BEHIND THE WHITE COAT:

Mapping the Pathways and Barriers to Healthcare for LGBTQ+ University Students in Malaysia



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The PRISM Study: Pathways, Rights, Information, Services, and Movement for LGBTQ+ Health in Malaysia

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About Pride In Research

Pride In Research is a community-led research initiative dedicated to documenting the lived experiences of LGBTQ+ individuals in Malaysia, with a focus on healthcare access, discrimination, and systemic barriers. We centre embodied knowledge and community priorities in all research activities.

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Acronyms

AFAB	Assigned Female At Birth
B40	Bottom 40% of Malaysian households by income
FGD	Focus Group Discussion
GCP	Good Clinical Practice
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
HRT	Hormone Replacement Therapy
HSP	Help-Seeking Behavior
IPT	Institusi Pengajian Tinggi (Institutions of Higher Learning)
IRTHJ	Intersectional Reproductive and Transformative Health Justice
JAKIM	Jabatan Kemajuan Islam Malaysia (Department of Islamic Development Malaysia)
KKM	Kementerian Kesihatan Malaysia (Ministry of Health Malaysia)
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Queer, and others
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer, and others (inclusive of additional sexual orientations and gender identities)

LGBTQIA	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, and others
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, and others (inclusive of additional sexual orientations and gender identities); the term used most frequently throughout this report
MAIS	Majlis Agama Islam Selangor (Selangor Islamic Religious Council)
MCMC	Malaysian Communications and Multimedia Commission
MMC	Malaysian Medical Council
MOH	Ministry of Health Malaysia
MSM	Men Who Have Sex with Men
NGO	Non-Governmental Organisation
NSPEA	National Strategic Plan for Ending AIDS
PrEP	Pre-Exposure Prophylaxis
SDG	Sustainable Development Goals
SOGIESC	Sexual Orientation, Gender Identity, Gender Expression and Sex Characteristics
STI	Sexually Transmitted Infection
U=U	Undetectable = Untransmittable

WHO	World Health Organisation
WPATH	World Professional Association for Transgender Health
YMSM	Young Men Who Have Sex with Men

Terminology

ASNAF RIQAB: A zakat category interpreted by some state religious bodies to include LGBTQ individuals as targets for "rehabilitation," channeling millions in public funds into conversion programmes.

ASEXUAL: Refers to a person who experiences little or no sexual attraction to others; they may still form romantic and intimate relationships.

BALIK PANGKAL JALAN: Literally "return to the correct path"; a phrase used to frame conversion practices and identity suppression as compassionate religious guidance.

BISEXUAL: Refers to a person (cis or trans) who is romantically and/or sexually attracted to more than one gender.

BUDAYA SONGSANG: Literally "deviant culture"; official state terminology adopted in 2026 to replace "LGBT," framing queer communities as morally wrong and in need of correction.

CISGENDER: Refers to a person whose gender identity aligns with the sex they were assigned at birth.

MINORITY ANTICIAPATORY ANXIETY/COEXPECTUS ANXIETY: Refers to the anticipatory fear and stress of a minority group, in this case the LGBTQIA+ community, carry before, during, and after a clinic visit, including fear of judgment, reporting to authorities, misgendering, or denial of care.

CONVERSION PRACTICES: Refers to formal or informal attempts to change, suppress, or deny a person's sexual orientation or gender identity, including soft approaches disguised as counselling or spiritual care.

FATWA: A religious ruling issued by a recognised Islamic authority; in Malaysia, fatwas have been used to restrict bodily autonomy, including banning gender-affirming surgery for Muslims.

GAY: Refers to men (cis or trans) who are romantically and/or sexually attracted to other men.

HEALTHCARE BARRIERS: Refers to financial, structural, legal, and cultural obstacles that block or delay access to safe, affirming care.

HETERONORMATIVE: Refers to the assumption that heterosexuality and cisgender identity are the default, normal, or preferred ways to live; a worldview embedded in Malaysian law, health policy, and education.

INTERSECTIONALITY: A framework for understanding how overlapping identities (such as being AFAB, Malay, Muslim, and queer) compound to

produce unique experiences of discrimination and disadvantage.

INTERSEX: Refers to people born with sex characteristics (genitals, hormones, or chromosomes) that do not fit typical binary definitions of male or female.

KEY POPULATIONS: Refers to groups at structurally elevated risk of HIV — such as MSM, trans women, people who use drugs, and sex workers — due to legal, social, and systemic conditions rather than behaviour alone.

LESBIAN: Refers to women (cis or trans) who are romantically and/or sexually attracted to other women.

MICROAGGRESSIONS: Refers to brief, everyday exchanges — intentional or not — that send denigrating or dismissive messages to marginalised people; in a clinical setting this includes invasive questions about genitalia or refusal to use correct pronouns.

MINORITY STRESS: Refers to the chronic psychological burden of enacted, anticipated and internalized stigma and navigating a system that criminalises or pathologises one's identity.

MUKHAYYAM: Refers to state- or religious-run "rehabilitation" camps targeting LGBTQ people, combining religious instruction with counselling framed as therapeutic care.

NON-BINARY: An umbrella term for gender identities that fall outside the traditional male/female binary.

PATHOLOGISE: Refers to the practice of treating a natural human variation — such as being queer or trans — as a disorder or disease that must be cured.

PENGKID: A pejorative local term for masculine-presenting women or AFAB people; treated in official health guidelines as a condition to be corrected rather than an identity to be respected.

PrEP (PRE-EXPOSURE PROPHYLAXIS): Refers to medication taken before potential HIV exposure that reduces transmission risk by up to 99% when taken consistently; available free at selected Malaysian public clinics since January 2023.

QUEER: A reclaimed umbrella term used by many LGBTQ people to describe sexual orientations and gender identities that are not heterosexual or cisgender.

SEX ASSIGNED AT BIRTH: Refers to the classification (male, female, or intersex) recorded at birth based on physical characteristics observed by a clinician.
TRANSGENDER: An umbrella term for people whose gender identity differs from the sex they were assigned at birth.

U=U (UNDETECTABLE = UNTRANSMITTABLE): Refers to the evidence-based principle that people living with HIV who maintain an undetectable viral load through treatment cannot sexually transmit the virus to others.

Section 1

INTRODUCTION

1.1 Understanding Laws, Fatwas, and Guidelines

a. Fatwas and Religious Legislation

TABLE 1.1 TIMELINE OF KEY EVENTS, 1983–2026

Year/Date	Event
13–14 Apr 1982	National Fatwa Council bans gender-affirming surgery for Muslims (Free Malaysia Today, 2026)
1996	Block on changing gender markers on identity documents (Human Rights Watch, 2014)
2011	JAKIM Mukhayyam "rehabilitation" camps begin (Human Rights Watch & Justice for Sisters, 2022)
2017	MOH gender-health guideline issued; "gender confusion" youth video competition launched (CodeBlue, 2023; Human Rights Watch, 2017)
Jan 2023	Free PrEP introduced at selected government clinics (CodeBlue, 2024)
Feb 2024	Nik Elin Zurina v. Kelantan: Federal Court strikes down 16 Kelantan Syariah provisions (The Edge Malaysia, 2025)
2024	MAIS allocates RM19.4m asnaf riqab zakat to three Majlis rehabilitation homes and 26 Rumah Pemulihan Riqab; 3,185 new HIV cases recorded (Sinar Harian, 2025; CodeBlue, 2025)
Jun 2025	9,309 people on PrEP across 35 clinics (CodeBlue, 2025a)

July 2025	Kelantan "gay party" raid; more than a dozen men arrested, condoms and HIV meds seized (Reuters, 2025)
Nov 2025	Otot2 KL raid; 201 men arrested at wellness centre (Justice for Sisters, 2025; Washington Blade, 2025)
Dec 2025	World AIDS Day: Malaysian AIDS Council warns Malaysia is at a "critical juncture" amid "growing social conservatism" (CodeBlue, 2025b)
Jan 2026	First reported Syariah prosecution for gender-affirming surgery in Kelantan (APTN, 2026; Free Malaysia Today, 2026)
Feb 2026	Government orders term "LGBT" replaced with budaya songsang; MCMC blocks Grindr and Blued (Amnesty International Malaysia, 2026; Washington Blade, 2026)
Jun 2026	Budaya songsang made official government terminology (Global Voices, 2026; PinkNews, 2026)

At the federal level, Sections 377A and 377B of the Penal Code, a relic of British colonial law, criminalise "carnal intercourse against the order of nature," carrying penalties of up to twenty years' imprisonment and whipping (Human Dignity Trust, 2024). These provisions have been used to criminalize LGBTQ+ identities, even without evidence of any sexual act, as seen in a 2025 Kuala Lumpur "gay spa" raid where more than 200 men were arrested and later released without prosecution (Metro Weekly, 2025). Operating a dual-legal track system Syariah enactments in most states also criminalise liwat (male same-sex intercourse) , musahaqah (female same-sex intercourse) , and cross-dressing, rendering gender minority people, particularly trans women, persistently visible targets for arrest (Human Dignity Trust, 2024).

Layered onto criminal law are religious edicts. A National Fatwa Council ruling issued in 1982, frequently cited in the press as 1983, declared gender-affirming surgery forbidden (haram) for Muslims, with only a narrow exception for intersex people, and held that a person's legal gender remains unchanged even after surgery (Free Malaysia Today, 2026). Human Rights Watch documents that, according to long-time transgender activist Khartini Slamah, name and gender-marker changes were permitted until around 1996, when a stricter policy came into

place; later cases such as Wong Chiou Yong (High Court of Ipoh, 2005) and a 2017 appeal confirmed the National Registration Department's refusal to recognise gender transition (Human Rights Watch, 2014).

The reach and limits of Syariah criminal law were tested in Nik Elin Zurina v. Kerajaan Negeri Kelantan (Federal Court, 9 February 2024). By an eight-to-one majority, the Court struck down sixteen of eighteen challenged provisions of Kelantan's Syariah Criminal Code as unconstitutional, on the basis that the state had legislated on matters within federal jurisdiction (The Edge Malaysia, 2025). Two points are crucial for this report. First, the ruling turned on federalism, not on LGBTQ+ rights, and the Chief Justice was explicit that it did not diminish Islam's constitutional position (The Edge Malaysia, 2025). Second, the provision criminalising gender transition was not among those struck down and remains in force, and legal scholars conclude that the decision left the doctrinal authority of the Syariah courts largely intact (Malaysiakini, 2026; Hidayati et al., 2024).

b) Current Medical Guidelines

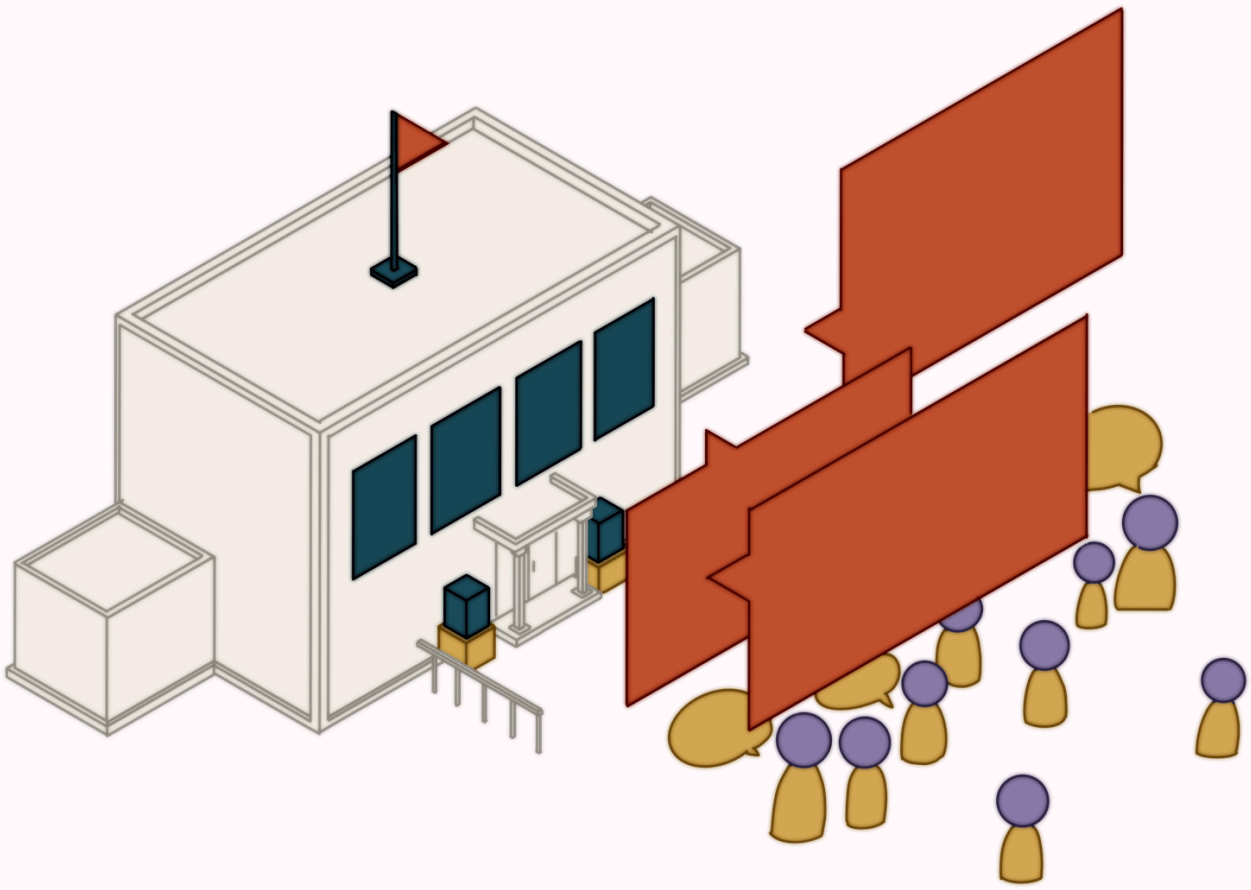
In 2017, the Ministry of Health released a guideline relating to gender-health (Garis Panduan Pengendalian Masalah Kesihatan Gender di Klinik Kesihatan), that was later confirmed in Parliament by the Minister in charge of religious affairs, to frame non-normative gender identities as health "problems" to be managed, including treating "pengkid" (a pejorative local term for masculine-presenting women or AFAB individuals) individuals in official health guidelines as a condition and advising parents to prevent children from being "influenced" by gender non-conforming peers or environments (CodeBlue, 2023; Justice for Sisters, n.d.-a). That same year, the Ministry launched a national youth video competition inviting entrants aged thirteen to twenty-four to produce videos on how to "prevent, control and seek help" for "gender confusion," with cash prizes attached (Human Rights Watch, 2017). After condemnation from Human Rights Watch and the Malaysian AIDS Council —who noted that the World Health Organization removed homosexuality from its disease classification in 1990, the Ministry renamed the category to "gender and sexuality" within days, without altering the underlying pathologising frame (Human Rights Watch, 2017; Malay Mail, 2017).

In regards to the topic of HIV, the Ministry of Health recognises men who have sex with men (MSM) and transgender women as key populations vulnerable to HIV and includes them in the National Strategic Plan for Ending AIDS 2016–2030, under which outreach programmes promote sexual health and refer people to clinics (Ministry of Health Malaysia, 2015).

In March 2025, Deputy Health Minister Lukanisman Awang Sauni told the Senate that rising HIV cases among men who have sex with men, especially those aged 20–39, were caused by a "YOLO, you only live once, mindset" that

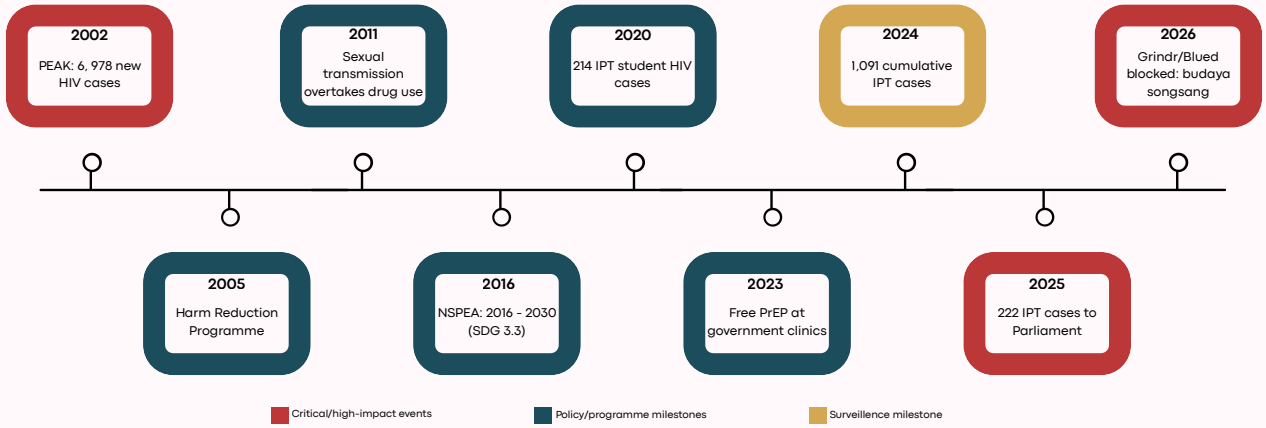
pushed young people to "try something new" and engage in "unnatural activities" supposedly encouraged by global social media normalising homosexuality (South China Morning Post, 2025). He offered no supporting evidence for this claim, even though existing Ministry of Health data showed that most increasing HIV incidence in Malaysia were among men and that transmission among men who have sex with men is associated with stigma, criminalisation of same-sex behaviour, and limited access to effective HIV prevention services (MOH Malaysia, Global AIDS Monitoring Report) . Civil-society and regional commentators criticised his remarks as homophobic and unscientific, arguing that focusing on a "YOLO mindset" distracts from structural drivers such as punitive laws, fear of disclosing sexual orientation to providers, patchy PrEP implementation, and abstinence-oriented sex education (South China Morning Post, 2025).

The policy direction in 2026 is generally aimed toward greater restriction. In February 2026, a deputy minister in the Prime Minister's Department directed that the term "LGBT" be replaced with budaya songsang ("deviant culture") in official discourse, explicitly to influence online search results and prevent "normalisation"; by June 2026, this had become standard government terminology (The Rakyat Post, 2026; Global Voices, 2026). Justice for Sisters warned that the label "dehumanises LGBT people and reinforces the dangerous belief that they should be corrected," and Amnesty International Malaysia described it as legitimising



discrimination against a highly vulnerable group (Amnesty International Malaysia, 2026). In the same month, the Malaysian Communications and Multimedia Commission blocked the websites of the dating platforms Grindr and Blued, restricting channels that isolated young people rely on for both connection and health information (Washington Blade, 2026; Bloomberg, 2026).

FIGURE 1 — KEY HIV POLICY MILESTONES IN MALAYSIA (2002–2026)



This timeline traces Malaysia's HIV policy landscape from the 2002 epidemic peak through the launch of the National Strategic Plan for Ending AIDS (NSPEA) in 2016, the introduction of free PrEP in January 2023, and the increasing legal restrictions on LGBTQ communities in 2025–2026, illustrating how public health progress has been simultaneously advanced and undermined by policy decisions (MOH Malaysia, 2016; Bernama, 2025; CodeBlue, 2025).

By contrast, in 2020, SEED Malaysia and the Galen Centre for Health and Social Policy jointly published Practical Guidelines for Trans-Specific Primary Health Care in Malaysia, a clinical reference explicitly informed by WPATH's Standards of Care (Galen Centre, 2020). Its central principle is that a patient's own self-identification should override any healthcare professional's personal opinion, at every level of care (Galen Centre, 2020). It was developed by a multidisciplinary group of Malaysian clinicians and researchers, and is described as the country's first transgender-led, community-informed clinical guideline (SEED/Galen Centre, 2020).

Nevertheless, this guideline was produced by NGOs, not adopted as official Ministry of Health or Malaysian Medical Council (MMC) policy. WPATH's own SOC-8 framework calls for gender-affirming care to be built into health systems, not left to individual providers to seek out on their own (Coleman et al., 2022).

TABLE 1.2: GOOD MEDICAL PRACTICE IN MALAYSIA (MALAYSIAN MEDICAL COUNCIL, 2019)

Domain	Malaysia Good Medical Practice Guideline 2019	Limitation
Non-discrimination	Doctors must treat patients "without prejudice of ... sexual orientation" and must not let "personal moral bias ... about patient's habits or lifestyles" influence care (GMP 2019, 3.1.7.21)	This is protective but largely passive: MMC does not require, teach, or assess LGBTQ+ or trans-specific competency, so providers can still avoid or mishandle trans care despite the non-discrimination clause
Dignity & confidentiality	Doctors must "respect privacy, dignity and confidentiality" of patients, and third-party disclosure requires the patient's "explicit written consent" (GMP 2019, Golden Rule 3 & §3.2.1; MMC Confidentiality Guidelines, 2011)	Outing, shaming, or improper disclosure are disciplinable breaches, but enforcement is complaint-driven and depends on patients being willing and safe enough to file a formal complaint
Consent & autonomy	Consent must be given "freely and voluntarily" (MMC Consent Guideline, 2016/2017), and the doctor-patient relationship should be "autonomous ... rather than paternalistic" (GMP 2019, §3.1.2)	In practice, provider judgment and moral gatekeeping still frequently override trans patients' self-identification, as neither MMC's Good Medical Practice nor the 2026 GCP explicitly recognises gender self-identification as a standard for respecting autonomy in everyday care (GCP 2026)

Legal Force	The Code and guidelines are enforceable as serious professional misconduct under the Medical Act 1971, s.29(2)	Accountability is largely reactive as it is triggered only after harm has occurred and when a patient is able and willing to lodge a complaint, which might be a threshold many trans patients cannot safely meet; similarly, GCP enforcement focuses on audits and inspections

The Practical Guidelines for Trans-Specific Primary Health Care in Malaysia



- **Figure 1.2. The Practical Guidelines for Trans-Specific Primary Health Care in Malaysia,** co-published by SEED Malaysia and the Galen Centre for Health and Social Policy in 2020. Though WPATH-aligned, it currently operates outside of official Ministry of Health or MMC policy frameworks.

1.2 Current Landscape of the Medical Industry in Malaysia

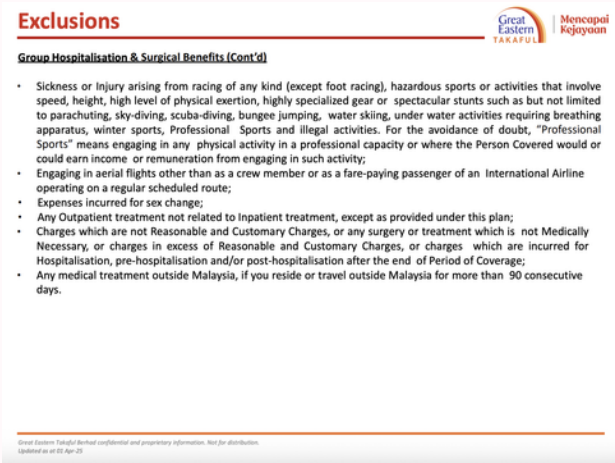
a. Structural Issues in the Medical Industry

Malaysia runs a two-track healthcare system: a heavily subsidised public sector alongside a fast-growing, for-profit private one. The public sector, managed mainly by the Ministry of Health, has traditionally served around 65% of the population and is kept affordable through deep state subsidies; the government covers the overwhelming majority of the cost of public hospital care, leaving patients to pay only a small fraction (Abd Samah & Kuek, 2019). As of 2024, the public sector is served by only 45% of registered doctors and fewer than 30% of specialists, despite treating the majority of Malaysians, a staffing imbalance that structurally limits consultation time and continuity of care (Quek, 2009; WHO, 2013). In practice, this means a standard visit to a government clinic (Klinik Kesihatan) costs only about RM1 for a general consultation and around RM5 to see a specialist (The Centre, n.d.). The private sector, by contrast, offers shorter waits, more specialised care, and greater privacy but is funded

largely through out-of-pocket payment, putting it out of reach for many (Abd Samah & Kuek, 2019).

That cost barrier falls hardest on the transgender women and low-income queer youth, many of whom sit within the B40 (the bottom 40% of households by income) (Telang et al., 2025; Ho et al., 2024). Private clinics sometimes offer pockets of affirming, SOGIESC-competent care, but that care sits behind a price wall most students and low-income patients cannot afford (Telang et al., 2025).
Many Malaysian health insurance and takaful products explicitly exclude gender-affirming procedures such as gender-affirming procedures and related hormone therapy, and trans patients report claims being rejected or premiums cancelled once their gender history or body becomes visible to the insurer (Telang et al., 2025; Galen Centre, n.d.).

The public sector, though financially within reach, carries its own costs for LGBTQ+ patients: which include moral policing, administrative hostility, and clinical microaggressions (Ho et al., 2024). Government clinics and hospitals operate as arms of the state, staffed by civil servants who work under prevailing religious and cultural directives. For an LGBTQ+ patient, walking into an affordable public clinic can mean entering a closely monitored environment where confidentiality feels uncertain and where a provider may read their identity through a lens of criminality, "abnormality," or religious transgression, a framing reinforced by national guidelines that continue to pathologise LGBT+ people (Ho et al., 2024). In short, dignity and safety inside Malaysia's healthcare system too often depend on wealth: those who can afford private care can buy a measure of discretion and respect, while those who cannot are left more exposed to the judgment of the state.



Exclusions

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Group Hospitalisation & Surgical Benefits (Cont'd)

- Sickness or Injury arising from racing of any kind (except foot racing), hazardous sports or activities that involve speed, height, high level of physical exertion, highly specialized gear or spectacular stunts such as but not limited to parachuting, sky-diving, scuba-diving, bungee jumping, water skiing, under water activities requiring breathing apparatus, winter sports, Professional Sports and illegal activities. For the avoidance of doubt, "Professional Sports" means engaging in any physical activity in a professional capacity or where the Person Covered would or could earn income or remuneration from engaging in such activity;
- Engaging in aerial flights other than as a crew member or as a fare-paying passenger of an International Airline operating on a regular scheduled route;
- Expenses incurred for sex change;
- Any Outpatient treatment not related to Inpatient treatment, except as provided under this plan;
- Charges which are not Reasonable and Customary Charges, or any surgery or treatment which is not Medically Necessary, or charges in excess of Reasonable and Customary Charges, or charges which are incurred for Hospitalisation, pre-hospitalisation and/or post-hospitalisation after the end of Period of Coverage;
- Any medical treatment outside Malaysia, if you reside or travel outside Malaysia for more than 90 consecutive days.

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Updated as at 01 Apr-25

Figure 1.3: Great Eastern Takaful Berhad (GETB) specifically excludes all expenses related to sex changes. Medical treatments, surgeries, and therapies related to gender transition are not covered by their medical cards. [1, 2, 3]

Where a person lives in Malaysia largely determines whether affirming care is a short journey or a practical impossibility. Affirming primary care and gender-affirming services are heavily concentrated in the Klang Valley, home to the small cluster of clinics and organisations that make up most of the country's known affirming infrastructure (Akses Bersama, n.d.).

The finding that people living outside

major cities report higher unmet needs give quantitative weight to the concept of "healthcare deserts" in states such as Pahang, Terengganu, Kelantan, Sabah, Sarawak, and Labuan (Ho et al., 2024). Respondents outside major cities reported unmet mental health needs that were 8–12 percentage points higher than respondents in the Klang Valley. The study also found that being younger (18–24) was strongly associated with higher unmet need, which aligns with the university student demographic we focus on. In these regions, public health infrastructure often overlaps with active religious enforcement, so the nearest facility may also be the least safe.

b. Barriers to HIV Treatment

A notable recent gain has been the scaling up of the Pre-Exposure Prophylaxis (PrEP) with the help of the Ministry of Health Differentiated HIV Services for Key Populations (DHSKP) model . Initially available only in private clinics at high out-of-pocket cost, PrEP has been dispensed free of charge at selected public health clinics, in partnership with NGOs, since January 2023, expanding from 18 pilot sites to 21 and then to 35 by mid-2025 (Telang, Cotter & Rashid, 2025; CodeBlue, 2024). Despite this, only 9,309 people had initiated PrEP as of August 2025 across 35 clinics, a figure that represents a fraction of the estimated eligible population, given that Malaysia has approximately 85,283 people living with HIV and concentrations of new infections among MSM in the 20–39 age group (CodeBlue, 2025a; MOH National PrEP Guidelines, 2025).

Pre-Exposure Prophylaxis (PrEP) is one of the most effective biomedical tools available for HIV prevention, reducing transmission risk by up to 99% when taken daily. Yet awareness among university students, the population most recently documented to have rising HIV infections, remains critically low. A 2023 study found that PrEP awareness stood at only 40.1% among medical students and 19.8% among non-medical students, meaning the majority of non-medical undergraduates had never heard of PrEP; once students were shown a brief informational video, acceptance jumped to about 69% across both groups, suggesting that awareness is the primary barrier (Koh et al., 2023).



- **Figure 1.4 Truvada and Descovy,** the two WHO-approved oral **PrEP medications**, have been available free of charge at selected Malaysian government clinics since January 2023.

TABLE 1.3 AWARENESS AND ACCEPTANCE OF PREP AMONG DIFFERENT UNIVERSITY STUDENTS

Indicator	Medical Students (n=187)	Non-medical Students (n=182)
Aware of PrEP (before video)	40.1%	19.8%
Willing to accept PrEP (after educational video)	69.0%	67.6%

c. Barriers to Gender Affirming Care for Gender-Diverse Individuals

In contrast, the public healthcare system in Malaysia offers almost no access to life-saving gender-affirming care for transgender and/or gender-diverse Malaysians. International medical consensus, including the World Professional Association for Transgender Health (WPATH) Standards of Care and a 2025 systematic review, affirms that gender-affirming care—such as Hormone Replacement Therapy (HRT), surgical interventions, and specialised psychosocial support, is medically necessary, not elective (Coleman et al., 2022; Cooney et al., 2025). A mixed-methods study of trans women on the west coast of Peninsular Malaysia found that 111 of 141 respondents were taking hormones, with most procuring them from pharmacies without prescriptions or basic examinations (Rashid, Afiqah & Iguchi, 2022). When trans people seek general primary care, they frequently report clinical microaggressions: intrusive questions about genitalia or surgeries, refusal to use correct pronouns, and open expressions of disgust, leading many to delay care until conditions become critical (Telang, Cotter & Rashid, 2025). A 2019 feature on activist Rania Zara Medina similarly describes medical staff "refusing to touch trans people," leaving trans women living with HIV to shoulder a double burden of stigma in both public and private facilities (CodeBlue, 2019).

d. Epistemic Mistrust between LGBTQ Patients and the Medical Industry

In a national survey of 696 LGBT+ individuals, more than a quarter (29.5%) reported an unmet need for mental healthcare, with unmet need higher among younger, asexual/queer, and non-major-city respondents (Ho et al., 2024). A factor in this may be because before seeking care, a young LGBTQ+ person may calculate the risk of the

doctor reporting them to religious authorities, lecturing them about sin, or subjecting them to invasive questions. The anticipated rejection can lead them to delay screening or ignore symptoms until a minor issue becomes an emergency, a pattern also documented internationally among LGBTQ+ populations navigating epistemic mistrust in healthcare settings (Cruciani et al., 2026).

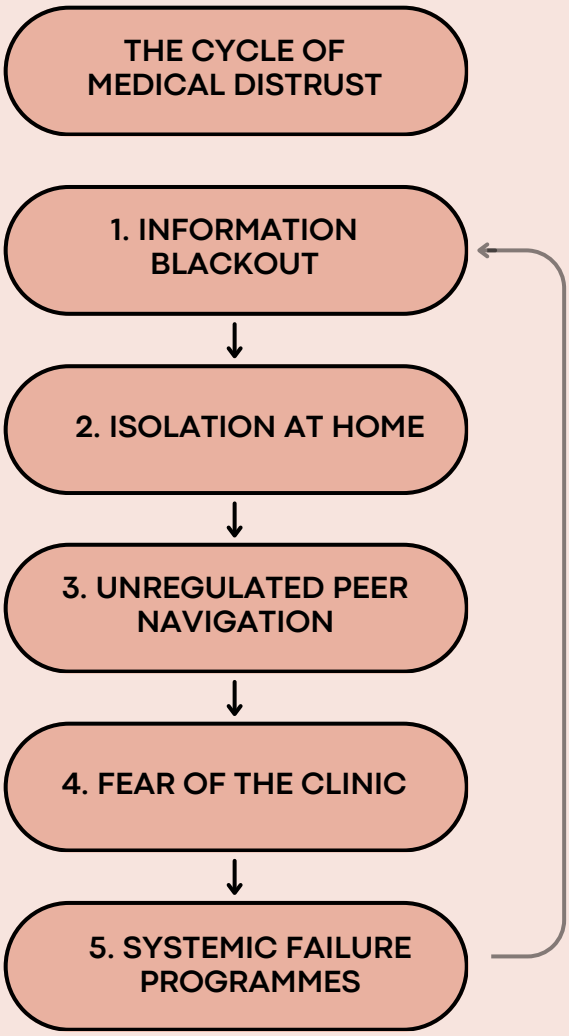


Figure 1.5: The Cycle of Medical Distrust.

These pressures compound into a self-reinforcing loop, which can be read as a circular flowchart:

1. **Information blackout.** Schools decline to provide SOGIESC-inclusive sex education, leaving youth without foundational health literacy; abstinence-only messaging treats sex as taboo (Burch, Hart & Lim, 2018).
2. **Isolation of the closet.** Strained family dynamics and fear of religious or familial backlash prevent youth from seeking health advice at home (Lim et al., 2018).
3. **Unregulated peer navigation.** Isolated youth turn to the internet and dating apps for sexual health information and community. A 2020 study found that Malaysian YMSM (young men who have sex with men) primarily used dating apps and online platforms for sexual health information, with 61.3% sourcing HIV information from social media rather than healthcare providers, a pattern reinforced by the blocking of Grindr and Blued in 2026 (Mansor, Ahmad & Rahman, 2020; CodeBlue, 2026).
4. **Fear of the clinic.** Anticipated microaggressions, moral policing, or state reporting deter routine check-ups (Cruciani et al., 2026; Ho et al., 2024).
5. **Systemic failure.** Because of that fear, public health interventions underperform, and worse outcomes confirm the belief that clinics are unsafe, closing the loop.

1.3 Cultural Background of Healthcare Barriers

A cultural barrier that LGBTQ patients face is the pervasive integration of "conversion practices" (SOGIE-change efforts) into formal medical and state settings. The state often disguises these human rights violations through a "soft approach" (menyantuni), using terms like balik pangkal jalan (returning to the right path) or hijrah (migration/repentance) to frame the suppression of queer identities as a compassionate, voluntary religious obligation (Human Rights Watch & Justice for Sisters, 2022). These practices frequently infiltrate the very

clinics where LGBTQ+ people go to seek standard medical help.

The institutionalization of these practices is heavily funded; for instance, the Selangor Islamic Religious Council (MAIS) channelled RM19.4 million in 2024 from asnaf riqab zakat (Islamic community fund) funds to help 15,288 asnaf riqab (those under bondage), supporting three Majlis rehabilitation homes and 26 Rumah Pemulihan Riqab targeting LGBTQ+ individuals alongside other marginalized groups (Sinar Harian, 2025). Furthermore, the state actively manipulates language to restrict access to affirming information.

TABLE 2.5: HOW CONVERSION PRACTICES DISGUISE THEMSELVES IN MALAYSIA

Approach	How it Appears in Malaysian Clinics	Hidden Harm
Psychological	Counsellors or psychiatrists attributing a patient's queer identity to "childhood trauma," "absent parents," or an "abnormal upbringing."	Validates the debunked idea that being LGBTQ+ is a mental illness that needs to be cured rather than an identity to be affirmed.
Medical	*Doctors prescribing unnecessary hormone tests, performing non-consensual genital exams on trans youth, or using personality tests (like MBTI) to "prove" a lack of masculinity/femininity.	Violates bodily autonomy and the ethical mandate of "First, do no harm." Uses pseudoscience to intimidate patients.
Faith-Based	Medical professionals abandoning clinical guidelines to lecture patients about sin, or referring patients to state-funded Mukhayyam (rehabilitation) camps instead of providing evidence-based healthcare.	Weaponizes the doctor's authority to impose moral and religious policing, permanently destroying the patient-provider trust.

(UN Independent Expert on SOGI, 2020; Justice for Sisters, 2022)

*It is vital for the LGBTQ+ community to recognize that conversion therapy is not just conducted in religious camps; it often takes place inside clinical consultation rooms.

Section 2

LITERATURE REVIEW ON BARRIERS TO HEALTHCARE



Globally, there are studies that have examined barriers of healthcare for LGBTQ+ individuals. For example, one North American study demonstrates how most participants, with the exception of transgender, non-binary and queer (TNBQ), were not discriminated against or given lesser treatment due to their identities and were met with a neutral or positive reaction when revealing their identities to their healthcare provider (Macapagal et al., 2016). Another quantitative study from this region described how stigma, a lack of LGBTQ+ specialised services and/or doctors, and affordability of healthcare is a concern that may impede the access to healthcare of the LGBTQ+ population (Romanelli & Hudson, 2017). These studies, while it may reflect the conditions in those countries, may not accurately depict the conditions faced by the LGBTQ+ community in Malaysia.

Focusing on the LGBTQ+ population in Malaysia, the literature that is available is fragmented and limited. In relation to HIV, most studies have noted how stigma still exists for accessing HIV prevention and treatments within different communities. Thus, the stigma

and the cost of obtaining medication like PrEP may be potential barriers to healthcare (Tan, Lee & Cheong, 2021; Rosen et al., 2023). This is also similar to how gender affirming care for transwoman individuals are limited by cost and discrimination from stigma, with the issues being further compounded by a system that does not recognize gender diverse identities (Gibson et al., 2016; Said et al., 2021; Telang, Cotter & Rashid, 2025). Hence, a survey in the LGBTQ+ community calls for better training of healthcare providers on community specific health issues and safer access to gender affirming care (Tan, 2025).

However, these studies are limited by the population the researchers chose and by the limited amount of studies on the matter. For example, most of the studies are primarily testing gay men's experiences with barriers to HIV healthcare (Tan, Lee & Cheong, 2021) and most studies on gender affirming care are also limited to trans woman experiences. Besides that, it is also notable that the samples of most of the literature above are diverse in age and in educational attainment. This is because the emerging adult student population may be associated with a higher level of skepticism and mistrust in regards to their healthcare compared with LGBTQ+ individuals of other demographics (Cruciani et al., 2025), which might alter the results of a study in regards to this group's healthcare needs.

Finally, academic literature regarding doctors' perspectives to the LGBTQ+ community recognise the discrimination and the lack of training from doctors to better treat the LGBTQ+ community (Amin et al, 2024) along with the lack of guidelines on gender affirming care (Said et al., 2021).

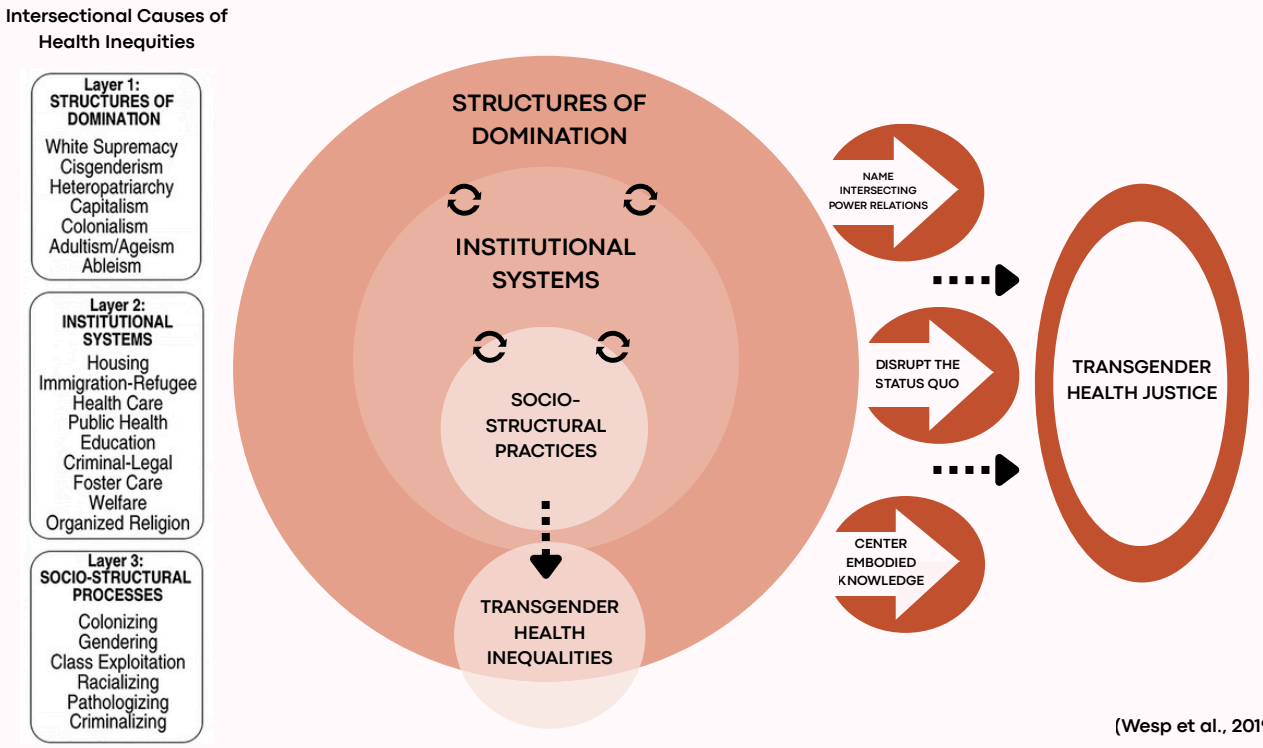
Hence, this community report will aim to study these topics; to analyse the relationship between sociodemographics and barriers to healthcare within the LGBTQIA+ community and to investigate gaps and challenges faced by LGBTQIA+ friendly healthcare providers. This report will also aim to develop cultural safety modules and learn via participatory action research on mobilizing the LGBTQIA+ community.

Section 3

THEORETICAL FRAMEWORK

This study is guided by the **Intersectionality Research for Transgender Health Justice (IRTHJ) framework (Wesp et al., 2019)**, which holds that health inequities facing LGBTQIA+ people are produced by overlapping systems of power, such as patriarchy, criminalising laws, institutional stigma, and heteronormative healthcare norms, rather than by individual behaviour alone. The framework directs this study to name these structural causes, centre the lived knowledge of community members, and disrupt research approaches that have historically excluded community voices (Tan & Liow, 2024). Other developed frameworks on access and barriers to healthcare fail to capture the interplay of patriarchy, structural racism, heteronormative beliefs, ableism and other power dynamics (Andersen, 1995; Burch et al., 2018; Institute of Medicine, 1993) that play a role in creating and reproducing health inequities for the LGBTQIA+ community.

Following the pathway of "center[ing] embodied knowledge" and "disrupt[ing] the status quo" within the IRTHJ framework, fixing the current misalignment of community priorities and past research on people who are LGBTQIA+ described by Tan & Liow (2024) will be prevented by focusing on educating health providers on LGBTQIA+ specific needs.



(Wesp et al., 2019)

What do we mean by structures of domination?

It is important to understand that power and privilege exists in everyday contexts and situations. Power is defined as "a two-way street where [people], even though they may think they have no influence, actually do, given the way in which the social system is set up" (Dobratz et al., 2012, p.9). Therefore, ordinary doctors, nurses, parents and school teachers all hold power and have influence depending on the type of privilege they have.

The structures of domination that we name in the framework encompass racism, heteronormativity, patriarchy, ableism and colonialism, all of which are defined in the glossary.

All of these structures play a role in the discrimination of the LGBTQIA+ community through many types of contexts: structural, symbolic and material as seen in the table below (Mannell et al., 2014).

TYPES OF DISCRIMINATION (MANNELL ET AL., 2014)

Context	Definition	Social Factors	Examples of Intervention	Samples of Indicator
Symbolic	Social norms, meanings, ideologies, worldviews	Stigma, discrimination, gender norms, politcal commitment	Mass media, gender sensitization, advocacy, transformative discussion groups	Percentage of women/men who believe a husband should beat his wife in specific circumstances (e.g., if she burns the food)
Material	Economic and practical realities	Poverty, capacity, criminalization	Social protection, redistribution (e.g., conditional cash transfers), capacity building, education, harm reduction, changing legislation	Percentage of orphanized and vulnerable children receiving adequate financial support

Context	Definition	Social Factors	Examples of Intervention	Samples of Indicator
Relational	Social relations within and between communities	Participation, social capital	Knowledge exchanges, community mobilization, greater involvement of People Living with HIV/AIDS (GIPA), partnerships	Percentage of community-based organizations with PLHIV participating in meetings of the executive board

Social norms operate as rules and they limit the power of certain groups and individuals. For example, queer women are often limited by the social norms of reduced rights such as being more burdened by household duties and facing epistemic injustice in healthcare. Due to this, our research does our best to name these processes of power within the Malaysian context to see how it operates in daily life for the LGBTQIA+ community.

Why did we focus on resilience?

It is vital to capture how the Malaysian LGBTQIA+ community have been responding and resisting to the structural barriers within society despite the immense criminalization to prevent pathologizing sexual orientation to poor health outcomes, as well as analysing the ability of the community to be resilient. This allows for future research to examine the positive effects of resilience within the community and foster other community-engagement practices to continue promoting said developing more resilience. A plethora of articles found in other literature reviews (Ceathe et al., 2021; Colpitts & Gahagan, 2016; Green et al., 2021; Gahagan & Colpitts, 2016) have proven this to be possible (Mutchler et al., 2008; Goffnet et al., 2025; Reisner et al., 2014; Smith & Gray, 2009) with findings showing the importance of LGBTQIA+ mentors, trusted teachers/lecturers, online communities and other LGBTQIA+ groups as well as the role of cultural values and scripts.

This follows the findings by Ungar et al. (2008) on the seven multi-level tensions that contribute to resilience, which includes factors that are structural within society and also individual. Social capital becomes another important conceptualization of positive relational ties that help the LGBTQIA+ community (Costa, 2022; Hwahng et al., 2022; Li et al., 2023), with social support being considered as "an important component of a larger group-level construct, social capital" (Perez-Brumer, 2017, p.2).

SEVEN MULTI-LEVEL TENSIONS (UNGAR ET AL., 2008)

Tension	Explaination
1. Access to material resources	Availability of financial, educational, medical, employment assistance and/or opportunites, and access to food, clothing and shelter
2. Access to supportive relationships	Relationships with significant others, peers, and adults within one's family and community
3. Development of a desirable personal identity	Desirable sense of one's self as having a personal and collective sense of purpose, ability for self-appraisal of strengths and weaknesses, aspirations, beliefs, and values, including spiritual and religious identification
4. Experiences of power and control	Experiences of caring for one's self and others, the ability to affect change in one's social and physical environment in order to access health resources
5. Adherence to cultural traditions	Adherence to, or knowledge of, one's local and/or global cultural practices, values, and beliefs
6. Experiences of social justice	Experiences related to finding a meaningful role in one's community that brings with it acceptance and social equality
7. Experiences of a sense of cohesion with others	Balancing one's personal interests with a sense of responsibility to the greater good; feeling a part of something larger than one's self socially and spiritually

3.1. Research Objectives

The objectives of the research are as follows:

- To analyse the relationship between sociodemographics and barriers to healthcare within the LGBTQIA+ community
- To investigate gaps and challenges faced by LGBTQIA+ friendly healthcare providers
- To develop cultural safety modules and learn via participatory action research on mobilizing the LGBTQIA+ community
- To uncover the symbolic and material contexts of structural barriers to healthcare the LGBTQIA+ community face

Section 4

METHODOLOGY

4.1. Research Design

This study used a community-led, mixed-methods design guided by the IRTHJ framework, where LGBTQIA+ students are included as co-knowledge producers rather than subjects. Data collection ran from 28 April to 12 July 2026 across three phases: an anonymous online survey with LGBTQIA+ university students, semi-structured interviews with a subset of respondents, and focus group discussions with healthcare providers.

4.2. Sampling and Recruitment

Given Malaysia's criminalised context for LGBTQIA+ people, purposive snowball sampling was used across all phases, prioritising safety and trust over representativeness. Recruitment ran through Pride In Research's Instagram/Telegram channels and direct outreach via JEJAKA, DIEM, and allied organisations.

- **Survey:** Open to LGBTQIA+ students (18+) at any Malaysian public or private university; final sample N = 209.
- **Student interviews**: Opt-in via a separate, unlinked form to protect anonymity; participants purposively selected for diversity in gender identity, sexual orientation, geography, and institution type
- **Provider FGDs:** Small groups of 5–6 clinicians with LGBTQIA+ patient experience or interest in affirming care, recruited via professional networks and allied referrals.

4.3 Data Collection Instruments

- **Online survey (15–20 min):** Five sections — demographics, an 8-item Health Literacy scale, a 3-item Help-Seeking Beliefs measure, an 8-item Barriers to Care scale (structural and interpersonal), and Patient–Provider Relationship/Discrimination items.
- **Student interviews:** Conducted via encrypted video call (1.5–2 hours), exploring sex education gaps, clinic anxiety, conversion practices, strategies for finding affirming providers, and community/peer support roles.
- **Provider FGDs:** 60–90 minutes, exploring training gaps, institutional constraints, ethical tensions, and what's needed to practice affirming care in Malaysia's context.

4.4. Ethical Considerations

No identifying data were collected in the survey; interview contact details were stored separately, password-protected, and deleted after data ollection. All participants gave informed consent (digital for the survey, recorded for qualitative sessions) and could withdraw at any time. Qualitative data were securely stored with access limited to the core research team.

Section 5

FINDINGS

5.1. Participant Demographics

FIGURE 5.1: PARTICIPANT DEMOGRAPHICS (N = 209)

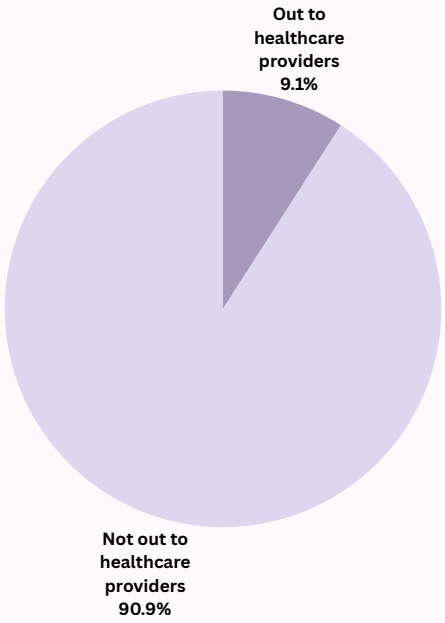
Demographic Category	Subgroup	n	Percentage
Age Group	18 to 24	173	82.8%
	25 to 34	26	12.4%
	35 to 44	10	4.8%
Gender Identity	Cisgender Female	69	33.0%
	Cisgender Male	61	29.2%
	Non-binary / Genderqueer	44	21.1%
	Trasngender (Male & Female)	24 (17:7)	11.1%
	Other	11	5.3%
Sex Assigned at Birth	Female	124	59.3%
	Male	80	38.3%
	Prefer not to say	5	2.4%
Sexual Orientation	Bisexual	50	23.9%

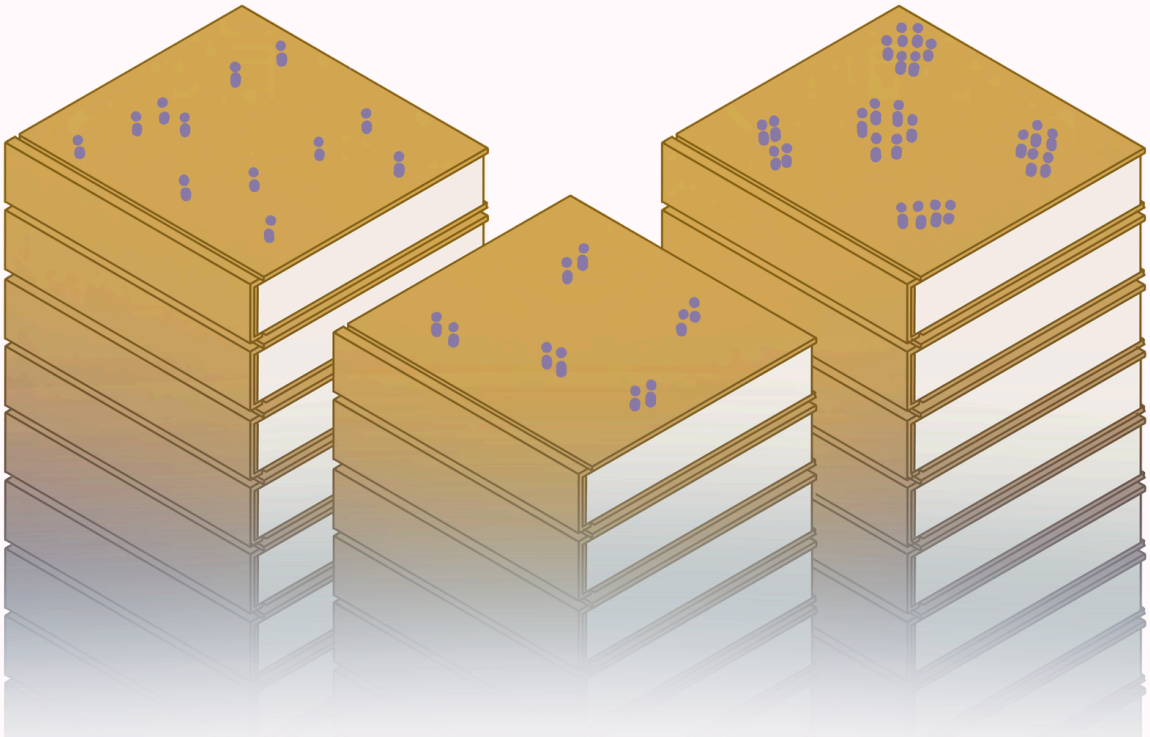
Sexual Orientation	Gay	48	23.0%
	Lesbian	31	14.8%
	Pansexual	27	12.9%
	Asexual	20	9.6%
	Queer	19	9.1%
	Heterosexual / Straight	11	5.3%
	Other	3	1.4%
Race / Ethnicity	Chinese	101	48.3%
	Malay	59	28.2%
	Indian	26	12.4%
	Other (incl. indigenous)	23	11.0%
Religion	No religion	54	25.8%
	Islam	53	25.4%
	Buddhist	52	24.9%
	Christian	25	12.0%
	Hindu	18	8.6%

Religion	Other (incl. Taoism and Sikhism)	7	3.3%
University Type	Private University	113	54.1%
	Public University	76	36.4%
	College / Polytechnic	16	7.7%
	Other	4	1.9%
Monthly Expenses (Financial Status)	RM500 – RM999	83	3.9.7%
	RM1,000 – RM1,499	47	22.5%
	Less than 500	45	21.5%
	RM2,000 or more	25	12.0%
	RM1,500 – RM1,999	9	4.3%
Received Formal Sex Education	Yes	117	56.0%
	No	92	44.0%
Outness / Disclosure* (Note: Participants could select multiple options for this category)	Out to close friends	117	84.7%
	Out to some family members	66	31.6%
	Out to university peers/staff	59	28.2%

Outness / Disclosure* (Note: Participants could select multiple options for this category)	Out to healthcare providers	19	9.1%
	Not out to anyone	16	7.7%
	Other	13	6.3%
	Out to all family members	7	3.3%

Disclosure to Medical Professionals





The final analytical sample consisted of 209 respondents who successfully completed the core scales evaluating healthcare access and barriers. The sample primarily skewed younger, with 82.8% falling into the 18–24 age bracket. The cohort was highly diverse in terms of gender identity, with significant representation from non-binary and transgender individuals.

5.2. Health Literacy & Help-Seeking

Participants were asked to rate how difficult it is to navigate the healthcare system. The results reveal that while many students are confident in finding initial information, structural navigation (like getting second opinions or finding the right facility) remains a challenge.

Survey Item: "How easy or difficult is it for you to..."	% Rating as "Easy" or "Very Easy"
Understand what your doctor says to you	83.05%
Use information from your doctor to make health decisions	73.91%
Get the information you need when seeing a doctor	66.09%
Find information on health issues that concern you	65.22%
Ask online communities for help to understand health information	63.76%
Judge the quality of health information from different sources	56.09%
Ask family or friends for help to understand health info	48.27%
Make sure you find the right place to get the healthcare you need	46.95%
Request a second opinion from a healthcare professional	46.09%

Table 5.2: Health Literacy Competency

When evaluating **Help-Seeking Beliefs**, just over half of the participants (56.08%) stated they 'Probably' or 'Definitely' would get professional help for a personal problem. Similarly, only a slim majority (50.87%) indicated they would feel comfortable talking about personal problems with a professional, underscoring the community's lingering hesitation to engage with the formal healthcare system

Students who possess higher health literacy are significantly better equipped to bypass or overcome the

structural and interpersonal barriers they face when seeking medical care. (Refer to Appendix)

5.3. Barriers to Healthcare Access

To understand specific hurdles, participants were asked how frequently they faced structural or interpersonal obstacles over the past 12 months. The findings highlight a profound lack of trust in the medical system and severe financial/structural barriers.
An overwhelming 83.92% of respondents stated they "Always" or "Usually" experience times where they do not trust or believe in doctors. Furthermore, nearly two-thirds (61.30%) routinely delay or put off necessary medical care even when sick.

Survey Item: "In the past 12 months, how often have you..."	% Responding "Always" or "Usually"
Experienced a time I didn't trust or believe in doctors	83.92%
Taken less medication than prescribed because of the cost	75.21%
Needed medical care but did not get it because I couldn't afford it	68.26%
Experienced not having transportation	62.61%
Put off care even though I was sick or needed advice	61.30%
Found the care I needed was not available in my area	56.96%
Not known where to go for care	47.82%
Found there was no LGBT friendly health care in my area	25.22%

Table 5.3: Frequency of Healthcare Barriers

5.4. Patient-Provider Relationship & Discrimination

When evaluating the Patient-Provider Relationship (PPR) among those who did access care, 66.82% reported that doctors "Usually" or "Always" explained things clearly, and 63.13% felt doctors showed respect for what they had to say. However, 16.13% of respondents reported that they are "Usually" or "Always" judged unfairly or treated with disrespect by providers.

Direct, enacted healthcare discrimination was measured by asking participants if they were denied or provided inferior care because of their LGBT identity. Overall, 15.41% of respondents reported experiencing at least one instance of being explicitly

denied or provided inferior healthcare in the past year.

	Subgroup	% Experiencing Denied/Inferior Care
By Gender Identity	Transgender	33.3%
	Non-binary	16.7%
	Cisgender Male	9.7%
	Cisgender Female	6.9%
By Race/Ethnicity	Malay	25.8%
	Chinese	12.4%
	Indian	6.9%
	Other	7.7%

Table 5.4: Rates of Denied or Inferior Healthcare by Subgroup

Transgender individuals face a significantly compounded risk within medical settings, experiencing denial of care at roughly five times the rate of cisgender women.

WHO IS MOST VULNERABLE?

- Identifying as (either) Transgender or Non-binary are the strongest independent predictors of experiencing heavy barriers to healthcare.
- Identifying as Muslim is also a highly significant, independent predictor of facing severe barriers to care. This proves that Muslim LGBTQ+ individuals face unique, compounded discrimination within the healthcare system that their non-Muslim peers do not experience.
- Older participants generally experienced significantly fewer barriers. This suggests that as LGBTQ+ individuals age, they learn to navigate the hostile system, build resilience, or secure access to safer private healthcare options.

5.5. Community Priorities: Qualitative Insights from Open-Ended Feedback

1. Judgment-Free Care, Free of Religious and Moral Policing

Respondents repeatedly described providers who weaponised their professional authority to impose personal or religious beliefs, and 13 responses named religion or personal ideology explicitly as the problem. The community is asking that medical professionals separate their clinical duties from moral policing.

> "Educate doctors on judgment-free healthcare, especially religious doctors who impose their views."

> "Less involvement of religion in the process. Just because I am Malay doesn't mean I am Muslim, and it doesn't give them the right to try and lecture me for it. I've had a friend get lectures while seeking abortion, and that's a terrible thing to hear when you're going through something traumatic like that. It's not relevant to their care."

> "Stop doctors from spreading their own misinformation/propaganda/mindset towards us. They need to learn how to separate healthcare from their own ideologies, because I've also had friends say even registered official therapists have told her being queer is a mental disorder."

The Hippocratic Oath and the Duty of Equal Treatment

Medical ethics in Malaysia are grounded in modern professional pledges such as the World Medical Association's **Declaration of Geneva**, reflected in the Malaysian Medical Council's Code of Professional Conduct. These standards prescribe clear duties:

- First, do no harm.
- Treat patients equitably, without allowing age, disease, disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing, or any other factor to intervene between a doctor's duty and their patient.

2. Mandatory SOGIESC Training for Healthcare Professionals

Thirty-four responses (18.0%) called explicitly for training or education. Participants noted a profound gap between general medical knowledge and LGBTQ+-specific healthcare needs, recounting microaggressions, invasive questioning, and outright clinical ignorance. One respondent described being pressured by a nurse to take a pregnancy test as a fully transitioned trans man before receiving an X-ray, having already refused twice, and pointedly observed that nursing and support staff are often the least trained of all. The community is demanding that providers develop genuine clinical competency regarding Sexual Orientation, Gender Identity, Gender Expression, and Sex Characteristics (SOGIESC).

> "I'd have healthcare providers be more well-educated on queer bodies. In other words, have those in the medical field (both practitioners and students) learn

> the means as to navigate a queer patient or client in an unbiased manner. Doctors should not leave a patient to die as a result of their background or beliefs."

> "Train staff to be consistently respectful (not just 'aware'). Not one-off diversity talks, but ongoing training on language, pronouns, and how to avoid assumptions. The goal isn't perfection — it's reducing those small everyday moments where patients feel judged or dismissed."

> "The first thing is training. Healthcare providers should receive proper education on LGBTQ+ health needs, including understanding different identities, using correct pronouns, and knowing specific health risks without making assumptions. When staff are informed, patients don't have to spend energy explaining or defending themselves."

3. Competent, Affirming Services in Specific Clinical Areas

Beyond general competency, respondents identified concrete service areas where provision is inadequate: sexual health, HIV, PrEP and STI services (25 responses, 13.2%), mental health and affirming therapy (22 responses, 11.6%), and gender-affirming care such as hormone therapy and surgery (17 responses, 9.0%). A further 12 responses (6.3%) raised affordability, noting that where affirming care exists it is often private and therefore out of reach for students.

> "I think that healthcare services, especially mental health services, need more empathy and a better understanding of identity issues (not just regarding queer identities). A lot of healthcare professionals seem to treat queerness itself as the problem instead of recognizing the real issues like the environment someone is in, the discrimination they have to face, the difficulty of navigating identity in an unsupportive society or with lack of understanding, and the religious guilt."

> "Reduce gatekeeping in care. Access to hormone care, gender-affirming services, or even basic respect shouldn't feel like passing an interrogation. Clear, fair, and evidence-based guidelines help a lot."

> "Malaysian healthcare education [has] failed because professionals still [call] for abstinence when that strategy [has] not worked based on substantial amounts of study... Healthcare professionals in Malaysia should not have blamed AIDS or any patient with sexually transmitted diseases and say it is because we 'engaged in sin'."

4. Confidentiality and Privacy Protections

19 responses (10.1%) raised confidentiality directly. Youth feel particularly vulnerable to having their identities disclosed, to family, to employers, or to acquaintances working within the health system, and several described avoiding care altogether for this reason.

> "Outing someone accidentally can be harmful. Clinics should have strong confidentiality practices especially for youth, people not out to family, or those in unsafe environments."

> "Some LGBTQ+ individuals, especially younger people, may not be 'out' in all areas of their lives. Healthcare systems should ensure that personal information is handled carefully so patients feel safe being honest."

Privacy concerns were most acute where anonymity is hardest to maintain. One respondent, who works in interior districts, connected confidentiality directly to geographic isolation:

> "Some say they can be transferred to [a] nearer hospital/klinik kesihatan, but being in [an] interior/rural setting where there is a high chance somebody may [know] you, or some long-distance family or neighbour working in a hospital may recognise you (maybe with stigma) make them feel 'unable to get treatment/continue their treatment'... I guess it is [a] systemic problem."

The same respondent described the downstream consequences of that inaccessibility: young people in interior districts having unprotected sex without access to PrEP, young people living with HIV skipping medication, and HIV-related deaths as early as the mid-twenties, because follow-up care sits hours away in the cities.

> "More online visibility. I am curious about HRT, but the only info I can find is from West Malaysia, when I am situated in East Malaysia."

5. Visible and Explicit Inclusivity: The Need for Safe Signals

For many respondents the fear of discrimination begins before they even speak to a doctor. Fifteen responses (7.9%) asked for explicit visual cues that a healthcare space is safe, and a further 16 (8.5%) asked for inclusive intake forms, chosen names and pronoun options — both of which spare patients the anxiety of risking disclosure in a potentially hostile environment.

> "Just putting a poster showing support for the LGBTQ+ community is a very simple way to make one feel much more welcomed in an area."

> "Health clinics showing that [they're] LGBTQ+ friendly on their doors so that we don't need to search online for safe places to go."

> "I think a very simple but important thing for healthcare services to do is to write notices about how they are 'open for everyone' or 'welcome to everyone.' It puts out a simple but powerful message; it's discreet and probably would not get them into any legal trouble, and at the same time allows queer people to know that they will be safe with them."

> "Normalize inclusive intake forms. Simple changes matter: options beyond 'male/female,' space for chosen name, and pronouns. It signals immediately: you don't have to explain yourself here."

Section 6

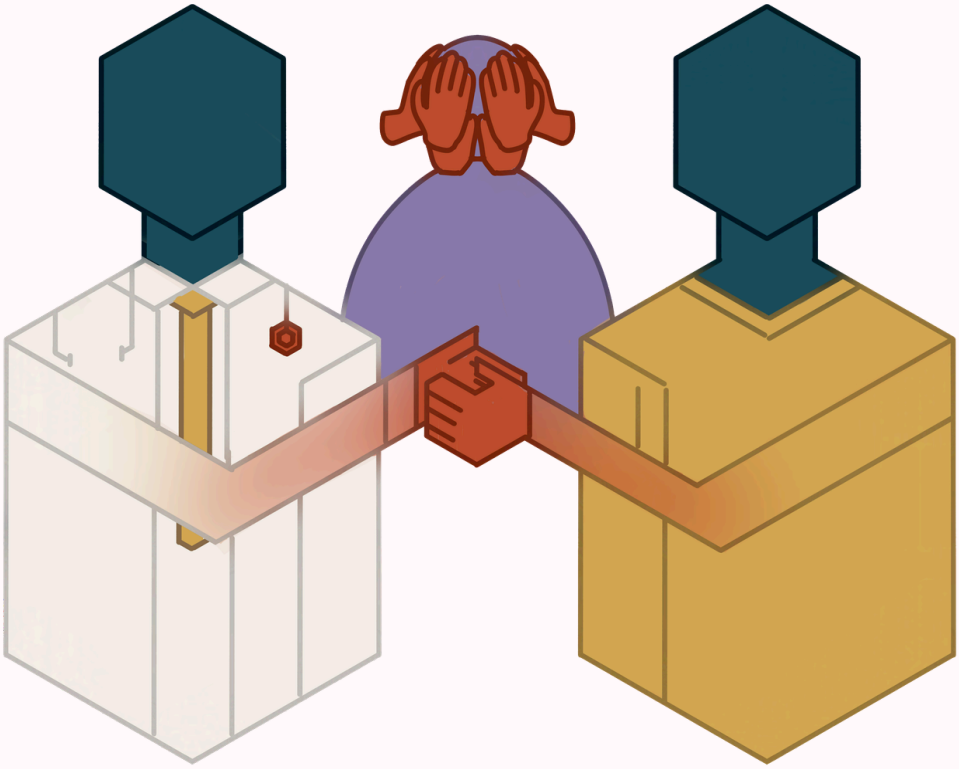
COMMUNITY VOICES

6.1. Family as a Site of Discrimination or Resilience

The study discovered the role of family as an enabling factor to increased barriers to healthcare. Due to the cultural norms of residing with family during young adulthood in Malaysia, families may be active in being the ones providing transport for young adults or accompanying adults to healthcare settings. This heavily limits interactions and open dialogue with healthcare providers due to the presence of family members throughout appointments or family members being informed of private matters without the person knowing, such instances were described by two interviewees.

"When I was going home with my mother, I told [my mother] that, hey, I might be autistic, but we don't know anything yet, and my mother said, 'Oh, I already know. Your doctor told me.' Which, for me, feels like a breach of confidentiality, since I'm pretty sure they said to me that...they would tell my parents anything that they find alarming... but I don't think me possibly being autistic at the time, before I got confirmed, is something alarming enough to tell my parents before without even telling me that they're gonna let her know. So that's something that made me start to worry about my privacy and confidentiality since."

"My own doctor told my mother about something I did not consent to. It was really stressful. A trusted friend told me where to go instead and it really helped me a lot."



Sibling relationships were accounted for as a reliable sense of support by participants.

> "My sister and I we do sometimes have some discussions...I can trust her to tell her what I've been through and then she has that same level of trust to me to share with me her experiences."

> "My brother...I'm 90% sure he is also queer...and he's very supportive. He's probably the most supportive person in my life, of me being queer and everything"

6.2 Lesbian and Bisexual Women's Experiences Dismissed in Healthcare Settings

Sexually active lesbian or bisexual women who face health complications are often assumed to be in cisheterosexual relationships . Thus, health complications regarding reproductive health are dismissed to lesbian women being pregnant, despite them insisting they have had no intercourse with men. Participants described navigating healthcare as a consistent reminders to doctors regarding their sexuality being seen as lies or not serious, with doctors fully disregarding their patients health history and sexual partners.

This was seen in Participant A:

> "There was this one time where I got... I was rushed to the ER because I just had, like, heavy bleeding, I was losing a good amount of blood. And they kept asking me if I was pregnant, or like, if I had and sexual intercourse in the past...few days, or in the past, and I'm like "Nope!" Even if I would, there's no chance that I would be pregnant. And they just would not believe me. Because I would say, oh, I don't sleep with men at all, I just sleep with women, but...I think they just, don't want to believe me. So they won't take my word for it until they take an ultrasound or whatever... [and] it will never be noted down in my chart.

Another interviewee describes a similar case:

> "The fact that every time my period comes in late, I keep telling my doctor there is no way I could be pregnant because of my sexual orientation, and he insists on doing a pregnancy test anyway."

6.3 Asexual Experience Dismissed in Therapy

Dismissal of asexuality is also part of how heterosexist narratives permeate through therapy and psychosocial support. From one participant, bringing up experiences of facing little to no sexual attraction was attributed to "commitment issues" instead of towards their queer identity.

This was seen in Participant A:

> "At the time, I talked about basically possibly being asexual, since I didn't experience too much outward sexual attraction or anything, at least not in the traditional sense. And I talked about my relationship with sexual things and romantic relationships and everything. And instead of chalking it up to just that being my preference, she jumped to it being a commitment issue, which I do not have, and later with my therapist basically confirmed that that's not

> really the issue here and it's more towards just like my attraction at the time rather than any issues to commitment."

6.4. Structural Reasons to Financial Barriers to Hormone Therapy

It is documented that in order for trans women in Malaysia to be able to achieve formal employment, they must be able to "pass the test of being a woman" to their employers (Liaw & Tharumaraj, 2023). This standard that is held for them is worsened by the discrimination they face from hiring agents who tend to look over applications for job listings from trans women and men. Seeking employment in the informal sector through gigwork or in the arts allows those who are nonbinary gender queer to maintain some form of employment and not be heavily scrutinized for their nonbinary gender presentation.

> "The places I try and contact to ask if there's any job vacancies are very much small businesses, rather than, like, big corporations or anything, since again, because of how I look, I know that I will probably need to take all my piercings, maybe like dye my hair back to black and everything. So I try and target places that I know would be a bit more open-minded and don't have a uniform or dress code or anything."

However, this further entrenches their vulnerability and inequality in comparison to their cisgender counterparts who seek employment in corporate settings, due to the lack of high wages in gig work and the inability to receive benefits of corporate work such as insurance for private healthcare. The lack of access to private healthcare due to their informal employment thus increases the barriers they face in accessing hormone therapy.

6.5. Medical Misogyny in Private Healthcare in Regards to Queer Reproductive Life Planning

Often, private healthcare is described as an immense improvement from public healthcare due to its personalized spaces, which increase privacy for LGBTQIA+ specific health concerns, and the lack of fear in regards to receiving conversion therapy by virtue of the lack of government intrusion in private clinics' procedures. However, what can remain continuous in private healthcare is the medical misogyny of women who are dismissed in terms of the pain they face or the mental distress being attributed to lack of emotional regulation rather than real, tangible medical or mental problems. This was seen with one of our participants who faced severe period pain and was repeatedly denied a hysterectomy:

> "I have asked multiple times, can you perform a hysterectomy? Can you just, yoink out my uterus? I don't need it. But they have, turned me down over and over again. One, because...they don't want me to make a decision that young, because I might change my mind later and have kids in the future, which is not

> happening. But another one is also because of my age, because I'm still pretty young, they don't want to do it. But I would say [that] my case was severe enough, which it is, they [should] perform the surgery, but right now, the doctors... They're just not convinced enough to perform the surgery."

To expand, pain medication is also not given for painful periods nor sick leaves, as period pain is chalked up to being bearable and dismissed entirely by health practitioners.

> "I would try to get an MC for the first day of my period because I can't go to class. And 8 out of 10 times I'd get rejected for it."

6.6. The Rural and Urban Divide's Impact Towards Barriers to Healthcare

LGBTQIA+ healthcare is often cited as being inaccessible in areas outside of Klang Valley but the description only stops there, despite how the rural and urban divide can manifest in other ways. One such factor that makes accessing healthcare harder in rural areas is that due to the vast distance to hospitals or clinics in rural areas, time becomes an increasingly important factor in whether healthcare can be sought out, which is described as follows:

> "The challenges after that is about the follow-ups, because, you need to find time, to make the appointments. Because sometimes, I cannot confirm my [availability] because I also have many things to do."

In addition, the lack of public transport and infrastructure such as buses in a car-centric town makes reliance on Grab and e-hailing integral to access healthcare. Not to mention that with public infrastructure's long waiting times and unpredictable appointment slots, healthcare is of unequal access as those with more time and availability, normally those who are not burdened with time poverty, end up being those who can rely on public healthcare regularly.

6.7. Difficulties in Attending Queer Community Events

Oftentimes, accessibility of queer events are not often mentioned or described. Queer Malaysians may struggle to find community due to the nature of it only being accessed through having a friend who already has access.

> "There's social media, and we all know that there's a bunch of communities in that area. I want to say they're very difficult to find, [because] normally to find them, you have to know somebody who's already in the community to actually be able to join like their activities, and so on."

Moreover, events in Kuala Lumpur can often be too far, and with people already short on time or with other commitments, it provides more barriers to finding queer community.

> "Not really. I wouldn't say so. I've never joined, like, a queer program yet, because I just, don't have time, because I'm always busy here [in university]..."

Section 7

HOW THE COMMUNITY STAYS RESILIENT AND HEALTHY IN SPITE OF DISCRIMINATION

Despite symptoms of oppression, the LGBTQIA+ community still finds ways to thrive and remain healthy through other means. Interviewees often described health as a holistic measure that included elements of both mental and physical health. Important lifestyle measures such as staying active and keeping in touch with friends or spiritual activities prove that there are ways to survive and collaborate with one another in spite of the criminalization and dire circumstances.

7.1. Reddit as an Important Source of STD and Safe Sex Knowledge

Reddit was the most mentioned site for navigating safe sex practices or questions in regards to sexual health. The platform's ability to provide anonymity, and vast amounts of subreddits and questions, allowed people to receive the answers for questions they cannot ask aloud to their families or friends. This was especially important for searching up on STI symptoms and practical advice for sex.

> "I usually go to Reddit for, I guess, more candid answers and everything, so the answers feel a bit more genuine from people who have experienced Reddit from, I mean, studies obviously are still good, but it's still good to hear more personal experiences and everything."

> "I have to rely on people online [and] they're okay. Because they only provide very specific and very specific kind of conversations, and very specific kind of contexts."

7.2 Independence From Family as A Way of Navigating LGBTQIA+ Health

One key aspect of being able to manage wellbeing was finding it in oneself to be independent from family as much as was doable. Participants often reported that becoming self-sufficient through close friendships, having a source of income and living independently from the family household gave them more peace and self-confidence for their queer identity. It also kept them safe from scrutiny when medical issues did occur from an active sex life.

> "I'm much more grown now, and I'm able to go out on my own. My parents' acceptance isn't that much of an issue for me anymore"

> "Being held back [from family] is one way to say it...[and] they are, but the way that I see it is that from the way they was raised...they are trying to live with it now that they're out of the house."

> "When you become older, you kind of just have to move somewhere else, and you feel that it's more safe."

7.3 Avoiding Conservative Religious Circles As A Way of Seeking Safety

Whether or not the informant lived within Klang Valley or in states other than Selangor, a frequent tactic of remaining safe was to avoid religious circles as much as possible.

> "If, like, that person is, like, super religious and stuff like that, it will not be safe to be yourself in front of them, and it's best to, like, keep things, like, surface level."

Participants outside of Selangor described that oftentimes, the majority community would play off as kind and concerned for others and would have it in their best intention to help, but would forcibly out a queer identity to parents or other people in authority.

> "They will try to help you [and] go out of their way to try to, like, help you in ways that they know they can. But because their moral code is, like...quite skewed by religion, it makes it quite hard for them to help in the right ways."

7.4 Finding Community in KL or Through Online Platforms

Towns and cities outside of Kuala Lumpur were described as places without no community or a safe sense of belonging for the queer community. Growing up well often meant being able to own or have access to transportation to be able to participate in events within KL or the town they resided in.

> "It's quite hard, uh, for me to go anywhere, because I'm...I don't have a vehicle right now and stuff like that, and there [is] nothing around here."

For those who could not afford transportation, they would either have to rely on their close friends to be comfortably out of the closet, or, rely on online communities as a site for self-expression and finding other like-minded people.

> "I used to be very active online, I had a lot of friends from out of the country and everything, but I did find that while the connection was real, of course, and I did value them as friends, there was still something missing and that at least I personally still needed that physical connection. But despite not having that and those people not really being in contact anymore, it still definitely helped me get through the times where I did feel really lonely and I didn't have. any, like, physical community to connect to, I couldn't really go anywhere, I couldn't even get, like, public transport to go anywhere."

7.5 Journalling As A Resilience Tactic for Queer Women

Journalling was described by many ciswomen as a way of processing emotions positively and making sense of their own thoughts. Many said that they kept a diary when young and had learned to journal either from there or seeing it mentioned online.

> "Yeah, when life gets hectic, I tend to journal a lot... I've had a diary since I was, like, 5."

> "I have to journal things out or else to keep my emotions in check. And that's something that I encourage for other people to journal. As corny as it sounds, it actually works if you do it right."

> "There's different types of people who would journal. There's those who would, like, full-on just, like, just writing, it's just, like, writing all over, and then, like, there's those who decorate, like, or full-thon decorate. Some people just, like, decorate just a little bit. Some people, like, go full-on. for their journals. I think it

definitely depends on the type of person, and I think it reflects the person a lot, too. I think I'm, like, somewhere in the middle, where, like, I'm, like, lingering in the middle, where... because I do... write a lot. I like... or I write my thoughts a lot, and, my experiences, and then sometimes I... if I'm feeling good that day, maybe I'll put little sticker here and there."

7.6 Having Knowledgeable Friends To Remain Educated on Safe Sex

Although finding friends who had practical experience and an active sex life proved difficult for most folks, those who did have these friends said they were a reliable source of information and assistance for navigating safe sex. Friends were able to give guidance and support as well as advice for important matters.

"We have, like, brunch with a bunch of older lesbians. Some are Gen X, a lot of them are Gen Y. Yeah, so because it's like a hangout session, so I'm free to ask, like, the older queers their experiences and stuff. I'm really really grateful to [be able to] join these communities and hear the experiences of older queers firsthand."

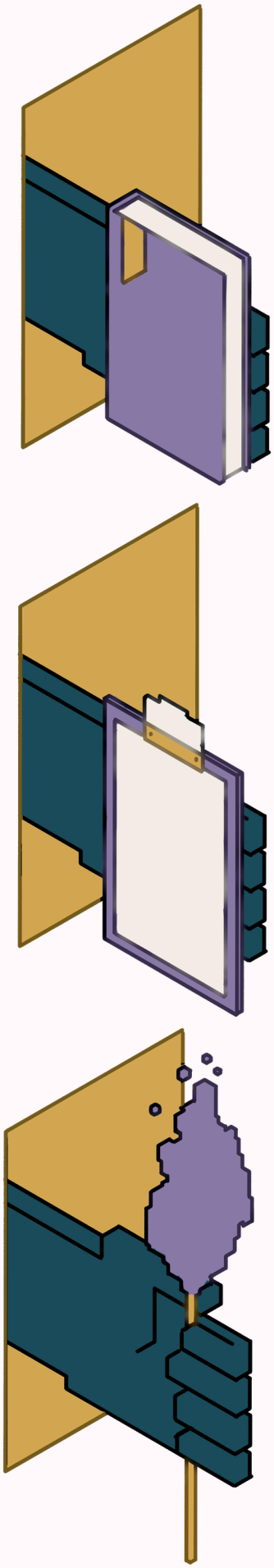
However, the most common case was for friends to not be a reliable source.

"Because, like, even though my friends are pretty much, like, you know, open, I don't think they would understand how sex, like, actually works."

"Most of my friends. They don't have that type of experience, they don't have any like practical experience. And I would say that maybe the awareness they don't really have that awareness... their awareness is very surface level, and like they haven't been through it themselves, so they also don't really have anything important [or] more specific to share. And it really depends on the friend, because some friends they have different values, so they might see this thing differently. So it's not really a common topic that I bring up to my friends."

Section 8

RECOMMENDATIONS FROM HEALTHCARE PROVIDERS



The top three ideas suggested from healthcare providers were (the rest are attached in Appendix 2):

- **Integrate LGBTQIA+ health to medical school curriculums**. Healthcare providers agreed that across the board in psychology to medical science there was a lack of classes and training in medical school in regards to the LGBTQIA+ community. Training on STIs or HIV needs were often done after medical school through providers' own initiative and the lack of cohesive recommendations from any institutional body often would lead to providers seeing colleagues do unnecessary and intrusive tests that are not needed.

- **Improve access to mental health services and enhance sexual and reproductive services**. Healthcare providers noticed a rise in cases of depression after being diagnosed as HIV positive and that counselling is an important element of being able to manage being HIV positive.

- **Strengthen collaboration between communities, providers and organizations**. Providers mentioned many initiatives that were already available to the public but were not well known due to the lack of coverage and awareness. Collaborations were also difficult to initiate as it would be highly dependent on the management of the clinics whether they were open to community based initiatives.

Section 9

STORIES AND PERSPECTIVES FROM HEALTHCARE PROVIDER AND COMMUNITY EXPERT PERSPECTIVES

9.1. Community-Based Outreach: PT Foundation

A peer navigator and community health worker at Malaysia's oldest HIV-focused NGO described a model of care built around community members supporting their own communities. Peer navigators share the lived experiences of key populations, which allows them to offer not only information and referrals, but also empathy rooted in similar struggles:

> "We are who we are, so we are helping ourselves. That is why we need to have community members working as our team, so that we can have the empathy about what they are facing along the way."

On confidentiality, he acknowledged that formal protocols in clinics are strong, but that subtler forms of stigma still leak through tone or body language, and these can discourage disclosure even when rules are followed. He also reflected on the specific pressures facing Muslim LGBTQ+ people, noting that public messaging which focuses only on identity can sometimes alienate community members who are still navigating their own values:

> "Many of our communities have their father; they have their mother; sometimes, they leave their family. These things are a bit hard for them because, sometimes, if we focus our public messaging on identity, we might accidentally alienate our community that is navigating their own values."

He highlighted the geographic limitations of PT Foundation's reach. While the organisation is based in Klang Valley, it relies on partner NGOs to reach communities in Sabah, Sarawak, and other underserved regions, and capacity remains limited.

When asked how clinics can signal safety to LGBTQ+ patients without provoking backlash, he emphasised the importance of resonant but careful messaging:

> "How we can make the service resonate with our key affected population, they will know, they will come. But addressing it too vividly and contrasting it with the majority's values, they feel threatened."

His own journey as a gay Muslim Malaysian living with HIV, diagnosed with autism spectrum disorder, and estranged from his family for a decade before reconciliation, embodies the multiple layers of vulnerability that this report documents.

9.2. Rural Public Health in Sabah: Distance, Cost, and Stigma

A public health specialist and former district health officer in interior Sabah offered a detailed picture of service provision in rural districts such as Keningau, Tambunan, Pensiangan, and Tenom. The area he served is geographically large, comparable to a whole peninsula state, with one main district hospital, two smaller district hospitals, and about 52 Health Clinic

(klinik kesihatan) and Village Clinic (klinik desa) spread across the interior.

For many village (kampung) residents, a single clinic visit can involve one to two hours of travel each way and multiple forms of transport. Bus tickets, chartered cars, meals, and occasional overnight stays in Kota Kinabalu add to the indirect costs of care, especially for people who need frequent appointments. This financial and time burden contributes directly to treatment default. He described a young man who stopped HIV treatment because he had no money and no friends to stay with in Kota Kinabalu; his condition worsened until district staff managed to trace and re-engage him. On confidentiality, he stressed that KKM staff are trained to protect privacy and not withhold care:

> "As KKM staff, we are very professional. Privacy and confidentiality are taken with the utmost care. We still treat and take care of every patient, and we still honour privacy and confidentiality."

However, he noted that community stigma remains a powerful barrier. In small districts where "everyone knows everyone," patients may fear being recognised by nurses or doctors, or becoming the subject of kampung gossip, even when staff strictly follow protocols.

He also described efforts within KKM to reduce provider stigma, including modules and desensitisation courses for teams working with MSM, PrEP, and sexual health services. He emphasised that KKM's principle is that service must come first regardless of personal beliefs, while acknowledging that community-level stigma towards people living with HIV and LGBTQ+ youth still requires more work.

On confidentiality with families, he explained that HIV status is not disclosed to parents or relatives without the patient's consent, except in specific situations such as minors or where a spouse must be informed and screened. For under-18 patients, legal consent requirements can force disclosure to parents, which creates difficult ethical and emotional dynamics in cases involving young LGBTQ+ people.

9.3. Private Sexual Health Clinic: Training, Signaling Safety, and Limits

A physician in charge of a private sexual health clinic that offers PrEP and STI services, described how affirming care can be built within the private sector. He completed a postgraduate in sexually transmitted infections and sees most of the clinic's sexual health and PrEP cases himself, which allows for consistent, informed care.

Training staff to work comfortably with LGBTQ+ patients was a significant challenge, particularly where staff had little prior exposure to the community or held strong cultural or religious beliefs. He described having to emphasise professional ethics and the duty of care:

> "I had to tell them that, although they are not doctors, they are in the healthcare line. They have to put aside their cultural and religious belief, and we need to put the patient first. We have to treat the patient regardless of their background, gender identity, or sexual orientation."

To support staff, he provided simple templates on how to greet patients, respond to WhatsApp or email enquiries, and refer them to consultations when he is on duty. Regular locum doctors are selected for their comfort treating LGBTQ+ patients, and he has not received complaints from patients about staff behaviour.

On signaling that the clinic is safe, he relies on both social media and physical cues. The clinic uses Instagram and other platforms to advertise PrEP and PEP services as non-judgemental and inclusive. Inside the clinic, posters about sexual health include words such as "non-judgmental" and "inclusive," so that closeted patients who may never see the clinic's social media can still recognise the space as safe to discuss their concerns.

When asked what advice he would give other private clinics wanting to be LGBTQ-friendly, he emphasised that training should come before branding:

> "Before they start promoting their clinic as a sexual health clinic or LGBTQ-friendly clinic, I would strongly advise them to get proper training first."

Clinics need not only inclusive language and posters, but also trained staff, clear internal protocols, and a culture that truly puts patient wellbeing ahead of personal bias.



DISCUSSION

The report currently provides data on the SOGIESC student population barriers to healthcare. The data indicates that 83.92% of participants indicated their skepticism towards doctors, which is consistent with Cruciani et al. (2026). This may be caused by the anticipation anxiety due to the community being a minority group of a younger age, which may be similar to the experiences of same sex couples (Thomeer et al., 2018). This suggests that the barriers to healthcare can be affected by age. The data is also consistent with results from Gibson et al. (2016) and Telang, Cotter & Rashid (2025). This result is interesting as it suggests that the discrimination is not limited to trans women and that the discrimination in regards to healthcare can affect both trans men and non-binary individuals.

Throughout the report, participants and the doctors have consistently raised the need for training and guideline among doctors to better treat the needs of the LGBTQIA+ community, which is congruent with other studies in the literature (Gibson et al., 2016; Romanelli & Hudson, 2017; Said et al., 2021; Rosen et al., 2023; Amin et al, 2024; Cruciani et al., 2026; Tan, 2025, Telang, Cotter & Rashid, 2025).

Besides that, cost has also consistently been a barrier to accessing healthcare, which is similar the experiences of participants from other studies (Gibson et al., 2016; Romanelli & Hudson, 2017; Said et al., 2021; Rosen et al., 2023; Amin et al, 2024; Cruciani et al., 2026; Tan, 2025, Telang, Cotter & Rashid, 2025).

Besides that, cost has also consistently been a barrier to accessing healthcare, which is similar the experiences of participants from other studies (Gibson et al., 2016; Romanelli & Hudson, 2017; Tan, Lee & Cheong, 2021, Rosen et al., 2023, Telang, Cotter & Rashid, 2025). This is especially relevant for the transgender community as 6.3% of individuals within the report express that gender affirming care is out of reach and privatised, which is similar to the Mak Nyah (trans woman sex workers) community (Gibson et al., 2016).

Participants also mentioned how doctors should create a judgement free zone that prevents moral policing of patients and provides care that is confidential. This is paired with participants experiences with stigmatisation that mirrors the experience of other participants within the literature, especially when it comes to family and religious values (Gibson et al., 2016; Tan, Lee & Cheong, 2021) This is notable as past studies have suggested that doctors have refused care out of stigma relating to the LGBTQIA+ community (Gibson et al., 2016; Ni et al., 2023) and the data is consistent with the survey conducted by Tan (2025). This is also notable considering that the study also takes into account experiences outside of the gay male sphere.

In the future, research into this field should explore perspectives such as the lesbian, non-binary and the trans male community, as well as expand research into the SOGIESC student population.

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