did you or were you										
Receive information about your health	45.8	54.2	86.4	13.6	80.9	19.1	76.5	23.5	73.4	26.6
Receive HIV counseling, test or treatment	37.5	62.5	84.7	15.3	63.8	36.2	79.4	20.6	68.5	31.5
Referred to a health care facility	37.5	62.5	81.4	18.6	59.6	40.4	69.1	30.9	63.5	36.5
Access health service	41.7	58.3	86.4	13.6	66.0	34.0	79.4	20.6	70.3	29.7

Level of Empowerment

Level of empowerment is defined as respondent's degree of confidence in conducting health-related activities, and is measured in 7 dimensions (see Table 21) as follows: 1) use of prevention device; 2) STI service utilisation; 3) HIV service utilisation; 4) need for PrEP; 5) access to health care; 6) giving advice; 7) giving opinions in public. The overall score for level of empowerment is a sum of the score for each dimension, followed with categorisation using the procedure outlined on page 8. Furthermore, since questions to measure level of empowerment include a question regarding pregnancy, which only applies to female respondents, the study categorises male empowerment separately from female empowerment.

Categories for Male Empowerment	Categories for Female Empowerment
Score 15-24: Less empowered	Score 17-28: Less empowered
Score 25-35: Quite empowered	Score 29-39: Quite empowered
Score 36-45: More empowered	Score 40-51: More empowered

Table 21 shows that overall, most respondents (81.5%) are in the category of quite and more empowered. Only 18.5% are considered less empowered. This means that respondents are not always confident they can perform the activity in question. In certain dimensions, respondents may in fact feel not confident about the activity, such as regarding the need for PrEP. The majority of respondents (48.6%) were not certain they need PrEP, which may be due to lack of knowledge about PrEP, combined with limited actual access to PrEP.

On the other hand, the majority of respondents feel confident to provide advice (91%) and convey their opinion in public (77%), provided those are done within their own circle or community. This may relate to the stigma and discrimination toward the LGBT community that is still prevalent in the general population. To obtain a more detailed picture about community empowerment, this study also looked at each dimension of empowerment in more detail.

Table 21

Level of Empowerment in Each Dimension

Dimension	Lesbian (n=48)			Gay (n=59)			Transgender (n=47)			Bisexual (n=68)			Total (n=222)		
	1[a]	2[b]	3[c]	1	2	3	1	2	3	1	2	3	1	2	3
Use of Prevention Device	29.2	50.0	20.8	13.6	52.5	33.9	14.9	72.3	12.8	5.9	60.3	33.8	14.9	58.6	26.5
STI Service Utilisation	16.7	75.0	8.3	16.9	72.9	10.2	14.9	74.5	10.6	16.2	73.5	10.3	16.2	73.9	9.9
HIV Service Utilisation	14.6	77.1	8.3	18.6	69.5	11.9	14.9	72.3	12.8	27.9	64.7	7.4	19.8	70.3	9.9
Neef for PrEP	45.8	27.1	27.1	57.6	22.0	20.4	42.6	23.4	34.0	47.1	35.3	17.6	48.6	27.5	23.9
Access to Health Care	8.3	75.0	16.7	1.7	72.9	25.4	4.3	72.3	23.4	8.8	75.0	16.2	5.9	73.9	20.3
Giving Advice	10.4	33.3	56.3	5.1	30.5	64.4	10.6	17.0	72.3	10.3	39.7	50.0	9.0	31.1	59.9
Giving Opinion in Public	20.9	33.3	45.8	25.4	30.5	44.1	21.3	27.7	51.0	23.5	35.3	41.2	23.0	32.0	45.0
Total	22.9	52.1	25.0	23.7	62.7	13.6	19.2	72.3	8.5	10.3	80.9	8.8	18.5	68.0	13.5

Note: [a]Less empowered. [b]Quite empowered. [c]More empowered.

Use of Prevention Device

The dimension of use of prevention device consists of 3 questions about respondents' confidence in their ability to use various prevention devices, taking into account the influence of sex partners and alcohol. Table 22 shows that a lot of respondents do not feel confident they will use prevention devices while under the influence of alcohol/drugs. This is in line with findings

from a number of studies that report how drug use increases sex drive as well as high-risk sex behaviours.

Table 22

Respondent's Level of Confidence to Use Prevention Devices

Component	Lesbian (n=48)			Gay (n=59)			Transgender (n=47)			Bisexual (n=68)			Total (n=222)		
	1[a]	2[b]	3[c]	1	2	3	1	2	3	1	2	3	1	2	3
How confident are you about using condom, dental dam or various STI prevention devices, when …															
You are with a sex partner	4.2	29.2	66.7	3.4	15.3	81.4	4.3	31.9	63.8	8.8	16.2	75.0	5.4	22.1	72.5
Your partner tries to convince you to not use it	2.1	12.5	85.4	3.4	10.2	86.4	6.4	19.1	74.5	2.9	8.8	88.2	3.6	12.2	84.2
You are under the influence of alcohol / drugs	10.4	14.6	75.0	13.6	22.0	64.4	10.6	25.5	63.8	16.2	26.5	57.4	13.1	22.5	64.4

Note: [a]Not confident. [b]Somewhat confident. [c]Very confident.

STI Service Utilisation

The dimension of STI service utilisation consists of 4 questions about respondents' confidence to go to a public health facility or private clinic for STI (not related to HIV) service, considering the attitude and behaviour of health care providers. Table 23 shows that more respondents do not feel confident to utilise the service when health care providers treat them poorly (68.5%) and do not provide the needed service (52.7%). This confirms the notion that health service improvement should not just focus on service completeness, but should also address the issue of staff's friendliness toward patients.

Table 23

Respondent's Level of Confidence to Utilise STI Service

Component	Lesbian (n=48)			Gay (n=59)			Transgender (n=47)			Bisexual (n=68)			Total (n=222)		
	1[a]	2[b]	3[c]	1	2	3	1	2	3	1	2	3	1	2	3
How confident are you to go to a public or private health facility (GP/Doctor's private practice) for STI service (not HIV-related), when ……															
Staffs know your sexual orientation / gender identity	18.8	39.6	41.6	10.2	22.0	67.8	12.7	27.7	59.6	10.3	32.4	57.4	12.6	30.2	57.2
Health providers treat you poorly	70.8	14.6	14.6	67.8	18.6	13.6	57.4	23.4	19.1	75.0	11.8	13.2	68.5	16.7	14.9
Health providers do not provide the specific service that you need	45.8	37.5	16.7	54.2	28.9	16.9	55.3	27.7	17.0	54.4	30.9	14.7	52.7	31.1	16.2
You are pregnant[d]	35.4	22.9	41.7	-	-	-	29.4 (5)	17.6 (3)	52.9 (9)	0	100 (2)	0	32.8 (22)	23.9 (16)	43.3 (29)

Note: [a]Not confident. [b]Somewhat confident. [c]Very confident. [d]Only asked to female respondent.

HIV Service Utilisation

The dimension of HIV service utilisation consists of 4 questions about respondents' confidence to go to a health facility for HIV voluntary counseling and testing, considering the attitude and behaviour of health care providers. Similar to the finding in the previous section, most respondents do not feel confident to utilise the service when health providers treat them poorly (see Table 24). The issue of confidentiality also seems to influence the decision to utilise care, which is a sensitive issue considering the strong stigma that the public holds toward HIV/AIDS. In this case health care facilities need to have, and strictly implement a standard operating procedure (SOP) on maintaining confidentiality of client's personal data.

Table 24

Respondent's Level of Confidence to Utilise HIV Service

Component	Lesbian (n=48)			Gay (n=59)			Transgender (n=47)			Bisexual (n=68)			Total (n=222)		
	1[a]	2[b]	3[c]	1	2	3	1	2	3	1	2	3	1	2	3
How confident are you to go to a public or private health facility (GP/Doctor's private practice) for HIV Voluntary Counseling & Testing, when ...															
Staffs know your sexual orientation / gender identity	16.7	41.7	41.7	10.2	18.6	71.2	19.1	12.8	68.1	14.7	35.3	50.0	14.9	27.5	57.7
Health providers treat you poorly	70.8	16.7	12.5	66.1	13.6	20.3	66.0	14.9	19.1	70.6	17.6	11.8	68.4	15.8	15.8
Health providers do not maintain your visit's confidentiality	50.0	27.1	22.9	54.2	22.0	23.7	51.1	19.1	29.8	69.1	16.2	14.7	57.2	20.7	22.1
You are pregnant[d]	29.1	27.1	43.8	-	-	-	41.2 (7)	23.5 (4)	35.3 (6)	50.0 (1)	50.0 (1)	0	32.8 (22)	26.9 (18)	40.3 (27)

Note: [a]Not confident. [b]Somewhat confident. [c]Very confident. [d]Only asked to female respondent.

Need for PrEP

In the dimension of need for PrEP respondents were asked one question about whether or not they believe they need PrEP (HIV pre-exposure prophylaxis). As mentioned previously, the majority or respondents do not feel they need PrEP, which may be caused by their limited knowledge about PrEP.

Access to Health Care

For the dimension of access to health care, respondents were asked 3 questions about their confidence to go to a public or private health facility and seek care (general health care), considering the attitude and behaviour of health care providers. The study finds that the aspect that has the largest influence on respondents' confidence is the attitude of service provider. In line with other findings, this emphasizes the need to improve staff's friendliness in providing care, in addition to improving completeness of service.

Table 25

Respondents' Level of Confidence to Access Health Care

Component	Lesbian (n=48)			Gay (n=59)			Transgender (n=47)			Bisexual (n=68)			Total (n=222)		
	1[a]	2[b]	3[c]	1	2	3	1	2	3	1	2	3	1	2	3
How confident are you to go to a public or private health facility (GP/doctor's private practice) for general health care, when															
Service providers know your sexual orientation / gender identity	20.8	35.4	43.8	13.6	16.9	69.5	14.9	19.1	66.0	11.8	32.3	55.9	14.9	26.1	59.0
Service providers treat you poorly	64.6	25.0	10.4	66.2	16.9	16.9	63.8	19.1	17.0	72.1	19.1	8.8	67.1	19.8	13.1
Service providers record your name and address during registration?	4.2	20.8	75.0	1.7	13.6	84.7	2.1	19.1	78.8	11.8	16.2	72.1	5.4	17.1	77.5

Providing Advice

For this dimension of empowerment, respondents were asked one question about their confidence to give suggestion/advice to another LGBT individual. A lot of respondents feel quite or even very confident to give advice to their peers, which indicates that respondents feel quite confident and comfortable interacting with their peers. This is natural considering the strong stigma and discrimination that the public has toward the LGBT population.

Giving Opinion in Public

In this dimension, respondents were asked with a question about their confidence in conveying their opinion in public. In contrast with the dimension of giving advice, fewer respondents say they feel confident to express their opinion in public, even if the audience is another LGBT group. Speaking in public does require skills and experience, and the LGBT community may not have a lot of opportunities to develop and sharpen their skills.

8. FACTORS ASSOCIATED WITH LEVEL OF EMPOWERMENT

Association between Exposure to Empowerment Activities and Level of Empowerment

Previously, the level of empowerment was divided into three categories, "less empowered", "quite empowered", and "more empowered". For logistic regression, the level of empowerment is changed into only two categories where the "quite empowered", and "more

empowered" categories are combined into one category. The resulting two new categories are "not empowered" and "empowered".

Table 26 shows significant association between exposure to empowerment activities and level of empowerment ($p < 0.01$). Individuals who are more exposed to empowerment activities are five times more likely to be more empowered than individuals who are less exposed to empowerment activities. This demonstrates the importance of outreach activities, provision of information and training as part of the effort to empower a community.

Table 26

Odds Ratio for Exposure to Empowerment Activities and Level of Empowerment

Variable	*Unadjusted*		*Adjusted for demographic variables*[a]	
	OR	95% CI	OR	95% CI
Exposure to empowerment activities	5.06**	[1.69, 15.05]	5.19**	[1.68, 16.05]

Note: OR = odds ratio; CI = confidence interval. [a]Adjusted for respondent's group, age and education.

Association between Level of Empowerment and Health-Seeking Behaviour

Tabel 27 shows that level of empowerment is significantly associated with health-seeking behaviour ($p < 0.01$). Individuals who are more empowered are 17 times more likely to adopt better health-seeking behaviours than individuals who are less empowered. A note of caution however, this finding is based on relatively few cases, so it is likely that the actual probability is not as high as this study recorded.

Table 27

Odds Ratio for Level of Empowerment and Health-Seeking Behaviour

Variable	*Unadjusted*		*Adjusted for demographic variables*[a]	
	OR	95% CI	OR	95% CI
Level of Empowerment	11.27**	[3.58, 35.49]	17.42**	[4.12, 73.66]

Note: OR = odds ratio; CI = confidence interval. [a]Adjusted for respondent's group, age and education.

Association between Level of Empowerment and Experience with Discrimination

Table 28 shows that level of empowerment is significantly associated with experiencing discrimination ($p < 0.01$). In this case, individuals who are more empowered are 2.5 times more likely to experience discrimination than individuals who are less empowered. This can be interpreted as individuals who are more empowered have better knowledge about their rights, and are therefore more aware about discriminatory behaviours.

Table 28
Odds Ratio for Level of Empowerment and Experience with Discrimination

Variable	*Unadjusted*		*Adjusted for demographic variables*[a]	
	OR	95% CI	OR	95% CI
Level of Empowerment	2.56	[0.94, 6.99]	2.56**	[0.89, 7.38]

Note: OR = odds ratio; CI = confidence interval. [a]Adjusted for respondent's group, age and education.

Association between Level of Empowerment and Power Relations

Table 29 demonstrates a significant association between level of empowerment and power relations ($p < 0.01$). Individuals who are more empowered are six times more likely to have better power relations than individuals who are less empowered. Similar to the interpretation for experience with discrimination, individuals who are more empowered are believed to have better knowledge and understanding about their rights and therefore have more courage and boldness to negotiate with others for the fulfillment of their rights or other LGBT people's rights.

Table 29
Odds Ratio for Level of Empowerment and Power Relations

Variable	*Unadjusted*		*Adjusted for demographic variables*[a]	
	OR	95% CI	OR	95% CI
Level of Empowerment	5.11**	[1.87, 13.89]	5.87**	[2.05, 16.85]

Note: OR = odds ratio; CI = confidence interval. [a]Adjusted for respondent's group, age and education.

Association between Level of Empowerment and Social Participation

Tabel 30 shows a significant association between level of empowerment and social participation ($p < 0.01$). Individuals who are more empowered are 12 times more likely to participate in social activities than individuals who are less empowered. One note of caution, this finding is based on a few cases, so it is quite likely that the actual probability is not as high as this study recorded.

Table 30
Odds Ratio for Level of Empowerment and Social Participation

Variable	*Unadjusted*		*Adjusted for demographic variables*[a]	
	OR	95% CI	OR	95% CI
Level of Empowerment	12.61**	[2.92, 54.43]	12.70**	[2.82, 57.13]

Note: OR = odds ratio; CI = confidence interval. [a]Adjusted for respondent's group, age and education.

Community Perception of Empowerment

For the LGBT community, empowerment is seen as awareness about their health, starting with the awareness about their rights for health as citizens, and that they can fulfill their needs

by utilizing the health services that the state has provided. The community also needs to realize that they have health needs and being healthy will benefit them, irrespective of their gender identity or sexual orientation.

Community awareness about health starts with knowledge about Sexual and Reproductive Health and Rights (SRHR) that can be obtained independently from various media, from information that is disseminated within each respective community or from health care providers. It is expected that knowledge will influence behaviours, so as a result of knowledge, the LGBT community will access health service, undergo routine health check-up, take medications during illnesses and avoid high-risk behaviours.

Another concept of empowerment relates to legal awareness. All this time, gender and sexual minorities frequently surrender to legal injustices, for example when they experience violence from family members or the authorities, raids or arrests. LGBT individuals accept those acts partly because they believe they deserve such treatment, and partly because they do not know what to do in such situations. Empowerment in this regard is providing sexual minority groups with knowledge that they have the same rights as other citizens, along with training on legal matters to give them a better understanding about their rights and to not surrender to injustices.

The majority of minority groups already establish an agreement with a legal aid institute in their area, who welcomes a collaboration with the LGBT community. Legal aid institute also conducts legal empowerment efforts through training or informal discussion sessions, which prompted the community to request the legal aid institute's assistance in advocating for community members who get arrested or experience violence from the authorities or family members. In addition, empowerment activities also teach the community to not violate the law.

Legal awareness starts with the awareness that each individual has equal rights, followed with knowledge about the law, and efforts to advocate for themselves upon experiencing stigma or discrimination.

Another concept of empowerment relates to capacity building, which is defined as development of one's potential in order to be more economically-empowered. To achieve this, community members receive training on specific skills that match their interest and needs. This provides them with opportunities to seek a more sustainable source of income that can improve their quality of life, and demonstrate their potential to the general population.

> *That's why whatever we have, expertise, skills, we polish those, sharpen, refine, so we'll be successful.* (Community Member, Manado)

Another form of being empowered is the initiative to seek information independently, without relying exclusively on service providers. The information, knowledge or skills are then shared with other members of the community who lack the knowledge, and knowledge transfer provides a way for members of minority groups to support one another. Learning becomes a continuous process resulting in more and more individuals being empowered.

In the health aspect, without empowerment, LGBT community will be a much more closed community, unreached by health services. In the absence of information about healthy behaviours, risks of unsafe sexual behaviours, and available health services, increased negligence about health is quite likely. The same concern is raised by NGOs and health care providers.

At the same time, healthy individuals may continue their high-risk behaviour, unaware of the consequences. Without any intervention, these individuals are at risk of experiencing some health issues, while those who need health care may not know where to go to access care or receive support. Ultimately this situation will increase the possibility of further spread of disease to other people outside the community, such as partners or children, affecting the general population as well.

9. ORGANISATIONAL CAPACITY OF THE PARTNER ORGANIZATIONS AND SERVICE PROVIDERS

The Concept of Empowerment

This section describes the concept of empowerment from the perspective of the LGBT community, NGO and service provider. The concept includes three themes, i.e. health awareness, legal awareness, and capacity building.

Health Awareness

From the perspective of health care providers, the most important thing is for community members to independently come to a realization that health is important. Initially health personnel or NGOs will provide information on health, but the next critical step is for each individual to come to a health facility and seek care. One private health facility in Manado hopes that members of minority groups can do so on their own.

> *It's teaching patients to be independent, to care about their health. It'll be strange that you have to depend on other people just to get your health checked, right? You want health treatment, no one can accompany you, so you don't go, and yet you need treatment, that's one example* (Health Facility Staff, Manado)

Health care providers hope that community members will not continously depend on encouragement or support from NGOs, and expect health personnel to be the one who care more about their health. Instead it is hoped that LGBT individuals will independently come for periodic health check-up, take medications at their own initiative, and even encourage their peers to also care about their own health. Such awareness will eventually result in behaviour change in which community members will actively make effort and fight for their health rights. NGOs and health facilites hope that their effort can motivate community members to improve their own knowledge, to pay attention to their health and have improved health-seeking behaviour, resulting in overall health awareness.

On the other hand, health care providers are also concerned about the consequences of receiving information from inappropriate sources, such as doing internet searches without further consultation with a health personnel. It is likely the community members will receive inaccurate information that may lead to fear, or even higher-risk behaviour and other negative impact. Health care providers believe that lack of empowerment will result in lack of information, and inadequate attention to healthy behaviours, which will increase the transmission of HIV and STI.

> *It'll be a mess. The number of infected people will certainly increase.* (Health Facility Staff, Pekanbaru)

Legal Aspect

The legal consequence of lack of empowerment will be a situation where community members do not understand their rights as citizens, they are entitled to receive legal protection. NGOs who work on the issue of LGBT discrimination report that this lack of knowledge makes LGBT individuals particularly vulnerable to hate crimes as a result of their gender expression, sexual status or profession that is considered a violation of societal norms. Among the different sexual and gender minorities, transgender sex workers are the most vulnerable group.

> *They don't understand their rights as citizens* (NGO Staff, Pekanbaru)

> *Generally, when they get arrested, they will just accept the situation even when they haven't done anything* (Service Provider, Manado)

LGBT individuals commonly get arrested in a raid, and endure rough treatment from the authorities even when they have not committed any violations. One legal aid institute reports that community members tend to accept the arrest and other treatment, as they do not know how to advocate for themselves. Even when a legal aid representative is present to lend support, LGBT individuals tend to remain quiet and do not try to defend themselves. They also will not take steps to ensure that the perpetrator of violence pays for their action. Legal aid institute

believes that this lack of legal knowledge will make community members continue to be criminalised.

> *They'll be criminalised, they don't know what the law says* (Service Provider, Jakarta)

Socio-Economic Aspect

Lack of empowerment will also have some socio-economic impact. NGOs who work on research and advocacy for the LGBT group believe that it will make community members continue to socially isolate themselves due to feelings of guilt and sinfulness for their sexual orientation. They will have little awareness about their right to be treated in the same way as any other member of the society. They also feel they deserve all the unfair treatment.

> *They will continue to be at the point where they feel sinful, guilty, and they don't know what to do* (NGO Staff, Jakarta)

An NGO that works on human rights issues and does advocacy for people who live with HIV/AIDS (PLHIV) adds that without empowerment, the negative image that the society has about sexual minority groups will remain rooted in the society. They will not be considered as part of the society, resulting in marginalisation. People may not accept LGBT people, stigmatise, and discriminate against them. In fact, their access to public services such as service in Puskesmas, may be limited. Hoaxes about the LGBT community that often circulate among people will further entrench the existing stigma, creating a more difficult situation for LGBT individuals.

> *It's the community itself who will feel the impact. First, all the negative stereotypes on the minority group will be more …, how should I put it, it'll be even more rooted in people's mind. Oh, you get that disease, so it's natural, it's normal to be like that since you're an LGBT* (NGO Staff, Jakarta)

NGO who works on the issue of LGBT also reports that the negative stereotype against the LGBT community will limit the community's opportunity to develop their potential and be more economically productive. They will be unable to sharpen their other skills, requiring them to stay working as sex workers. Empowerment is hoped to provide trainings that match the community potential and interest, helping community members to develop their ability.

> *They won't be able to rise from their economic desperation. Just take our trans-friends at that hub for example … 'that's where they will stay their whole lives' … and yet if they can get empowerment, they can participate in trainings, to manage a salon, be a make up artist, a hairdresser, etc.* (NGO Staff, Pekanbaru)

Empowerment Program

This section describes the focus of empowerment program and service provision for the LGBT community. The program is grouped into three categories, namely education, service and advocacy. The educational program provides information or capacity strengthening that

indirectly relates to STI and HIV/AIDS, such as information on Sexual Orientation, Gender Identity, Gender Expression and Sex Characteristics (SOGIESC), human rights, paralegal support and training for certain skills.

Service program provides information or health service (outreach, referral, treatment, testing and support) that directly ties to STI and HIV/AIDS. Advocacy is a program that aims to influence a policy at the national and local level.

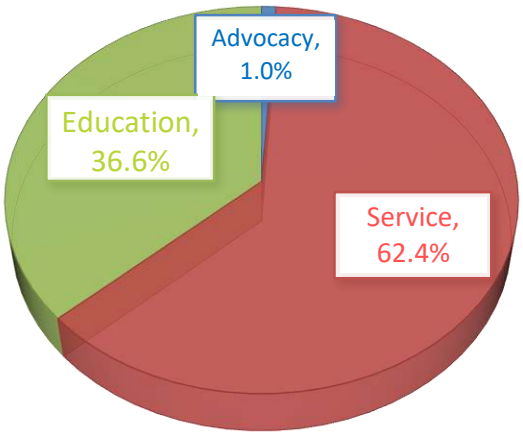

Figure 1. Proportions of Focus in Empowerment and Service Delivery Programs for the Community

Figure 1 shows that community empowerment programs that have been implemented to date have mostly focused on service delivery. Only a very small proportion of activities are focused on advocacy. It is recognised that health promotion activities are important and necessary, but they need to be complemented with policies that are inclusive and are able to guarantee the community's rights. Changes at the policy level are therefore essential to ensure the sustainability of health promotion programs.

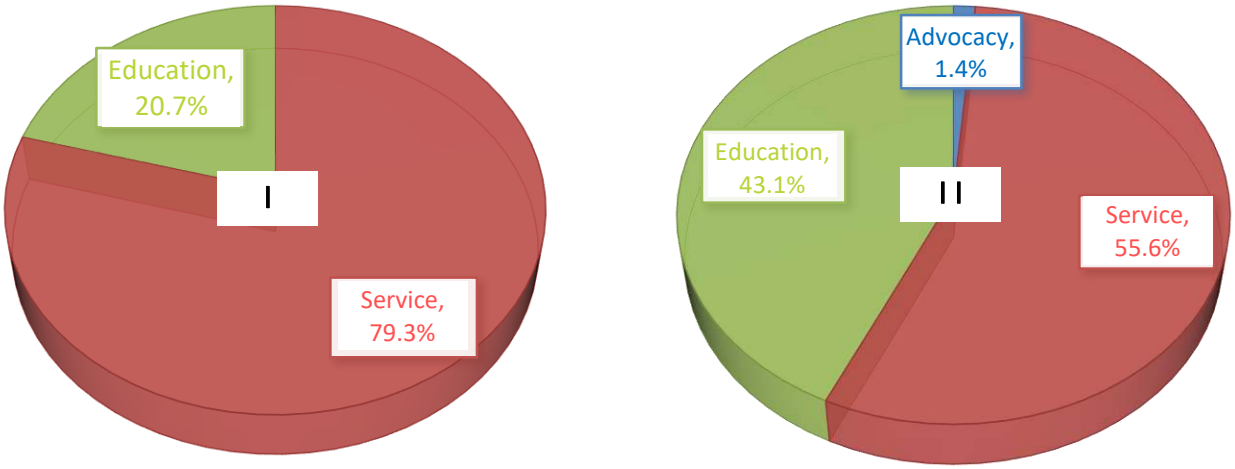

Figure 2. Proportions of Focus in Empowerment Program that is Implemented by Service Provider (I) and NGO (II)

Figure 2 shows that both service providers and NGOs give a bigger proportion to service programs. Actual program activities however are different. Activities conducted by service providers are dominated by testing and treatment, while NGOs focus heavily on community outreach and mentoring support (see Figure 3). This demonstrates good collaboration between service providers and NGOs in delivering services to the LGBT community.

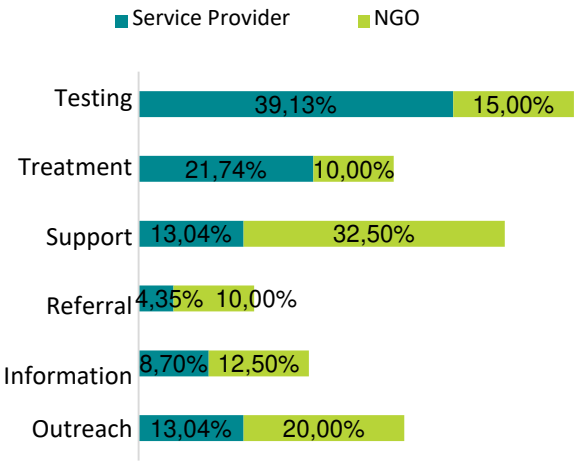

Figure 3. Comparison of Activities in the Service Program that is Implemented by Service Provider and NGO

With respect to the educational progam, Figure 2 shows that service providers primarily focus on health promotion activities, leaving only a little portion for education on issues that are not related to STI and HIV/AIDS. A closer look at Figure 4 will reveal that activities on education that NGOs carry out are more variable compared to activities performed by service providers, and are not limited to information dissemination, but is also directed toward skills building. This demonstrates the crucial role of NGOs in empowering minority groups in aspects that are non-health related such as economy, legal and human rights aspects,

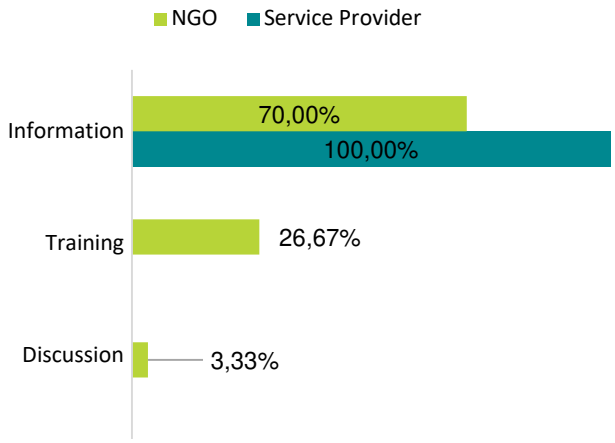

Figure 4. Comparison of Activities in the Educational Program that is Implemented by Service Provider and NGO

With respect to program's target, it was observed that programs that are implemented by service providers do not specifically focus on the LGBT community, since health services are supposed to be inclusive, without discriminating or giving exclusive treatment to any specific group. In contrast, some programs that NGOs implement are specifically focused on empowering LGBT groups or sub-groups. Their program target is therefore the gay or MSM and transgender community.

Program Accessibility

This section describes the perspectives of NGOs and related service providers about access of LGBT community to empowerment program and health services. Most community empowerment programs seem to focus on MSM and transgenders. NGOs tend to focus on these two groups as the most vulnerable and stigmatised group, while service providers say that they rarely encounter other sexual minority groups, especially lesbian.

> *"Oh yes, among the four groups, the one I have never encountered is the lesbian. I don't know if there are none in this area, or maybe it's because they are absolutely unwilling to open up."* (Health Facility Staff, Pekanbaru)

With regards to provision of health service, health care providers say that services can be accessed by anybody and there are no special services for any specific sub-groups. Health care providers focus on the health aspect, so service will be provided without any differentiation based on specific attribute/status. NGOs who work with sex worker communities also confirm this statement.

> *"For that aspect it's basically the same, there's no difference. Female, male, transgender, there's no difference."* (NGO Staff, Pekanbaru)

Service providers in one private clinic added that every patient who comes to their facility will be served following the same procedure. All patients will follow the same procedure and wait in the same waiting room. This is specifically done to avoid any stigma or impression that the LGBT community are being given a special treatment.

> *"If you ask about discrimination, over here, in this facility, if you observe the situation, there is no differences…. because we're all mixed together here … you see over there… we don't have a special room, like a waiting room for the LGBT community members here, then another waiting room over there … we do it this way on purpose."* Service Provider, Manado)

Even though the intention of having the same procedure, and the same waiting room is to not discriminate any patients, this practice actually becomes a matter of debate in the LGBT community. Service providers often receive input that community members feel uncomfortable

with such practices and some government officials who were interviewed also said that some health facilities do provide a separate waiting room for LGBT people.

> *"There's actually no difference, the service is the same, but to make our friends from the community more comfortable, we indeed …, this is not discrimination, there is a separate space, so when they come to a health facility, they don't mingle with patients from the general population. So this is… I think this is not discrimination, and it's not giving them special privilege either, but it's basically a way to make our friends more comfortable in accessing service."* (Government Official, Manado)

More efforts are still needed to decrease discrimination at a health facility since a lot of community members still feel discriminated during accessing health care. This is a challenge for us all, community members as well as health care providers.

> *"In general, it should be possible, but since there is stigma and discrimination, that's what prevents them from getting access, that's the situation. It's there, but it's not supposed to be like that, they're the same, it's just the access to service that's different. The health facility makes the distinction."* (Health Facility Staff, Pekanbaru)

Stigma and discrimination are often impacted by the political situation in Indonesia. During the general election period, there were pressures in various neighborhood to not organize any LGBT-related activities in an open manner. A number of organisations adopted a more concealed approach in promoting and announcing upcoming activities for fear of attack or crackdown during the activity.

> *"For example, if we're having a get-together, don't share it publicly. It's enough to just spread the word within our community, within our organisation …. If we are too conspicuous, it may be dangerous for us and for the organisation"'*(Community Member, Riau)

NGOs who actively work on LGBT issues also withdrew from several social media, some even shut down their website out of concern about the developing political situation. Private health facility was less actively promoting the availability of service for sexual minorities to prevent problems or avoid being criminalised.

> *"The other day I said that the website has to be shut down temporarily. If things have become so bad like that one time, then okey, let's not have our weekly meeting. Just meet every two weeks or something, and if things get worse in the future, hopefully it'll never get to be that bad, maybe we shouldn't even go to the office. We'll work from various places we are in. So we've thought of everything."*(NGO Staff, Jakarta)

> *"We're a bit afraid to promote our service openly … we can't hold a big promotion, we can't be frank, we have to sometimes limit ourselves, or we probably won't promote things here."*(Private Health Facility Staff, Jakarta)

The LGBT community also limit their activities and started to hold them at a place that is different from the usual place. NGOs that focus on transgender issues report that several

members of the LGBT community were worried of attacks from the general population or certain organisation, and decided to withdraw from their daily jobs. They have experienced violence and attacks, and therefore tend to isolate themselves more.

> *"the hotspot is shrinking. It's here, you see, over there by those shop-houses, that's the hotspot for transgender, then violence often occurred there, so they moved to another hotspot by the park. So now they all gather there."* (NGO Staff, Manado)

The less-conducive situation caused community members to make special efforts to secure the safety of themselves and the organisation. Fostering good relationship with people in the neighborhood is one approach that an advocacy and LGBT research institution adopts. They also introduced themselves to community figures who are respected in the area with the hope that getting in touch with respected leaders will help minimize the pressure that the public puts on the LGBT community.

> *"Maintain good relationship with the neighbors like for example Idul Fitri is coming up, so we will prepare gifts for neighbors near our place, sweet drinks, cookies, those things. It turns out they reciprocate, so all of a sudden on the day of Idul Fitri, they deliver a beef dish, you know how we also do things like this at the office."* (NGO Staff, Jakarta)

> *"We approach community leaders since we interact with the people. It's important to engage the stakeholders, but in the field, the first people we meet are members of the general population, so it's critical that we develop good communication with community figures"* (NGO Staff, Jakarta)

In implementing activities, NGOs who work with the LGBT community would first ensure that an activity is held at a location that is safe for the community to safely express themselves. Some organisations also developed an 'escape plan' should a raid or attack occurs, so community members can save themselves.

> *"To prepare for an activity, we first survey the site to see if it's a suitable place. One example is when we had our congress. We prepared an emergency exit for us to take if a mass of people suddenly barge in, then we have an escape route."* (NGO Staff, Pekanbaru)

> *"When they're in a safe space, they will be able to express themselves freely … when they're not in a safe sapce, they also have to learn to mind their manners and mingle with the general population."*(NGO Staff, Pekanbaru)

In contrast, a number of organisations in Manado explained that criminalisation has not impacted the service that they provide. This was particularly true for organisations in the area where people are more accepting of LGBT individuals. Health facilities, both public and private ones, also reported a similar situation, and reiterated that health services have to stay focused on health, and service delivery without differentiation on the basis of service beneficiaries.

Overall, even though criminalisation did not impact the delivery of health service, it did have an indirect effect on the number of LGBT individuals who utilised the service.

> *"If you're talking about direct impact, I think no, but we're also always careful so that people will not use this issue to cause problems for us, that's always what you need to do"*(Private Health Facility Staff, Jakarta)

> *"No, not at all,… we are accepted by the Board of a number of faith-based organisations, so there's no impact"*(NGO Staff, Manado)

Based on the data above, it can be concluded that different LGBT groups do have different access to service due to NGOs giving more attention to certain sub-groups, combined with the political situation in Indonesia. The community is also still dissatisfied about being treated with the same procedure as the general population in health facilities, showing that there is still fear toward discrimination by the public, such that the community feels they need a separate waiting room away from the general population.

Barriers to Program Implementation

Barriers that NGOs and service providers have been facing indicate that the empowerment efforts that have been conducted and health services that have been provided have not been optimum.

One barrier faced during field activities actually comes from the LGBT community who according to NGOs are not as committed to the activity and even seem to resist the program. An NGO in Manado who actively performs outreach to the LGBT community reports experiencing the same situation. Community members on the other hand say that they think the program is not as important, and will only result in a negative impact for them.

> *"A lot. Even until now we still get a lot of rejection from the community."* (NGO Staff, Manado)

Aside from the barrier that comes from community members, a legal aid institute in Jakarta mentioned that problems often come from the media that broadcast inaccurate or insensitive news about sexual minority groups. The media also tend to exaggerate certain issues, creating more pressure to the community.

> *"You know how media like those kinds of things, they blow things out of proportion. So one challenge is from the community themselves, and another challenge is from the media that's less ideal. It's like this, they actually know their role, but they take advantage of that role and use it for their own interest. They broadcast things like it's a huge thing, it's hot news."* (Service Provider, Jakarta)

This situation shows that advocating to the media is one aspect that NGOs need to attend to. At the same time, sexual minority groups are not yet fully accepted by the public, as reported

by NGOs who focus their intervention on young key population. This is a finding that needs attention as well.

> *"There's resistance, rejection. If for example we talk about key population in social media, we mention about sexual identity, gender identity, and the numerous challenges to empower the people who are basically lay persons. Then for sure there will be rejection, resistance, or whatever you want to call it, preaching, etc."* (NGO Staff, Jakarta)

Some constraints also come from the government, creating more and more tasks for NGOs. NGOs who actively work with sex workers believe that government programs have not been appropriately targeted, and government officials are not responsive to the needs that arise during NGO's program implementation.

> *"There is something else, but it's not through us. That's why they're now working with a social welfare agency (LKS). To my observation, their assistance is not appropriately targeted."* (NGO Staff, Manado)

> *"For example if we hold a workshop or seek an audience with the District Health Office, it's really difficult to invite them to our event."* (NGO Staff, Jakarta)

In addition there are also problems with the unethical behaviour of law enforcement officers. Legal aid institute staffs still see police officers not processing reports about community members' experience objectively, and focus on the individual's gender instead.

> *"For example they're accused of stealing, but the police focused on their gender instead. Why are you a transgender? What is it with you? They don't know how to deal with the police, so when they're being questioned with the police, things go out of hand."* (Service Provider, Manado)

These findings demonstrate that NGOs need to reflect on the empowerment efforts that they have made, and start developing a new strategy to overcome these barriers. It may be necessary to reorient activities to not focus on outreach alone, but give a larger proportion to advocacy activities.

There are also constraints from health care providers who may seem less friendly or do not use the proper approach in providing service, causing community members to feel uncomfortable, One NGO who works with transgenders report this.

> *The service …. Not all service facilities provide it in…. in a way that's friendly to the community… not all of them are friendly, so far in my opinion, that aspect is weak …. weak…. weak in what way …. well… in everything. The service, the organisation, and the effect I'm feeling right now, it's not … I can't describe it.* (NGO Staff, Pekanbaru)

Inadequate number of field personnel who can serve the community is another constraint. NGO who works with MSM also thinks that the frequent change of health personnel in health facilities affects the relationship between health facility staff and community members.

"For example, health personnel at health facilities just keep changing, so we have to do advocacy all over again." (NGO Staff, Jakarta)

Human resources availability also affects the operating hours of health facility that do not match community members' schedule. There have been efforts to have longer operating hours, but in the end, health facilities cannot maintain the effort, which means that the LGBT community has to adjust to the health facility's schedule to access service.

"They'll complain for sure. Why do you stop giving service at night? Maybe until 9:30 pm, but again, we don't have enough manpower for that." (Health Facility Staff, Jakarta)

These findings indicate that health facilities still need to improve its human resources development effort in order to have a work force that is inclusive and responsive to the needs of the LGBT community.

All the information above demonstrates one critical issue that requires attention. It is important that the LGBT community is regarded not as an object that a program has to achieve, but activities that are carried out for the LGBT community should be based on the actual need of the community.

10. CHANGES

Perceived Benefit of Empowerment

Health facilities and NGOs agree that members of the LGBT community have demonstrated some health-related behaviour change as a result of empowerment activities. More and more community members are taking the initiative to visit a health facility for routine check-up like getting tested for HIV or STI. A small number of individuals still need to be encouraged or accompanied to a health facility, but the majority have done so on their own. Awareness to reduce high-risk sexual behaviour is also better and condom use is increasing along with higher retention in treatment. Health care providers and NGO staffs who do outreach to transgender report this.

It's basically serving clients so that they know their status, they can lead a better life. What I mean by a better life is that they use condom when they have sex … (Health Facility Staff, Jakarta)

No condom no sex, so it's more about information about health and HIV. No condom no sex. (NGO Staff, Manado)

Some MSM also act as peer educators and help NGOs reach out to their peers, encourage individuals to get tested, and provide support during the treatment process. Members of various LGBT community also establish a communication forum where individuals can voice their

opinion, discuss various issues and network with other groups and academic partners. Some communities have also started to disseminate information at schools.

> *One success that we've seen is that some of the individuals we mentored have become NGO staffs. We've seen some change in behaviour, they now are more aware about safe behaviour, so they routinely get health check-up, and as peer educators they bring their friends to the health facility to get checked as well.* (NGO Staff, Jakarta)

Empowerment program also brings benefit with regards to legal knowledge. Legal aid institute helps the LGBT community be more aware about their rights as citizens, by teaching them the basic laws of Indonesia, training them about the role of a paralegal, and ways to advocate for themselves. Hands-on training is provided in the form of simulation of questions that may be asked by law enforcement officers, also simulation of a trial so that individuals will not remain quiet when they are criminalised by law enforcement officers.

> *If the statement is incorrect, they can say so, or if there are trick questions, they won't directly respond but they can turn the question around to the police* (Service Provider, Manado)

Some communities and service providers noted how legal awareness as a result of empowerment program has increased. Community members no longer remain quiet when they are stigmatised or discriminated by a family member or a police officer, they know what strategy has to be adopted and steps that should be taken to advocate for themselves.

Despite the successes, empowerment program implementation still needs to be optimised. Some LGBT community feel that some programs have a strong focus on target, and are then carried out without making effort to truly consider the need of the community. Some NGOs who work with transgender feel that their community do not reap any benefit from the program, but are a mere object of achievement.

> *When they have a program, we become an object that will make their program run smoothly, so their program goes well, and the effect falls on us, we don't get anything else.* (NGO Staff, Pekanbaru)

In terms of health care, some LGBT community desires to be able to get access to mental health care from a psychologist for example, for emotional problems that they often have. Not all health facilities and NGOs have a SOGIESC and human rights program so some health care providers and community members have not been exposed to these two issues, which may partly cause services to be less-friendly, plus self-stigma among community members who feel they deserve unfair treatment.

It can be summarised that as a result of empowerment program, members of the LGBT community do feel more empowered, and have better knowledge about health and legal issues. Individuals with more knowledge are also teaching their peers and disseminating information,

but on the other hand, there is an impression that existing programs tend to primarily focus on target achievement.

Community Engagement

The LGBT community and health care providers both agree that community engagement is critical in any empowerment and health care provision effort. The community members are the ones who are most knowledgeable about the situation and the needs in the field, as well as the most appropriate strategy that should be employed to carry out activities. They can reach out to their peers more effectively than health care providers. As part of the community, they are trusted by their peers and can therefore give information and invite fellow community members to go to a health facility. NGOs and health facility therefore rely on LGBT community representatives to reach out to their peers. The same approach is adopted by one private clinic.

> *For example if outreach to a LGBT is done not by a fellow LGBT, if we take that as an example, then certainly they will be embarrassed, awkward, something like that. In my observation all this time, I'm thankful there are field workers who can directly be put to use* (Health Facility Staff, Manado)

Community engagement can take a number of forms, such as through a formal discussion like FGD, or routine periodic meetings. FGD can be conducted by an NGO and government institution in order to get information about pressing issues, or to discuss the situation and needs of the community. Informal discussion also occurs on a daily basis in a relaxed setting where community members will feel free and at ease to convey their opinion. NGOs and health facilities also performed client satisfaction survey or provide a suggestion/comment box for community members to give input. Input from social media are taken into consideration during program planning.

> *Yes FGD, on a certain topic, whether it's about services, or some issues, stigma, or discrimination that they still experience* (Government Official, Manado)

One input that comes from the LGBT community is the need for psychological care, in addition to health care and legal assistance. It started as an idea that was explored further by NGO in an FGD. Afterwards some NGOs who work with the LGBT community start providing counseling service in their program.

> *At first our service was basically health and legal aspect, that's it. Oh you can't do that, we also need counseling* (NGO Staff, Jakarta)

Empowerment Best Practices

Empowerment efforts and service provision for the community do not just generate various assessment and evaluation, but also a number of best practices that can be used as a

model, though perspective differences between the community and service providers may not always make it easy to arrive at a best practice.

One example is regarding employing a special procedure for the LGBT community in health facility. Some community members feel it is necessary for the community's comfort, while other members believe it will create a new stigma instead. Staffs at a private health facility in Manado think that a special procedure will actually demonstrate discrimination.

> *"About discrimination, here, in this facility, to my observation there's none …. we are all together here, you see out there … there is no special room like a waiting room for the community, another one over there … no, we purposefully don't do that"* (Health Facility Staff, Manado)

Empowerment and health care provision that is provided with the active engagement of the community is a best practice that should be noted, like for example a collaborative outreach effort between health care providers and NGO staffs. Outreach activity by NGOs have to a certain extent create awareness among community members so that they will take the initiative and access information and services.

> *"A lot of friends are already aware about health, they're independent, I mean for example they'll go for VCT (voluntary counseling and testing) every 3 months, we don't have to remind them anymore they already get into the habit of doing it."* (Community Member, Manado)

Some government programs are also trying to improve the health status of the LGBT community. Service providers feel that their program activities receive full support from the government, and do not feel constrained in delivering service. This is also only achievable as a result of efforts from various NGOs.

> *"None… the government so far, … they… support us, back us up, since the program is clear, and the government is supportive, they're always supportive, … there's no… no barriers or problems during the program so far."* (Health Facility Staff, Pekanbaru)

NGOs also play a role in helping community members adjust to the less ideal situation that they face in the society. NGOs help the community to have self-control and protect themselves. At the same time NGOs build relationship with the general population as well as important community figures to gain support for the empowerment program.

> *"What we do here, if for example there is a heated issue, so I ask our friends to maintain self control, protect themselves. Then once things are back to normal they can go back expressing themselves. So they are aware when they need to be more restrained and when they can be free, that's all."* (NGO Staff, Jakarta)

> *"We approach those community figures as we are interacting with the general population."* (NGO Staff, Jakarta)

NGOs also build relationship with other agency/organisation to provide a suitable support for the LGBT community during a specific situation. Networking with a legal aid organisation greatly helps the community manage human rights violations wisely and appropriately. One NGO who works with transgender states that this collaboration allows minority groups to receive assistance at no cost.

> *"There's an activity that when our friends from the LGBT community have a problem with violence or whatever, any problem with the law, our friends from the legal aid institute will help, and the help is provided for free."* (NGO Staff, Manado)

In the aspect of health care delivery, best practices that need to be maintained is the ease in accessing HIV and STI service at an affordable or even no cost (for certain services) to the community.

> *"Over here, testing is still free, HIV and syphilis test, they're still free. Other costs outside those probably are of no problem."* (Health Facility Staff, Jakarta)

Overall services for the LGBT community still need to be improved, as community members may also disagree with each other about their needs. Some notable efforts have been made to involve NGOs and the community in making adaptation to the service. As a result, some programs have been running well such as legal advocacy activities and free health care.

11. EFFORTS TO STRENGTHEN EMPOWERMENT PROGRAM

Improving Community Acceptance

To encourage community members' participation in empowerment program, service providers and NGOs need to adopt a specific approach. Without this specific approach, participation is not intense and some individuals question the importance of an empowerment program. One legal aid institute even think that community members will only attend a meeting when a reward is provided.

> *"Except when we get a large program, from outside donor, and we invite friends to stay at a hotel, with transport money for several days. So then they do the activity but they don't focus on the material. They only focus on how much they will get. What a shame" (Service Provider, Manado)*

Several NGOs believe that to make community members pay more attention to the program that is actually intended for them, some things need to be done or provided. One example is provision of information about SOGIESC that a lot of community members are not familiar about. This is essential knowledge to prevent stigma and discrimination, starting from self stigma that the community frequently holds. Several NGOs report that without changes

within the LGBT community itself, they will not recognize any stigma and discrimination that they receive from outside the community.

> *"Education is super important, I feel education is very important and my friends do not understand that, even something like gender, so we have to start with details about gender, do they understand that, and then we can talk about gender diversity and sexuality since if that is not done, the rest will be really difficult"* (NGO Staff, Jakarta)

NGOs believe knowledge about SOGIESC can help the LGBT community stop thinking that they deserve to be stigmatised and discriminated due to their sexual orientation and gender identity. Many individuals have self stigma that because they are "different" they do not have equal rights as other people. Information is therefore provided so that the community can accept themselves better and believe that they are entitled to receive the same service as any other individual in the society.

> *"They also have to believe, this is me, they shouldn't think oh I'm not normal. Such mindset really has to be changed. It's like… so what if I'm different, since I'm different I don't have the same rights as everybody else? That's what our friends need to internalise"* (NGO Staff, Pekanbaru)

A community educational program should not only provide information on SOGIESC, but should provide education about the basic rights of each individual, one of which is the right for health, that the state has to fulfill. Government institution states that education about rights will improve public acceptance of health care for the LGBT community, so that the community will also feel more comfortable to access service.

> *"So people's mindset has to be transformed, the way we see it is this, health is a human right, health is something that everyone has to have, it's their right and it's the obligation of the government to provide service, regardless of who the person is."* (Government Official, Manado)

LGBT groups also suggest that acceptance of the community in health facilities can be improved by giving SOGIESC education to health care providers. To avoid stigma and discrimination during health service delivery, health care providers are a relevant target for education as they need to understand and accept the community they serve.

> *"Stigma is usually prevalent, you know how most people think when it comes to these things. There'll certainly be stigma, that's all. Hmmm… for staffs in health facility, information about SOGIE."* (Community Member, Pekanbaru)

After information about SOGIESC, health care providers, in collaboration with private health facility, should also receive basic knowledge about HIV to improve the quality of service that they provide to community members. Several trainings should be conducted to improve health care providers' knowledge about HIV/AIDS. The hope is to reduce stigma and

discrimination during health service delivery as a result of service providers' better knowledge about HIV/AIDS.

> *"Yes, over here, they're together with us … so we hmmm… reach out to the doctors, nurses, we all took the course. It was 6 months, it was a flash, 6 months learning, then a meeting, we learn there for 3 days. It was quite intense, what year was that, perhaps 4 or 3 years, there were several periods, several times perhaps. At least the medical people have better basic knowledge about HIV. That's it. When their knowledge increases, the discrimination and stigma decrease."* (Health Facility Staff, Manado)

Along with the educational program, health facility also institutes the same service access procedure for the LGBT community and the general population. Having the same procedure is hoped to eliminate discrimination and have people be aware that the LGBT community has the same right for health. An NGO that works on human right issue in Manado also states that the LGBT community feels comfortable with this arrangement.

> *"Regarding discrimination, over here, in this facility, to my observation there is none … we are mixed together over there … there is no special room like a waiting room for the community over here, another waiting room for the others over there … no, we purposefully do not do that"* (Health Facility Staff, Manado)

> *"The fear to access health service is no longer there because the public and the community are treated equally, the service hours, the service, access for information, the community is doing it freely already."* (NGO Staff, Manado)

The training and various program have an impact on health facility staffs who started to perform some stigma and discrimination reduction efforts. Staffs at one private health facility share that one way to accept the LGBT community is by looking at the issue of gender, etc as an individual's personal issue that is separate from health services.

> *"Actually it's about how we can accept them, isn't it. If we can accept them, "accept" the fact that sex is their personal matter, orientation is their personal matter, while this is a health matter. That's all. Then people will feel comfortable."* (Health Facility Staff, Jakarta)

Some government institution also advocates for the LGBT community to gain access to other services, in addition to health service. One example is possession of an identification (ID) card for transgenders. A lot of transgenders do not have an ID card as they do not have a transfer letter from their hometown to their current residence. Assistance is therefore given for transgenders to prepare the required paperwork and get an ID card.

> *"Why can't they get an ID Card? Because they didn't arrange for a transfer letter. You know they may be marginalised in their hometown, so they came to Manado. So we helped our friends from the community and approached BPJS, and now they can get BPJS insurance collective membership, so it's like they're grouped under an orphanage"* (Government Official, Manado)

Overall, to address resistance from the LGBT community toward empowerment programs, NGOs provide education on SOGIESC and basic rights in order to reduce self-stigma and self-discriminatory practices among community members. Health care providers also receive various trainings to decrease stigma and discrimination in health facilities.

Improving Stakeholder Acceptance

A critical effort to improve stakeholder acceptance of empowerment programs is by building a strong network with them. Several NGOs utilise their network with related stakehodlers and engage the different stakeholders, primarily government agencies, in program implementation. The purpose is not just to build a collaborative relationship but also to strengthen the position of any upcoming program.

> *"Networking. For example, or it'll be good if for example one of our friends becomes a government official, then we support him, this is a legislative body for example"* (NGO Staff, Jakarta)

Considering that the desired improvement or change is not limited to the health aspect, network and relationship building should include various strategic institutions in a number of sectors. A legal aid institute also says that a good relationship with government institutions will increase stakeholder's acceptance of program and bring about positive changes in the LGBT community.

> *"For example the educational office, educational institution, health institution, manpower, etc. So while we have approached people at the field level, at the same time we also need to be more strategic and approach government institutions with the hope we can have something that is more certain, or there will be changes to the situation."* (Service Provider, Jakarta)

A number of private health facilities express their need for funding support from the government. There is a concern about the decreasing funds from external donors, so support from the government is needed for private health facilities. In this regard, organisations have to be more proactive in convincing the government to provide funds and support.

> *"If for example there is money from the government, then don't just give it to Puskesmas… but give it to private clinics also, since private clinics have been in this program for quite some time already … please support us again"* (Private Health Facility Staff, Manado)

Another aspect that requires attention is the legal status of an organisation. An organisation needs to have a permit and be registered, which will strengthen its position in implementing a program. A legal status should also enable the respective NGO to access funding from the government or other donors. A government agency is available to assist NGOs legalise their organisation.

"Has legality, if they already have the strength to get all the legal documents for their organisation, and then register it at the National and Political Unity Office (Kesbangpol), the Social Affairs Office, so they can get all the assistance from the local government that is specific for their community. The objective is actually not to get funding, but so that their existence is acknowledged." (Government Official, Manado)

NGOs also perform advocacy, though only a few NGOs are targeting policy changes at the national and local level. As an initial step, the LGBT community has met with some government representatives not just to increase their acceptance of empowerment program, but also so that government stakeholders understand the constraint LGBT community experience in accessing health care.

"We contact people who have influence, like the assistant to the Mayor, we want to meet the community members.. they may have input and ideas for the mayor, for the future.. and we did it."' (NGO Staff, Manado)

In an effort to increase stakeholder acceptance of empowerment program, NGOs try to foster strong collaborative relationship with related stakeholders. In addition efforts are made to legalise the NGO so that they receive recognition as an organisation and can hold events that are acknowledged by stakeholders.

Increasing Program Effectiveness

To increase program effectiveness, there needs to be a solid program plan, a measurable target, and systematic monitoring and evaluation. This is stated by a private health facility in Jakarta.

"Develop a program perhaps, an annual work plan, quarterly activities, with content, objective, something along that line." (Health Facility, Jakarta)

A lot of programs are implemented without a clear measurable target, some programs even do not measure any achievement of target. Without a good monitoring and evaluation system, program evaluation will also not be optimum. Quite frequently NGOs measure their achievement by observation on a number of individuals only.

NGOs who work on community empowerment also feel it necessary to actively involve community members in the program, and not make them a target of program achievement. NGOs therefore are starting to invite community members to participate in the program from planning to implementation.

"In my opinion we have to sit down together, we have to see, don't just make our friends an object, but we sit down together, listen to their needs. That will be very effective …"(NGO Staff, Jakarta)

"Well, if the program is indeed for the community, then the beneficiary and the implementation has to be with the community too, after all, the community is the one who knows their needs and desire."(NGO Staff, Pekanbaru)

Government institution also states that community involvement is essential in economic empowerment programs. A lot of programs provide training to empower LGBT individuals economically, but the program does not match the community needs. Engaging the community can make them more interested in the program since it will be matched with their interest.

"How come everyone has to learn about cosmetics and make up, yes it's true the image for this group is that they like cosmetics, but not everyone is interested in that, they may have other skills, etc.."(Government Official, Manado)

NGOs, health facility and legal aid institute agree that community members need capacity strengthing in order to effectively support program implementation. Strengthening efforts need to include health personnel and legal support staff as well. In addition there needs to be efforts to increase community attention to the program, and the organisation's commitment to support the LGBT community.

"In my opinion, if we don't have enough resources, then the priority is community strengthening. Strengthening in the aspect of quantity and quality. There can be a lot of difference in the amount. After that certainly it'll be easy to get quick wins from advocacy." (NGO Staff, Manado)

"They finally realise that they have to take their medicine, they have to take it frequently… as doctors we also have to teach them to be independent. When this program doesn't receive subsidy anymore, like funding from a donor, or other funds, then patients are already able to finance themselves." (Health Facility Staff, Manado)

"The bottom line is you need more players to be involved, and you need to first be sure we're of one vision and one goal." (Service Provider, Jakarta)

In addition to engaging with the LGBT community, NGOs also approach people in the area to ensure acceptance. Other NGOs also expand their program coverage to the general public to achieve broader acceptance of the community by people.

"One effort is to organise their buddies, so we get solid support, and then we do a lot of activities, various social events and services, that's good for our internal organisation, and also for the people outside the organisation and community" (NGO Staff, Pekanbaru)

To improve program effectiveness, community engagement is critical. Involving the LGBT community is an effective way to develop a program that suits the community. This has to be accompanied with knowledge improvement and capacity strengthening of the community.

3. DISCUSSION

The LGBT community in Indonesia is in a difficult position. They are stigmatised, rejected, discriminated and criminalised by various parties. According to Arus Pelangi, an organisation that defends the rights of LGBT individuals, between year 2006 to 2018, as many as 1,850 persecution cases against LGBT people were recorded. This high number is thought to be linked to hate speech made by community leaders, law enforcement officers, and representatives of government legislative and executive agencies.

A lot of religious leaders regard the LGBT group's existence as against the will of God. This is often included in religious sermons, creating even more widespread stigma and discrimination toward LGBT people. Events such as conference, edutainment, concert or any public gathering that involves LGBT groups receive threats of disbandment from organisations who are against sexual and gender minorities. Law enforcers cannot guarantee the safety of LGBT people and encourage events to be cancelled, Demonstration to protest the existence of LGBT community is often held by organisations on behalf of a certain religion or group.

LGBT people also face discrimination in their workplace. Corporations and the government are concerned that employees' sexual orientation or gender identity will give the company a negative image, so anyone suspected or publicly discovered as an LGBT will be fired. One example was the dishonorable discharge of a member of the Indonesian Army who admitted to be a homosexual. Unpleasant treatment is experienced by LGBT groups even in educational institutions. An idea was once put forward to ban LGBT people from universities.

A draft bill of the Criminal Code (*RKUHP*) has increased the risk of persecution that LGBT groups may experience in the future. However, despite all the limitations, stigma, discrimination and criminalisation, a number of organisations still perform efforts to empower the LGBT community, such as the organisation who participated in this study. Community-based organisations, service providers and legal aid support also maintain their activities and service in a less ideal situation as part of the effort to further empower LGBT people.

This study documents the success of empowerment programs that were carried out by NGOs and service providers. Each program conducts interventions with a goal to achieve changes, and as a result of exposure to empowerment program, the majority of LGBT individuals become more empowered, which is shown by a number of positive changes. For example, the initiative to access information and health care independently, the willingness to defend one's

rights and fight oppression, the willingness to help other discriminated LGBT individuals. All these examples demonstrate that the goal of empowerment programs has been achieved.

It is already known that most empowerment programs are implemented as part of HIV/AIDS intervention that is focused on gays and transgenders. This study however shows that bisexuals and lesbians also have a relatively high level of empowerment. Since it is relatively harder to identify the sexual orientation of lesbians and bisexuals compared to gays and transgenders, their risk for discrimination may be smaller. This finding also explains why sexual orientation is an important social determinant of health (Logie, 2012).

NGOs have successfully created a positive environment for health care delivery, evidenced by the fact that a majority of LGBT people are no longer discriminated at health facilities. The LGBT community are no longer delaying to access health care, and are participating more in health promotion efforts. This finding can explain the result of previous studies that report a link between stigma, marginalisation, discrimination, and health (Hatzenbuehler *et al*., 2014; Meyer, 2003).

Service providers as an extension of the state also need to guarantee the fulfillment of each citizen's right, irrespective of the polical situation, one's sexual orientation and/or gender identity. Service provision should not focus only on the facility or infrastructure, but should also pay attention to the quality and friendliness of the services provided. This poses a unique challenge for NGOs and the community as frequent transfer of health personnel requires them to keep repeating the education on gender and rights for health to new health personnel.

Empowerment programs that have been implemented still require improvement in effectiveness. NGOs also need to respond to the challenge of focusing more on advocacy programs. Limited advocacy results in limited macro-level change and rampant discrimination that is conducted by community groups and law enforcers. It also makes efforts to make policy changes at the national or local level more difficult. Information dissemination and empowerment activities need to be expanded in coverage and scope to include other issues besides health. Other aspects that relate to human rights, economic empowerment and legal issues also need to be the focus of LGBT community empowerment.

This study finds that community engagement is beneficial for improving access to health care. This is in line with the result of a study by Batch and Wakerman (2015) that shows that community participation has a positive impact on "intermediate" health results like improving access and utilisation of health care. A collaboration between service providers and community members should be able to improve health access to hard-to-reach individuals.

Community engagement is believed to also make an empowerment program more appropriately targeted, and better accepted by the community. Most importantly it also functions as a capacity building mechanism for the community. This has been reported by various studies that note how community participation promotes community development, and facilitates fulfillment of community needs in ways that are socially and culturally effective (Sule, 2005; Cyril *et al*., 2015).

In line with what Bauermeister *et al*., (2017) reported, this study summarises a number of elements that are critical to community engagement efforts. First, the community has to be considered equal to all the other parties who are involved, and have a voice in decision-making. Second, engagement of the community should be holistic, which is defined as meaningful participation since the start of program. Third, the community can be involved in a number of aspects, including in the actual implementation of activities. Despite the positive impact that can be reaped from community engagement, their involvement during implementation should also be conducted carefully considering the high level of stigma that people still hold against the LGBT community.

To achieve optimum and effective empowerment, collaboration with strategic parties such as policymakers is essential. Partnership is key for maximum impact. Cyril *et al* (2015) noted that collaboration and partnership positively correlate with empowerment.

It is clear that the LGBT community, NGOs and service providers agree that community empowerment is necessary and is believed to improve the health status of a community. The biggest barrier however is the actual implementation of an empowerment program. Programmatic targets often distract program implementers away from the actual goal of empowerment. As NGOs focus on target achievement, they sometimes focus less on program quality, giving the impression that the LGBT community is a mere object of achievement, instead of the subject whose quality of life needs improvement.

Another thing that should be noted is the limitations of this study. First, study sites were determined based on the ability to access the LGBT population and the study team's network. It is therefore possible that the result is not fully representative of the LGBT community in Indonesia, particularly the unreached individuals. Informants in the qualitative component of the study are also people who have been working with the LGBT community for quite some time, such that their input and perception about empowerment efforts may tend to be homogeneous and positive. Results from the qualitative study should therefore not be generalised as representative of all service providers.

4. CONCLUSION AND RECOMMENDATION

CONCLUSION

1. The majority of LGBT groups, lesbian, gay, bisexual, and transgender can be categorised as empowered, particularly with regards to giving advice and conveying an opinion in public. LGBT people are also relatively empowered to access STI, HIV, and general health services, though the majority are less empowered with regards to use of PrEP. Level of empowerment is significantly associated with outcome variables such as higher health-seeking behavior, more reporting experience of discrimination, better power relations and more likely to participate in social activities. It can be concluded that empowerment programs that have been implemented by NGOs successfully empower the LGBT community to access STI, HIV, and general health services and to giving advice and conveying an opinion in public.
2. Programs implemented by NGOs or CBOs can be grouped into three categories, namely education, service and advocacy. However, service delivery program is the most common implemented by the NGOs and CBOs. The programs tend to focus on MSM and transgenders these groups are categorized as key population in HIV and AIDS control. While programs that are implemented by service providers do not specifically target to LGBT community, since health services are supposed to be inclusive, without discriminating or giving exclusive treatment to any specific group
3. The impact of activities that LGBT organisations have carried out on the knowledge, attitude, and practices of service provider and policymaker can be seen in changes awareness to their health and independently access and utilize the existing HIV/STI services. Lack of empowerment would result in lack of information, and inadequate attention to healthy behaviours that would increase their likelihood of being transmitted by HIV or STI. There is also awareness among the health providers and policy makers that the negative stereotype against the LGBT community have limited the community's opportunity to develop their potential and be more economically productive. The communities unable to increase their skills and undeniably stay working as sex workers. Empowerment is hoped to provide trainings that match the community potential and interest, helping community members to develop their ability.

RECOMMENDATION

Based on the study results, several recommendations are proposed that are hoped to be able to facilitate further community development efforts. Separate recommendations are made for each group: the LGBT community, NGO and service provider.

For the LGBT Community

1. Strengthen psychosocial support for fellow LGBT people through dissemination of positive information about sexual orientation and gender identity, and maximising use of information media.
2. Employ innovative approaches like virtual outreach, and dating application to reach LGBT people while continuing to focus on providing psychosocial support.

For NGOs

1. Program implementation approaches that have been adopted by NGOs seem to not fully involve the LGBT community yet. The feeling of being considered as a target is still there, which makes community members reluctant to participate in program activities. More active engagement with the community will be necessary to eliminate the impression of being a programmatic target.
2. The LGBT community also needs to be involved in programs that focus on socio-economic and legal empowerment so that program activities will match the needs of the community.
3. NGOs can help create an LGBT-friendly environment in health facilities by facilitating frequent interaction between service providers and members of the LGBT community. NGOs and health facilities can establish a mutually-beneficial partnership for provision of health service (refer, support, educate, etc.) and create opportunities for positive interactions between the community and service providers.
4. This study finds that advocacy for fulfillment of the rights of LGBT people is still limited. Yet, it is necessary to consistently advocate to related stakeholders for provision of rights-based services, instead of identity-based services. Throughout the advocacy process and activity, it is critical that NGOs also involve the LGBT community. This will create an opportunity for them to interact with stakeholders and further empower them to defend their rights.
5. Community involvement in program activities can be maximised by employing the peer educator system, and involving the general population through positive and

interesting activities. This will also increase people's acceptance of the LGBT community.

For Service Providers

1. Create a mechanism for knowledge transfer and capacity building between health care providers in order to increase their awareness and understanding about rights-based services.
2. Network with the LGBT community in order to provide more effective health services, and create opportunities for frequent interactions between health care providers and the community.

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