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A Social Ecology of Sexual Health and Well-being among Older Gay Men and Transgender Women in Chiang Mai, Thailand: A Qualitative Study

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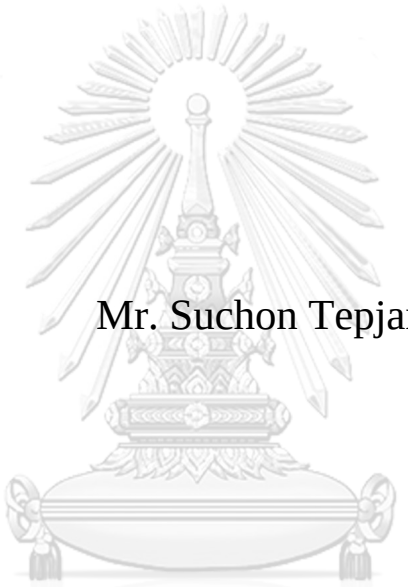

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การศึกษาเชิงคุณภาพเกี่ยวกับแนวคิดนิเวศสังคมด้านสุขภาพทางเพศและสุขภาวะของเกย์และหญิงข้ามเพศสูงวัยในจังหวัดเชียงใหม่ ประเทศไทย

นายสุชน เทพจันทร์

วิทยานิพนธ์นี้เป็นส่วนหนึ่งของการศึกษาตามหลักสูตรปริญญาสาธารณสุขศาสตรมหาบัณฑิต
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ด้วยจำนวนประชากรสูงวัยที่เพิ่มมากขึ้นในประเทศไทยรวมไปถึงประชากรที่มีความหลากหลายทางเพศนั้น การให้ความสนใจกับกลุ่มเกย์และหญิงข้ามเพศสูงวัยยังถือว่าได้รับการเล็งเห็นและให้ความสนใจน้อยมากโดยเฉพาะอย่างยิ่งด้านสุขภาพทางเพศและสุขภาวะ งานวิจัยจากต่างประเทศหลายๆชิ้นได้บ่งชี้ว่ากลุ่มประชากรนี้มักจะตกเป็นกลุ่มที่ด้อยโอกาส โดยเฉพาะอย่างยิ่งในประเทศที่ไม่มีการรองรับและปกป้องด้านสิทธิมนุษยชนของกลุ่มที่มีความหลากหลายทางเพศต่อการถูกตีตราและแบ่งแยกจากสังคม สุขภาวะของประชากรที่ถูกกีดกันทางสังคม ถูกทำร้าย และต้องปกปิดตัวตนมายาวนานเหล่านี้ควรจะได้รับความเข้าใจมากขึ้น การศึกษาครั้งนี้จึงต้องการสำรวจและการทำความเข้าใจถึงปัญหาและประเด็นเหล่านี้ โดยจะเน้นศึกษาเกี่ยวกับปัจจัยแนวคิดนิเวศสังคมที่ส่งผลกระทบต่อสุขภาพทางเพศและคุณภาพความเป็นอยู่ของเกย์และหญิงข้ามเพศสูงวัยในจังหวัดเชียงใหม่ การศึกษาเชิงคุณภาพครั้งนี้ได้มีการจัดทำขึ้นกับเกย์สูงวัย 9คนและหญิงข้ามเพศสูงวัย 9 คนที่อายุ 60 ปีขึ้นไปและมีภูมิลำเนาอยู่ในจังหวัดเชียงใหม่ ผู้วิจัยได้มีการใช้แนวสัมภาษณ์แบบกึ่งโครงสร้างในการสัมภาษณ์เชิงลึก การสัมภาษณ์มีระยะเวลาประมาณ 40-90 นาที และมีการอัดเสียงไว้ทุกบทสัมภาษณ์ได้มีการถอดเทปและใช้วิเคราะห์แบบแก่นสาระ สาระและเนื้อหาที่สำคัญและสอดคล้องกับโครงสร้างของระบบแนวคิดสังคมนิเวศน์ได้ถูกจัดตามรูปแบบนั้นโดยมีหมวดหมู่หลักคือ ระดับบุคคล ระดับระหว่างบุคคล ระดับสังคมและวัฒนธรรม และระดับโครงสร้างของสังคม โดยผลลัพธ์ที่ได้นั้นแสดงถึงปัจจัยและปัญหาต่างๆในแต่ละระดับซึ่งมีความสอดคล้องและสามารถส่งผลกระทบถึงกันโดยชัดเจน การศึกษาในครั้งนี้ทำให้เล็งเห็นความขาดแคลนและความต้องการการรับรองระดับโครงสร้างทางสังคมที่จะส่งผลถึงปัจจัยระดับบุคคล ซึ่งจะสามารถเป็นตัวช่วยในการพัฒนาสุขภาพชีวิตทั้งสุขภาพทางเพศและทางใจของเกย์และหญิงข้ามเพศสูงวัยในประเทศไทยได้

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Suchon Tepjan : A Social Ecology of Sexual Health and Well-being among Older Gay Men and Transgender Women in Chiang Mai, Thailand: A Qualitative Study. Advisor: Nuchanad Hounnaklang, Ph.D.

With increasing ageing populations in Thailand, including sexually diverse communities, there has been little attention to older gay men and transgender women regarding their sexual health and well-being. Several international studies indicated that these communities have been underserved, especially in countries that lack human rights to protect against social and cultural stigma. The well-being of this population, that had experienced discrimination, victimization, and identity concealment in their early years, could have been better understood through open-ended exploration. This study explores the social-ecological factors contributing to the sexual health of older gay men and transgender women in Chiang Mai. This qualitative study was guided by a grounded theory approach. Eighteen in-depth interviews were conducted in Thai with 9 older gay men and 9 older transgender women aged 60 years and older and were locals. The semi-structured interview guide was informed by the social-ecological model. The interviews were digitally recorded and transcribed. The researcher conducted thematic analysis using line-by-line and thematic coding from the transcripts. Several themes emerged from the interviews across the social-ecological model–individual level: embarrassment of ageing, feeling of loneliness; interpersonal level: isolation, friends and family support; sociocultural level: culture and beliefs, stigma and discrimination; structural level: social exclusion, discrimination and stigmatization from service providers, and lack of law supporting ageing sexual minority populations. The intersectional impact of multi-level factors on sexual health and well-being of older gay men and transgender women demonstrated that individual- and interpersonal-level experiences could contribute to their well-being, both physically and mentally. Interventions on acknowledging awareness and the health needs of such marginalized communities may support understanding and improvement of their health quality. Sociocultural- and structural-level factors suggest that further social policy and intervention research should promote inclusion and equality for older gay men and transgender women in Thailand.

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Suchon Tepjan

TABLE OF CONTENTS

Page

..... iii

ABSTRACT (THAI) iii

.....iv

ABSTRACT (ENGLISH).....iv

ACKNOWLEDGEMENTS.....v

TABLE OF CONTENTS.....vi

CHAPTER I.....1

INTRODUCTION 1

1.1 Background 1

1.2 Research questions 5

1.3 Objectives.....5

1.4 Conceptual Framework 5

1.5 Operational Definitions 5

CHAPTER II.....8

LITERATURE REVIEW 8

2.1 Sexual and Gender Minorities.....8

2.1.1 Gay and other Men who Have Sex with Men, and Transgender Women.....9

2.2 Older Adults 10

2.3 Sexual Health 11

2.3.1 Sexual Health among Gay Men and Transgender Women 11

2.3.2 Health Disparities.....14

2.4 Well-being and Health Quality.....16

2.5 LGBT Stigma & Discrimination in Thai Culture.....16

2.6 Concept of Resilience.....18

2.7 Social Ecological Model 19

CHAPTER III 21
RSEARCH METHODOLOGY 21
3.1 Research Design 21
3.2 Study Area 21
3.3 Study Period 22
3.4 Study Population 22
3.4.1 Inclusion criteria: 22
3.4.2 Exclusion criteria: 23
3.5 Sample size 23
3.6 Sampling Technique & Recruitment 23
3.7 Measurement Tools 24
3.8 Data Collection 25
3.9 Data Analysis 27
Figure 1 28
3.10 Ethical Considerations 28
3.11 Compensation 29
3.12 Expected Benefits and Application 29
3.13 Proposed Timeline 29
CHAPTER IV 30
RESULTS 30
Table 1 30
Figure 2 31
Individual Level 31
Interpersonal Level 35
Sociocultural Level 38
Structural Level 40
CHAPTER V 45
DISCUSSION 45
LIMITATION 47

CONCLUSION....48
RECOMMENDATIONS....49
REFERENCES....51
APPENDICES....59
APPENDIX A....59
Sample Flyer....59
APPENDIX B....60
Screening Questions....60
APPENDIX C....62
Semi-Structured Interview Guide....62
APPENDIX D....65
Consent Form....65
VITA....69

CHAPTER I
INTRODUCTION

1.1 Background

Sexual health has been formally defined by the World Health Organization (WHO) in 1975 as "*The integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication, and love*" (WHO, 2017). Through literature review, research, and evolving cultures, the understanding of sexual health has developed with inclusion of reproductive health (Edwards & Coleman, 2004). The attempt to best define sexual health has progressed through times, from the report of the 1994 International Conference on Population and Development (ICPD) to Surgeon General's Report (2001) and the National Strategy for Sexual Health and HIV (2001), WHO had tasked global experts to understand and develop a clearer definition for sexual health and finally concluded in 2002 as "*A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled*." (Edwards & Coleman, 2004; Minnesota Department of Health, 2010; WHO, 2017).

While both clinical and social aspects of reproductive health have been largely studied globally, the important elements of sexual health can be ignored (WHO, 2017). The WHO, together with the Human Reproduction Program (2017) has developed a framework of guiding principles to link sexual health to reproductive health, which also include essential basic elements of human rights (see Figure below). This framework, as well as several recent studies aim to include the context of human rights, especially vulnerable and minority populations (e.g., migrant, ethnic minority, the poor and underserved, sexually diverse people, and people living with HIV). This framework also suggests that in order to achieve the inclusion of all sexual health components, the human rights on "sexual right" shall be respected (WHO,

2006, 2010). The WHO 2010 report indicates that the ability of men and women to achieve sexual health and social well-being depends on accessibility of information, services, as well as environment. Each gender has different roles, responsibilities and expectations, given by society and culture, which shape their relationship of gender-based rights and their general sexual health.

Sexual and gender minorities (SGM), also known as lesbian, gay, bisexual, and transgender (LGBT) persons, are a diverse population (Littlejohn et al., 2019). Despite the fact that these communities have become more visible and engaged in society, there have been disparities in their health and well-being. Stigma, discrimination, and criminalization towards these populations have been such social and structural barriers in accessing health care needs (Logie et al., 2016). These challenges and experiences in life address the burden of mental and physical health issues.

The study of SGM populations in Thailand has been given attention to by both local and international researchers across various aspects, such as health, mental

health, and social health. However, there has been little attention to SGM older adults around their sexual health, mental health and well-being (Ojanen et al., 2016; Tun-atiruj, 2019). Several international studies revealed that SGM older adults have been underserved, especially in countries lacking human rights to protect against social and cultural stigma, which could seriously impact their aging, mental health and health quality (Fredriksen Goldsen & de Vries, 2019; Knochel et al., 2011; Shilo et al., 2015; Yarns et al., 2016). According to Best Living Taste (BLT) Bangkok statistics, Thailand has the fourth largest of SGM populations in Asia, at 4 million persons among the nation's population (BLT Bangkok, 2019). Moreover, the Department of Older Persons has investigated the older person populations in Thailand and ranked Chiang Mai as the third largest number (18.75%) of the province's total population), following Bangkok and Nakhon Ratchasima respectively (Department of Older Persons, 2019). Among these, there could be a significant number of older adults ages 60 or more, defined by the United Nations Population Fund, & Help Age International as "*older person*" (UNFPA, 2012), and also defined in section 3 of the Act on the Elderly, B.E. 2546 as "*the elderly*" (Department of Older Persons, 2003). They have lived in times where acceptance and equal treatment for SGM might not have been advanced. Kittiteerasack et al. and Hair et al. are among the first researchers to examine Thai SGM older adults' mental health issues (Hair et al., 2019; Kittiteerasack et al., 2021). Although, a number of key populations remain visible and active, there is scant evidence about sexual health and health disparities in Thailand (Ojanen et al., 2016).

In Thailand, several studies have been attempting to investigate issues around general sexual health and well-being, there seems to be scant interest on the LGBT populations regarding their sexual health deviance (Sinnott, 2011). As stated previously that most focus of LGBT populations in Thailand has been around sexually transmitted diseases and related health issues. Studies around mental health among some gay men and transgender women are nonetheless related to risky behaviors, including sexual risk behaviors—substance abuse, harmful alcohol use, and suicide (Guadamuz et al., 2011; Patel et al., 2013). Moreover, the majority of the studies have been done among adolescent, youth and young adults, which raises a gap in research among LGBT populations who are older.

A study by Kaewpan and colleagues (2015) focused on the quality of life of young gay men in Bangkok, Thailand and found that almost half of them (44.3%) had a moderate overall quality of life (Kaewpan, 2015). However due to work and society-related factors, the psychosocial, environmental and social-relationship aspects remained moderate by approximately half. The authors also suggested that more research should be conducted with a focus on other subgroup of gay men (i.e., working group and those with health problems). Several studies also supported that older LGBT populations should be more focused regarding overall health and sexual health research in all aspects (Kittiteerasack et al., 2021; Public Health England, 2014). The foremost concerns that affect older LGBT people are similar to those that affect older heterosexual people: loneliness, health-related problems and financial issues. About 36% of older men report concealing their sexual identity throughout their lives and realized that this had led to internalized homophobia (Heaphy, 2014). There is very little research on the mental health of older gay men, but there are suggestions that older gay men have raised levels of depression compared with older adults in the general population (Shippy et al., 2004). Additionally, some older transgender women tend to experience depression which led to concerning issues such as suicide attempt. A study among Thai transgender women found that one half of the participants lived with depression, and one-third of those were older (Tantirattanakulchai et al., 2019).

A LGBT rights activist, Ryan Figueriredo, is probably one of the first people who attempts to vocalize the importance of attention to ageing LGBT people in Thailand, publicized in mid 2019 (TimeOut, 2020). Due to the culture of Asia as well as Southeast Asia where the older people tend to depend on care from younger generation, it creates a bigger risk for those who are LGBT individual to experience social isolation.

Therefore, this study aimed to explore the sexual health and well-being of older gay men and transgender women in Chiang Mai, Thailand, as well as to gain better understanding of their resilience systems. Having a better understanding the challenges of this marginalized population could raise awareness in the community to be more inclusive of ageing SGM individuals, regarding basic human rights, social interactions and inclusion, and access to healthcare, including policy development and

improvement to protect this populations.

1.2 Research questions

1.2.1 What are the contributing individual, interpersonal, sociocultural, and structural factors to sexual health of older Thai gay men and transgender women?

1.2.2 How do older Thai gay men and transgender women cope with these issues?

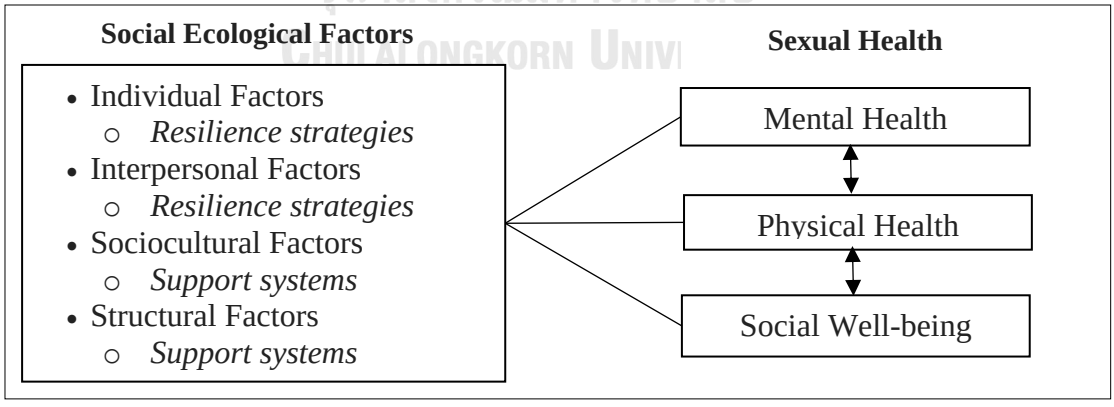
1.3 Objectives

1.3.1 To explore the sexual health of older gay men and transgender women in Chiang Mai, Thailand.

1.3.2 To identify the social ecological factors contributing to sexual health issues of older gay men and transgender women adults in Chiang Mai, Thailand.

1.3.3 To gain qualitative understanding of the resilience of older gay men and transgender women in Chiang Mai, Thailand and the support systems available to them.

1.4 Conceptual Framework



1.5 Operational Definitions

In this study, the key terms of the investigation through the discussion are as follows:

Study Population

Gay men refer to male whose sexual identity or sexual behavior is predominantly directed toward other men.

Transgender women: (male-to-female) an individual who was originally assigned the sex of male at birth, but has claimed a female identity through clothing, surgery, hormones, and/or attitude changes (GSAFE: Gay Straight Alliance for Safe School, 2020).

Older adult: a person who is at the age of 60 years or more (UNFPA, 2012).

Conceptual Framework

Social ecological model: a theory/framework that explores multiple and interconnecting levels of factors influencing human behaviors including individual, interpersonal, social-cultural and structural context (Bronfenbrenner, 1979; Stokols, 1996).

Individual factor: factors identified within a person, including attitudes, knowledge, skills, genetics, and characteristics.

Interpersonal factor: factors that involve or occur among two or more people

Sociocultural factor: factors in a larger scale which influenced by society and culture that affect a person's thoughts, emotions, and behaviors.

Structural factor: social, economic, political, policy, and environmental factors that affect a person's thoughts, emotions, and behaviors.

Sexual Health and Challenges

Mental health: a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO, 2014).

Minority stress: mental health problem faced by members of stigmatized minority groups caused by a hostile and stressful social environment (Meyer, 2003).

Depression: a common mood disorder, characterized by sadness, loss of interest affecting how one feels, thinks and behaves and can lead to emotional and physical problems (Mayo Clinic, 2020).

Discrimination: negative attitudes and behaviors (verbal, action, nonverbal) towards

the participants, or any experiences they have perceived to be considered as negative.

Stigmatization: similar to discrimination, this refers to any disapproval or negative perceptions towards the participant's characteristics.

Social isolation: a state of lack of contact between other individuals and society.

Living arrangement refers to the participant's living status: living alone, with family, with relatives, with partner, or with friends.

Family support: support from family and relatives (in terms of moral support, financial support, and any type provided by the participants' own families.

Social support: support from friends, colleagues, or the structural condition that the participants live in which contribute to their well-being aspects.

Physical health: normal functioning of the body at all levels as well as ability to perform daily tasks and live comfortably in one's body.

Sexual health: a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

Resilience: the ability to cope with and recover (mostly mentally) from difficulties, hardship, discrimination and stigmatization.

Quality of life: a standard of health, happiness and comfort in their living.

Well-being: a state of being mentally, physically, and socially happy and healthy.

Social well-being: the ability to make and maintain positive relationships and connections with other people in community, as well as receiving social inclusion with equality.

CHAPTER II

LITERATURE REVIEW

In this chapter, an understanding of sexual and gender minorities, including gay men and transgender women, and theoretical aspects of sexual health are explained in order to conceptualize the foundation of the study's purpose, populations of interest, and the possible outcomes.

2.1 Sexual and Gender Minorities

Sexual and gender minority (SGM) populations include, but are not limited to, the following: individuals who identify as lesbian, gay, bisexual, asexual, transgender women, transmen, Two-Spirit, queer, and/or intersex. Individuals with same-sex or -gender attractions or behaviors and those with a difference in sex development are also included. In this study, the SGM individuals of interest include gay, men who have sex with men and transgender people. These populations in Thailand have become quite visible but the lives of older SGM populations, especially in rural parts of Thailand, have not been the subject of much research.

Transgender people include both male-to-female and female-to-male (Ojanen, 2009). Transgender women have a longer history and public recognition in Thailand, and will be the focus for this research. But it is important to acknowledge that transmasculine persons also exist and may face distinct challenges from transgender women. This is in part due to the very low public awareness about transmasculine people. Transgender women (male-to-female) and their experiences of physical change over time can become a challenge in living, and could be one of contributing factors of social isolation (Yadegarfard et al., 2014). This is especially for those transgender women who have undergone sex reassignment procedures and have been taking hormones. It is important to note that not all transgender people choose to undergo surgery, or have access to surgery as an option due to its high costs; however, they share in common an experience of identifying with a gender different from the sex they were assigned at birth. Hormones can help transgender persons to feel more congruence between their experienced gender identity and sex; however, they have several effects on a person's body and mentality in the long term (Gooren et al., 2013). Plus, most transgender people stop taking hormones from a certain age in life

due to physical and financial factors, which this research also seeks to explore.

2.1.1 Gay and other Men who Have Sex with Men, and Transgender Women

The history and cultural contexts for understanding the emergence of gay, lesbian, and transgender identities in Thailand is different than in most Western contexts. As a result, it is more appropriate when discussing the history of these populations to include gay men and transgender people in the same context. In discussing the present-day life situations and experiences of gay men and transgender people, it becomes important to distinguish between these groups due to some of the distinct challenges faced by each group.

Same-sex attractions and behaviors have been documented for centuries in Thailand, as in other countries; however, historically these did not refer to specific identities or types of persons, but only to behaviors. Importantly, the general understanding of sexual orientation and gender identity in most Western contexts as distinct categories is different in Thailand. There are words in Thai for translations of the terms gender, sexual orientation, and gender identity, but they are not often used in everyday speech. These terms are mostly known and used by academics, researchers, and LGBT activists (Ojanen, 2009). In Thailand, sexual orientation and gender identity are conceptualized as a fixed categorical identity of gender (*phet*), rather than two distinct categories (Jackson, 2003a). This is based on the history and culture of Thailand, which is important for understanding and addressing the present challenges faced by gay men and transgender women, especially older adults.

A number of countries in Southeast Asia have cultures that recognize more than two genders, often including at least one transgender identity (Winter, 2012). Multiple sexes or genders have been recognized historically in Buddhist scriptures from around 2,500 years ago (Likhitpreechakul, 2012). The word kathoey, in the Thai context, has traditionally referred to people who did not fit into gender binaries of male and female; presently, it is a common term to refer to transgender women (Chonwilai, 2012). According to Peter Jackson, an extensively published expert on the history of Thai sexual and gender identities, a specific kathoey (transgender) identity began to be recognized in the 1950s (Jackson, 2003a).

In the Thai context, transgender identities preceded gay and lesbian identities in public discourse. Jackson describes more masculine gay identities as gradually emerging from the 1960s onward, which diverged from earlier kathoey identity. These became increasingly understood as different groups (Jackson, 2003a). Among same-sex attracted women, masculine tom and feminine dee identities emerged in the 1980s. Importantly, these identities are dynamic. As in other societies, further identities and new identity terms are adopted over time; in part, this is in response to changing sexual cultures—not just among gay people but among all people in society. These terms also emerge and change when an older term seems inaccurate, or when it is highly stigmatized (Ojanen, 2009). For example, the older term "homosexual" is nowadays frequently seen as a pathologizing label, as it was used to label gay people as mentally ill; nowadays, in Thailand as in many Western contexts, "gay" is the preferred term as it does not refer to pathology, but it is a self-adopted identity based on a history of social and political activism to achieve equal rights. Indeed these universal rights apply to people of diverse sexual and gender identities, as recognized by the United Nations.

In addition to the dynamic nature of sexual and gender identities, which may evolve over time, these identity labels can change in the same person over a lifetime (de Lind van Wijngaarden & Ojanen, 2016). The nature of these changes remains an open question in terms of older gay men and transgender women in Thailand as little if any research has explored their experiences.

2.2 Older Adults

Currently, Thailand is facing rapid increasing rate of ageing population. The demographic change of age structure from younger to older population in Thailand is a recent occurrence. This suggests that Thailand will face evolving issues related to social security, health care costs and social (in)equity and more in a much shorter time span than in the West. These issues need appropriate programs and policies to deal with (WHO, 2020). According to the National Statistical Office, Ministry of Digital Economy and Society, Thailand, the ageing population has increased by 16.7%. This can be said that Thailand is becoming one of the ASEAN's aged society—a society with increasing ageing population of 60 years and older at 10% of the total nation's

population (National Statistical Office, 2017). It is expected that in 2021 this population is increasing by up to 20% and younger and working age populations tend to decrease, making the country become a “complete aged society.” Moreover, it is also expected that Thailand in 2022 will become a “super aged society”—that is the number population of 60 years and older is higher than 28% of the whole country’s population.

According to Best Living Taste (BLT) Bangkok statistics, Thailand has the fourth largest of LGBT populations in Asia, at 4 million persons among the nation’s population (BLT Bangkok, 2019). It is very likely that a substantial number within this population comprises older people of 60 years and older. There is less to few evidence on investigation or studies done among this particular population. Older gay men and transgender women may face greater challenges than heterosexuals. They may also face challenges that are more pronounced than younger LGBT persons. This is due in part to the fact that older gay men and transgender women in Thailand lived much of their lives in earlier times in which LGBT people in Thailand, as well as in other countries, were less visible, and less accepted. Earlier experiences of stigma and discrimination, alienation from family, and discrimination in employment and education may have lasting effects.

2.3 Sexual Health

2.3.1 Sexual Health among Gay Men and Transgender Women

Sexual Transmitted Infections and HIV/AIDS

According to the UNAIDS’ report in 2014, it was predicted that there HIV patients globally would increase to 36.9 million, which is 5 million higher than the past decade; 2 million of new HIV infected; 1.2 million deaths from AIDS; 0.8% of World population that would be living with HIV; 0.3% and 0.5% would be male and female adolescent HIV positives, respectively (UNAIDS, 2020). It was also found that in 2013, the Asian and Pacific region witnessed 5 million cases of HIV positive (including 1.7 million female cases), a 20% decrease from last decade. However, there were 340,000 new HIV positive cases; and 240,000 deaths of HIV positives. HIV/AIDS scenarios mostly found in the following 12 countries: Cambodia, China, India, Indonesia, Malaysia, Myanmar, Pakistan, Papua New Guinea, Vietnam, Nepal,

the Philippines and Thailand (Ministry of Publc Health Thailand, 2015).

In Thailand, the prevalence of HIV infection has been gradually reported over the past 25 years since the first HIV positive patient was diagnosed in 1984, with unsafe sex as the main cause of the prevalence, indicated by the National Health Insurance. Additionally, in 2019 Thailand had around 470,000 people living with HIV; and 80% adults and 66% children taking HIV antiretroviral treatment, according to the 2020 UNAIDS report. Also, there were 5,400 new patients. In 2018, more than 95% of pregnant women in Thailand were tested for HIV and more than 95% of those living with HIV received antiretroviral drugs to reduce the risk of mother-to-child transmission. In the same year, more than 95% of infants born to HIV-positive women were tested for HIV within two months of birth (UNAIDS, 2020).

Regarding accessibility to those with HIV/AIDS, Thailand has continually developed a systematic services provision between 2004-2006 covering anti-virus medical treatment and health care partially funded by Global fund. Also, the establishment of health insurance system to replace the anti-virus medical service provision system came about in the year 2006. Even though the health insurance scheme offered medical treatment rights to Thai citizen, some Thai groups were still left out. So, the government's project (2007-2014) tried to resolve the health insurance policy by giving equal opportunity to those unqualified to apply, i.e. ethnic minority groups, trans migrant workers, immigrants, to ensure that the policy would be effectively and efficiently administered as regards to the provision of antiretroviral medication, laboratory tests, improving the health care services system, as well as strengthening the healthcare staff's medical ability and technical know-how capacity (Ministry of Publc Health Thailand, 2017).

The 1991's 100% Condom Program in Thailand offering condoms for free in the country, particularly to those in sex worker industry, is widely credited with stopping a comprehensive HIV epidemic in Thailand. Successive condom distribution and awareness campaigns have since operated and mostly focused young people. In 2016, health authorities introduced a new, 3-year condom campaign targeted at youth populations, supplying about 40 million free condoms per year (Thepgumpanat, 2016). Despite this, condom use among this age group is still low. For instance, Thailand has the second highest rates of teenage pregnancy in South East Asia

(UNAIDS, 2020). Among adults of all ages, it is projected that about 35% of the times they use condoms with non-regular partners.

The Public Health Ministry, in collaboration with concerned organizations, international and Non-governmental Organizations (NGOs), has provided protection, healthcare and medical treatment to those HIV infected patients by distributing contraceptive condoms, educating, giving consultations, sexually transmitted infections (STIs) screening. Regarding anti-AIDS medicine accessibility, Thailand was partially financed by the Global Fund to provide the medicine required for migrant workers since 2014. Besides, the Public Health Ministry has expanded the health package benefits to give anti-virus medicine to all migrant workers who voluntarily applied to join migrant workers' health insurance policy. Nevertheless, an influx of migrant workers to Thailand has raised serious concerns about the possible risk of more virus infections and greater healthcare demand over services supplied.

It was reported that the sexually transmitted infection scenarios between 2010-2016 being that the rate of infections has increased from 20.43 to 25.74 per 100,000 general populations. The first top 5 categories of sexually transmitted infection rate mostly found included Gonorrhea, Chlamydia infection, Syphilis, Chancroid, Lymphogranuloma venereum, and the comparative statistics between 2010-2016 indicated that:

Nevertheless, it was found that the population group aged between 15-34 had the most Syphilis and Gonorrhea infection, and those with sexually transmitted diseases also had a 5-9 times higher chance than ordinary people to get an HIV infection from unsafe sex. Based on the 2015's sexually transmitted situation survey, the findings indicated that 91 cases got Syphilis infection since newly born (newly born-2 years) and, among these, some babies were delivered by mother without antenatal care and Syphilis screening; or even those with antenatal care but without blood test follow-up procedure, thus resulted in no medical treatment received; some cases were found to have infections when they visited health care centers for delivery services provided.

Currently aware of the above scenario, the Thai government and the Public Health Ministry are determined to curtail the Syphilis to less than 0.05 per 1,000 baby born cases in the year 2020 by decreasing it less than 50 cases in order to do away

with the Syphilis since newly born. In this, it is necessary to come up with the process of screening, diagnosis and antenatal care, including providing health care for the couples and newly born babies. Besides, the policy launched also covered health education, encouraging early antenatal care among pregnant women, promoting prior to 12 months antenatal care, twice Syphilis blood testing for each pregnancy, improving quality of consultations system, health care quality, following up on pregnant women with Syphilis infection. Besides, all levels of medical staff and operational procedure would be improved on antenatal and postpartum care and, last but not least, labor room services.

In Thailand, HIV issues have been focused among particular key populations. The most affected population is men who have sex with men (MSM), who account for around 40% of new infections per year; sex workers and their customers at around 10%; transgender people and people who inject drugs also at around 10% each (AVERT, 2020). The country's HIV epidemic has been concentrated within big urban areas with MSM and transgender women. Thienkrua and colleagues (Thienkrua et al., 2018) indicated in a cohort study that HIV incidence among young MSM in Bangkok was 7.4 per 100 person-years. Another recent study also shows epidemiological data that the prevalence of HIV infection among adult MSM in the study (4.0%) was higher than that of young MSM from 2010-2011 by almost two fold (2.6%) (Jose et al., 2021). Transgender women are a separate population but often included within MSM, however with different social, cultural and behavioral characteristics, it makes them more vulnerable to HIV infection (Pawa et al., 2013). Additionally, about 44.4% of new HIV infections from 2012-2016 were among MSM and transgender women (Seekaew et al., 2019).

2.3.2 Health Disparities

Healthy People 2020, from the Office of Disease Prevention and Health Promotion, defines *Health Equity* as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." (U.S. Department of Health and Human Services, 2010).

Healthy People 2020 also defines a *Health Disparity* as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion." (U.S. Department of Health and Human Services, 2020).

According to the National Institute of Ageing (2020), *Health Disparities* differ in any health-related factor (i.e., disease burden, response to treatment, quality of life, health behaviors and healthcare accessibility, etc.) which occur among population groups (National Institute on Minority Health and Health Disparities, 2016). Health disparities are associated with a broad, complicated, and interconnected range of factors, which may indicate:

- Age
- Race
- Ethnicity
- Socioeconomic status
- Disability status
- Identity and expression (e.g., gender, racial, ethnic)
- Geographic location (e.g., rural or urban environment)
- Education
- Health care (e.g., access, quality, coverage, support)
- Culture (e.g., norms, traditions, beliefs, religious practices)
- Health behaviors (e.g., smoking, violence, alcohol and substance abuse)
- Biological (e.g., sex, chronic inflammation, telomere attrition, cellular senescence)
- …Or a combination of these

In 2016, the LGBTQ+ community was identified as a "health disparity population" by the National Institute on Minority Health and Health Disparities, somewhat because people who self-identify as part of this population tend to experience challenges in accessing health care. LGBT people include all races,

ethnicities, social classes, and religions; however when accessing to health care services, they seem to experience prejudice and discrimination from providers (National Institute on Minority Health and Health Disparities, 2016).

A 2017, a national survey for the LGBT community was conducted by the Center for American Progress brings out an interesting fact. The survey found that almost one in 10 LGBT people reported that a health care provider refused to see them in the prior year just because of their real or perceived sexual orientation. Approximately three in 10 transgender people reported that providers denied to see them due to their gender identity (Center for American Progress, 2017).

2.4 Well-being and Health Quality

To study the well-being and health quality of specific population such as SGM or LGBT people, one needs to understand the cause and possible factors of discrimination and hardship in life that these communities have experienced (Office of Disease Prevention and Health Promotion, 2020). Social determinants related to LGBT people's health are mainly due to the lack of LGBT human rights (UNDP, 2014, 2020). Many studies have tried to raise awareness and advocate the importance of health quality of SGM populations around the world. SGM population, especially older adults, should have equal human rights to live without discrimination, criminalization, stigmatization and equal access to care as well as being treated equally by service and healthcare providers, in order to reach the stat of well-being and maintain the health quality.

2.5 LGBT Stigma & Discrimination in Thai Culture

Thailand has been described as complex in terms of attitudes towards LGBT people. It is important to understand stigma and discrimination faced by LGBT people in the Thai context. Applying understanding from other cultures may not adequately or accurately reflect the experiences of LGBT people in Thailand.

Overall, Thailand has been described as "tolerant but unaccepting" of sexual and gender minorities, such as transgender people and gay people (Jackson & Sullivan, 1999). One aspect of this is that sexual and gender diversity can be acknowledged in some situations and social contexts that are deemed "appropriate".

Acceptance and nonacceptance is not fixed and unchanging but depends on what is considered appropriate for a particular situation (Jackson, 2003a). For example, research with young same-sex attracted people in Thailand shows how maintaining harmony in the family and protecting the family's image are primary goals; and more important than one's own inner feelings or experiences (de Lind van Wijngaarden & Ojanen, 2016). In some situations, the family is not seen as an appropriate context for revealing ones sexual or gender identity. This follows Thai cultural norms in which controlling one's personal emotions for the sake of social harmony is highly valued (Mulder, 1997). Therefore, for LGBT people, they may experience acceptance in some contexts, but typically in more formal contexts may feel they need to hide or not disclose their identities (Jackson, 2003a). When these contexts include the family, which ideally should be a source of social and emotional support, this can become particularly challenging.

A related challenge is that some persons may have a much more difficult time as "passing"—in not disclosing their sexual orientation or gender identity—than others. For example, transgender women or gay men who appear visibly different from the mainstream gender presentation may experience greater discrimination than those who might be able to fit in. Several studies show that being visibly different is associated with experiences of discrimination; this includes in contexts such as employment (Ojanen et al., 2019), education (Suriyasarn, 2016), and families (de Lind van Wijngaarden & Ojanen, 2016). However, it is also important to acknowledge that there are psychological and social costs to having to hide ones sexuality or gender identity. Although this may help someone to "pass" in a particular situation, a lifetime of having to monitor what one is allowed to say, how one is allowed to act, who someone is allowed to mention as their friends or partner, can take a psychological toll. This is referred to as "sexual minority stress" (Meyer, 2003).

Finally, in terms of stigma and discrimination, it is important to describe that there are differences within LGBT people. Not all LGBT people face the same challenges, and some have greater resources to deal with these challenges. As in many other cultures, LGBT people face distinct challenges according to their socioeconomic status, their education, as well as ethnicity, family background, and their HIV status (Ojanen et al., 2016). One interesting and unknown aspect of being

LGBT in Thai culture is that not only may low socioeconomic people face challenges due to the fact, for example, that they cannot easily decide to move out of their house, to relocate, to change jobs; sometimes they are limited in options that might be available to LGBT people with greater financial resources and education. On the other hand, in Thai culture, given the central importance of family and the family's standing in the community, higher socioeconomic status and educational attainment also may present vulnerabilities. Individuals from high-status families may struggle to protect their public and family image more than others as they feel the family has more to 'lose' (Ojanen et al., 2019). This is an unexplored topic among gay men and transgender women in Thailand.

2.6 Concept of Resilience

A unique study of resilience across cultures shows that the majority of resilience research, conducted on Western countries' populations, is not representative of majority world populations (Ungar & Liebenberg, 2011). Applying a social ecological framework to people's living aspects as well as resilience address both the capacity to navigate resources, including psychological, social, cultural and physical, and the capacity to advocate and negotiate the provision of those resources. Thus the limitations to understanding resilience from a universal approach occur both from ignoring potentially different sociocultural indicators of identity and conceptualizations of the individual, as well as different qualities of the environment that constitutes those factors (Ungar, 2006).

Resilience in Sexual Minority Context: As resilience is defined by positive adaptation in the face of difficulty experienced by SGM older adults, it is an important component of understanding their resilient skills which contribute to their health and well-being. Thai law does not criminalize homosexuality, however legal protections for SGM in Thailand are limited. A recent national poll indicated Thais were generally accepting of SGM friends and colleagues (89%), less so of family members (80%), and much less supportive of legal rights for LGBT people, particularly transgender people (53-59%) (Suriyasarn, 2016). SGM in many countries face hardships, including stigma, verbal and physical harassment, and victimization that manifest across school, work and family contexts (Bos et al., 2008; Collier et al.,

2013). A few studies identified pervasive cyberbullying among Thai youth (Songsiri & Musikaphan, 2011), and suggest that cyberbullying among SGM people may be more persistent, and gender-specific. To our knowledge, no published studies have focused on resilience among SGM populations in Thailand or Southeast Asia. One study with LGB people in Hong Kong, although it did not define or focus on resilience, or specify participants' ages, addressed social media use as a platform enabling community building and emotional support in a sociocultural context described as common with public stigma and discrimination (Chong et al., 2015). Social media, however, may be noticeable for SGM people in Thailand, with among the highest rates of cell phone usage in the Asia-Pacific region.

2.7 Social Ecological Model

The Social Ecological Model (SEM) tackles the complexities and interconnections between psychological, individual, interpersonal, environmental socioeconomic, cultural, and political , and determinants of health (Stokols, 1996). It acknowledges that while individuals' responsibility to establish and maintain life style adjustments needed to reduce risk and improve health, individual behavior is influenced by factors at several levels (Elder et al., 2007). An essential strength of SEM approach to health in this study is that it can potentially provide strategies of behavioral change and social/structural development. Multilevel explorations among individual, interpersonal, sociocultural, and structural factors can allow one to better understand how deep and importance the relationship and connection one level has towards the other.

SEM of health acknowledges that the individual lives within a complex system and that it is simple to understand human behaviors and perceptions in rare direct terms (Besthorn, 2013). Instead, SEM emphasizes that individual level of sexual health factors and perceptions are influenced by interconnected interpersonal, social, community, and wider societal contexts, such as culture or even politics (Glanz & Bishop, 2010; Linnan & Grummon, 2017). These contexts impact sexual health decision making for an individual and can either allow or prevent healthy sexual behaviors (Skovdal, 2013).

The SEM complex levels include the details as follows: *individual* level which

includes the personal characteristics that impact behavior such as knowledge, attitudes, skills, and beliefs; *interpersonal* level, which provides social identity and role definition such as friends, partner, and family; *sociocultural* level which determines norms and cultural contexts given by the society and community including environmental determinants of where the person lives; and *structural* level which includes rules, policies, healthcare services, and access to care (Newman et al., 2013).

While conducting the content analysis, the investigators identified that the coding scheme's categories regarding young men's barriers/facilitators to care derived from multiple levels of their socio-ecology and that the strategy for coding and theme development better aligned with contexts as described by Bronfenbrenner's Social Ecological Model (SEM) (Bronfenbrenner, 1979), rather than Andersen's BMHCU which emphasizes mainly personal contexts. In the SEM, individuals are nested within multiple levels of their socio-ecology, and personal behaviors are influenced by social (e.g., family, peers, intimate-partners), structural (e.g., clinical settings), and cultural (e.g., socialization) contexts in addition to the personal context. Thus, overall categories were organized using SEM contexts (i.e. culture, structure, social, personal).

CHAPTER III

RSEARCH METHODOLOGY

3.1 Research Design

The research design of this study is qualitative, in which the researcher applied the concept of social ecological theory (Bronfenbrenner, 1979) to explore individual, interpersonal, socio-cultural and structural factors associated with sexual health and coping strategies of 9 older gay men and 9 older transgender women (N = 18, or until the study concepts are well defined and explained (Corbin & Strauss, 2008)) in Chiang Mai, Thailand. In qualitative research, a certain amount of participants could suffice. Namey (2017) indicated and summarized the number of qualitative interviews needed to reach data saturation (Namey, 2017). Most concepts and themes are met with approximately 5-6 interviews (Francis et al., 2010), and that deductive approach interviews with 8 persons can be saturated (Coenen et al., 2012). Francis and colleagues also stated that the interview data yield no further themes or concepts after conducting 10 interviews. Online in-depth interviews were conducted using semi-structured interview guide, to ensure anonymity and privacy, with verbal consent. The interviews were digitally recorded, transcribed, and reviewed by interviewees for ratification and authenticity of the data (Mero-Jaffe, 2011). Data analysis was conducted using line-by-line coding and thematic approach (Charmaz, 2006), then translated into English.

It also very much supported the need for a qualitative approach. Because the topic around the population of interest has been largely unexplored. It would be premature to design a survey, since essential questions have not yet sufficiently investigated. That would allow for greater generalizability but at the expense of validity. Like what the main issues really are and what the diversity among the issues is too—not all LGBT people are the same. So, that wouldn't allow for an appropriate survey of the issues. This qualitative approach would allow open ended exploration which was critical to do.

3.2 Study Area

The study area was in urban and rural areas of Chiang Mai, Thailand. As a second largest city of Thailand, Chiang Mai has several community-based

organizations (CBOs) serving LGBT populations. Some of which covers other clients and members from neighboring provinces. These CBOs provided services including counseling, health and sexual health and human rights. Districts, sub-districts, and villages of potential participants were identified and located with assistance from the CBO staff who have members and clients from those areas of Chiang Mai. The researcher aimed to generalize the population of interest to both city and outside of the city area to ensure variety of socioeconimic characteristics. The urban area of the province has higher economic growth than others in the northern region, thus people living in the urban area tend to gain better access to improved facilities, infrastructure, career choices and economic status. Whereas people residing in rural areas of the province—which may lack what the urban area has—tend to maintain family-provided professions such as farming, selling agricultural produce or run a small home business. Older gay men and transgender women who resided in rural areas could potentially provide different aspects of living in their communities and what their challenges were as well as how to cope with them.

3.3 Study Period

Data collection: June-July 2021

Data analysis: July-August 2021

Preparation of report & draft of manuscript for submission: August 2021

3.4 Study Population

Gay men and transgender women aged 60 and older who have been residing in the city and rural areas of Chiang Mai.

3.4.1 Inclusion criteria:

- Thai nationality
- Self-identified as gay man or transgender woman
- Age ≥ 60 years old
- Reside in the urban and rural areas of Chiang Mai for at least 10 years
- Be able to understand basic Thai language or northern dialect

3.4.2 Exclusion criteria:

- Gay man or transgender woman who doesn't consent/isn't willing to participate in the in-depth interview
- Individuals who have difficulty hearing or speaking

3.5 Sample size

9 gay men and 9 transgender women (N = 18)

3.6 Sampling Technique & Recruitment

This study used the purposive sampling which aimed to provide rich information of the study focus and population of interest (Palys, 2008; Patton, 2002). The researcher purposely recruited older gay men and transgender women, aged 60 years or older, in both urban and rural areas of Chiang Mai in order to achieve participants that represented the population of interest with variability of socioeconomic differences (Newman et al., 2017). From the researcher's experience, random sampling might not be appropriate for the hard-to-reach populations.

The study information and objectives were introduced to members and staff of CBO serving marginalized populations to reach the target group, with which the researcher has been collaborating on several research projects. The staff shared the information as an invitation to the study (see *Appendix A*) via their existing social media platforms (e.g., Facebook, Instagram, LINE group chat) where existing relationship and trust between staff and members/clients could facilitate and assist with recruitment. Additionally, referral and introduction by word-of-mouth from CBO staff & members to their clients or friends who met the requirements of the study was also considered. Interested candidates responded/contacted via CBO members or online portal where they saw the invitation information, to indicate their interest. CBO staff initiated the contact to the interested participants to ask a few screening questions to ensure eligibility of participation (see *Appendix B*). Once interested participants have met eligibility criteria, a confirmation and permission were given to the researcher by CBO staff in order to contact the participants. An appointment was then arranged between the researcher and the participants for date, time and location (and in some case, means of the interview: Skype, zoom, etc.—due to the COVID-19

pandemic situation), based on the participant's convenience and comfort in order to ensure confidentiality. A private meeting room at the researcher's office in the city of Chiang Mai was also offered as a place for conducting an interview.

3.7 Measurement Tools

As this is a qualitative research, the researcher employed in-depth interviews for collecting data. Thus, the important research instrument for data collection was the researcher who conducted in-depth interviews and ensured that the research objectives were achieved. The research procedures were strictly systematic in order to obtain a valid and reliable final outcome, and the in-depth interviews were digitally recorded using a recorder or through zoom application (or via preferred application of the participants—e.g., Skype or LINE). The researcher received approval from the research ethics committee prior to research commencement to ensure the quality and trustworthiness of the scripts proposed. Details of research procedures are summarized as follows:

- Preparation on research methods by desk research on qualitative research philosophy, objectives, ethical issues, data collection as well as data analysis.
- Preparation on contents, theories, principles relating to sexual health among gender and sexually diverse people, so that the above information and body of knowledge acquired could be analyzed and synthesized prior to being used as questions guideline for in-depth interviews.
- Preparation on qualitative research skills and techniques for quality data collection, especially in-depth interviews which required a comprehensive knowledge and experience possessed by the researcher.
- Preparation on relevant questions needed for data collection by conducting a comprehensive literature review on sexual health and well-being from various academic sources, including related theories and principles. Flexible questions as well as versatility in holding a discussion on sensitive topics were essential to achieving impactful data. After completing the interviews, the recordings were transcribed verbatim and

thoroughly examined to confirm the research objectives were met. Transcripts were then sent to the interviewees for reviewing and checking for correctness and authenticity of what had been said during the interview.

Questions were based on previous research on mental health and resilience among LGBT in Thailand (Kittiteerasack et al., 2021; Ojanen et al., 2016; Yadegarfard et al., 2014) with adaptation to research on older adults (Fredriksen Goldsen & de Vries, 2019; Knochel et al., 2011; Shilo et al., 2015; Yarns et al., 2016). Additionally, the context of sexual health and health services among gay men and transgender women were then discussed adapting from the researcher's previous studies (Newman et al., 2013; Newman et al., 2012); and recent related studies' interview guide to meet the Thai context (Gamariel et al., 2020; Law et al., 2015; Pratt-Chapman, 2020; Reichstadt et al., 2010). Interview guide for the discussion included (see *Appendix C*):

- Basic socio-demographic information: age, gender, sexual orientation, highest education, occupation, relationship status, living arrangement, etc.
- Sexual health (mental, physical & social), healthcare accessibility, resilience, quality of life, based on the Agency for Healthcare Research and Quality (2017) & WHOQOL—Measuring Quality of Life (2012), and adapted with the above mentioned studies in Thailand with the specific populations. (Agency for Healthcare Research and Quality, 2017; WHO, 2012)

3.8 Data Collection

In-depth interview using semi-structured interview guide. Given the current COVID-19 pandemic situation, face-to-face interview is to be avoided, especially studies involving vulnerable populations (e.g., older people, people with existing health conditions, etc.). However, in-depth interviewing is yet most effective when done face-to-face. Therefore, the researcher aimed to conduct the interview in person with protective measures (distancing, gloves, face masks/face shield, and hand sanitizer). The researcher offered to use a private meeting room in his office space in the city of Chiang Mai. This was an option for participants residing in the urban area

as to ensure confidentiality. As for rural area, the location for conducting an interview was up to the participant's preference. The researcher was willing to arrange and travel there. Depending on the participants' safety, convenience, accessibility and comfort, the interviews could also take place on an online platform, if preferred, via zoom, Skype or LINE applications. The interviews were conducted in Thai (or northern dialect, depending on the participant's wish) and digitally recorded. To ensure strict confidentiality, the participants were not asked to turn on their camera. The interviews were approximately 40–90 minutes.

As stated in the recruitment section, the staff CBO serving gay men and transgender women in Chiang Mai provided service for the study by recruiting their members and peers, as well as initial screening via telephone. The CBO staff then provided the researcher basic information of an eligible participant as well as giving permission to contact the participants in order to discuss the study, answer some questions (if any) and schedule an interview appointment.

Prior to the interviews, each study participant reviewed the consent form (through the selected application's chat box for online interview). They were then given an opportunity to pose questions about the study before consenting to participate in the interview. The consent outlined the study objectives and potential benefits of the study, as well as the process of the interview and withdrawal option (see *Appendix D*). Participants were asked to ensure understanding of the process of participating in this study, then to sign the consent form. The participants could choose to sign their initials or signature, full names were not required. Participants also verbally consented when the recording has begun (for an online interview), by being asked to confirm if they acknowledge and understand their participation in the study (Marshall, 2006). No names, photos, or any identifying information have been collected from the participants. Any names mentioned during the interview were deleted from the transcriptions.

The researcher is local of Chiang Mai which could ensure reflexive understandability and credibility of the population and issues being studied that results in the quality of the data (Probst, 2015). The researcher has had considerable experience in qualitative research over a decade, including conducting in-depth interviews and focus group discussions with LGBT and marginalized populations in

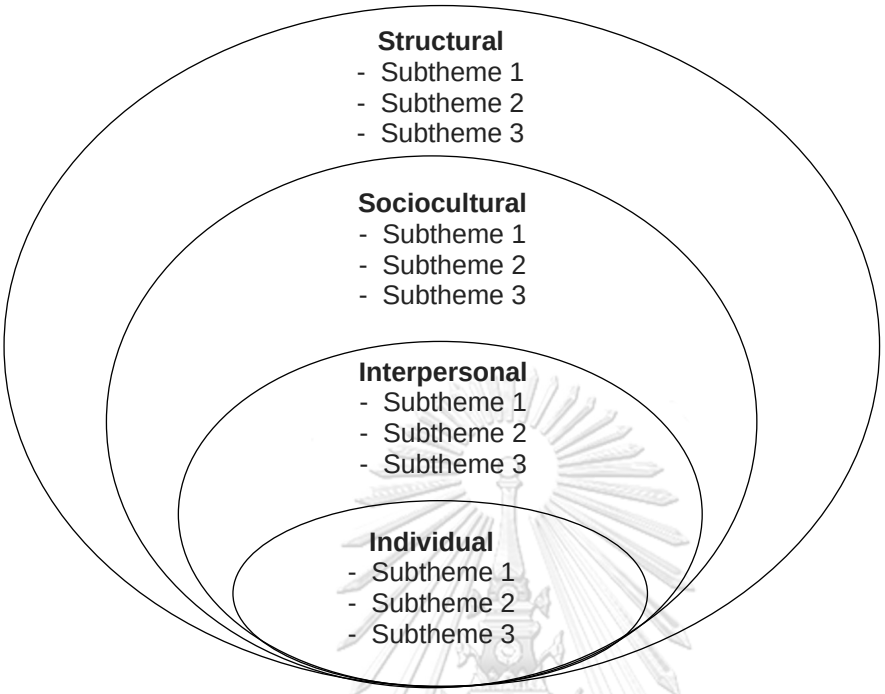
Chiang Mai, Chiang Rai, Bangkok and Pattaya, as well as performing qualitative data analysis.

3.9 Data Analysis

Based on an analytical technique of van Manen (1990), all data collected were analyzed accordingly (van Manen, 1990). As it was necessary that the data analysis, as well as the collection of data were administered simultaneously, right after each interview session, verbatim transcription of data was done to ensure its precision. Transcription was then completed soon after each interview and the transcripts were sent to the respondents to review for ratification and authenticity of the information given during the interview. Any misinterpretation or information that the participants wished to remain confidential—not to disclose or publish—they could inform the researcher immediately to delete such segment from the transcript, as to fully respect their privacy (Mero-Jaffe, 2011). This allowed the researcher to see the quality of the data and to determine whether the study concepts have been reached and when the data saturation would be expected.

The in-depth interviews were transcribed (any personally identifying information was removed) and reviewed using thematic analysis (Nowell et al., 2017). Coding technique was used through Atlas.ti program. The theory of social ecological approach, developed by Bronfenbrenner (1979) and successfully applied by several relevant studies (Bronfenbrenner, 1979; Chakrapani et al., 2012; Newman et al., 2013), was applied as guidance to exploring and understanding the multilevel context—individual, interpersonal and social-structural—of factors that contributed to mental health and health quality of Thai SGM older adults. (see *Figure 1* below)

Figure 1. Example of Social Ecological Themes



3.10 Ethical Considerations

The study received approval by the Research Ethics Review Committee for Research Involving Human Research Participants, Chulalongkorn University (No. 157/2564). Participation in the study was entirely voluntary, no identifying information was collected. The researcher assisted in explaining the nature of the study including process, objectives and benefit to the respondents (Note that the participants in the study were 60 years or older, some experienced difficulty reading). The researcher ensured that the respondents clearly understood the study before allowing them to consent to participate. Consent forms and digital recordings are kept in a locked cabinet in the researcher's locked office, to which only the researcher has access. Respondents may request a copy of the consent form by informing the researcher. All data obtained from the participants will be destroyed 1 year after the data analysis has been completed, in case of the need to re-review the raw data. Participants understood the rights to withdraw from the study at any time and the data collected up to the point of withdrawal would be deleted. Referral information was provided to the respondents in order to assure the safe and friendly health- and human

rights-related organizations and clinics serving the gender minority populations.

3.11 Compensation

The participants received compensation of THB400, upon completion of the interview, for their time spent in the study. The payments were done through online banking, PromptPay process, or cash depending on the participants' wish. Participants who wished to withdraw from the study during the interview would still be compensated for their time; however, there was no withdrawal from this study.

3.12 Expected Benefits and Application

- Describe the social ecological factors that contribute to older gay men and transgender women in the urban and rural areas of Chiang Mai
- Raise awareness to LGBT communities to integrate older adults' well-being to public health policy and intervention programs
- Promote specialized healthcare services for LGBT older adults

3.13 Proposed Timeline

No	Activities	Timeline							
		2021							
		1	2	3	4	5	6	7	8
1	Proposal development	X	X	X					
2	Semi-structured interview guide development	X	X	X					
3	Ethics application/ consideration				X	X	X		
4	Recruitment							X	
5	Data collection							X	
6	Data Analysis							X	X
7	Preparation of report							X	X
8	Preparation of manuscript for conference proceeding							X	X

CHAPTER IV

RESULTS

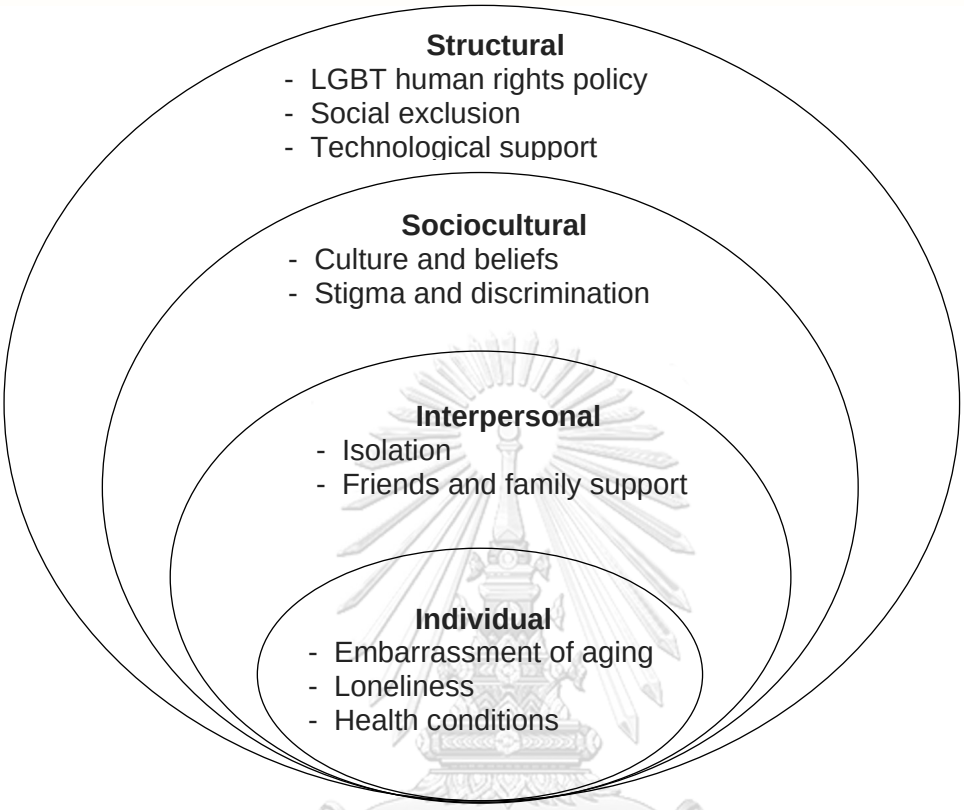
Nine older gay men and nine older transgender women of Chiang Mai locals were interviewed. The majority of the respondents had post-secondary education with full-time professions. Half of them live alone. *Table 1* shows the sociodemographic characteristics of the respondents. Guided by the social-ecological model, several themes emerged under each level (see *Figure 2*), explaining multi-level issues and challenges addressing the sexual health and well-being of older gay men and transgender women in Chiang Mai.

Table 1. Participants sociodemographic characteristics

ID	Age	Sexual Orientation	Education	Occupation
TGW1	61	TGW	University	Unemployed
TGW2	62	TGW	Vocational	Hair & beauty artist
TGW3	68	TGW	Primary	Handicraft maker
TGW4	65	TGW	Secondary	Unemployed
TGW5	63	TGW	Vocational	Unemployed
TGW6	61	TGW	Secondary	Baker
TGW7	60	TGW	University	Florist
TGW8	63	TGW	Vocational	Florist
TGW9	61	TGW	University	Lottery seller
GM1	62	GM	University	Unemployed
GM2	63	GM	Secondary	Vendor
GM3	64	GM	Vocational	Massage therapist
GM4	61	GM	Primary	Perfume seller
GM5	62	GM	University	Florist & wedding organizer
GM6	60	GM	Secondary	Staff coordinator
GM7	61	GM	University	Florist
GM8	61	GM	University	Accountant
GM9	65	GM	Secondary	Unemployed

GM, gay man; TGW, transgender woman

Figure 2. Presenting Themes of Social Ecology of Factors Associated with Sexual Health of Older Gay Men and Transgender Women



Individual Level

Embarrassment of Ageing

Physical appearance plays an important role in today's world. Their experience of ageing is unavoidable, yet ways to respond to it could affect the person's public and social connections. Some respondents expressed a lack of confidence and feeling of embarrassment in being in public due to physical ageing:

"I don't usually get out much. I don't look the same anymore. I can't compete with teenagers these days. You can fool people on social media using filters, but the reality is reality…no filter. If it is not for work or something important, I would just stay in." (TGW2)

"I am not like before. My skin is no longer tight and fresh. My belly is bigger, and my hair is thinner. If there is a group photoshoot, I tend to stay away. I accept it, but I don't like to show it that much." (GM8)

"I'm happy that my boyfriend, who has been with me for 22 years, accepts me for who I am. Am I happy with my look now? No. It's ageing. It's nature. What can I do, right? If I were single, I would be so depressed with myself and how to meet anyone." (TGW9)

Another respondents indicated loss of attention, including sexual attention, from being seen as an older person, compared to when they were younger, and that personal standards needed to be much lower in seeking sexual relationship:

"Going out and about is never the same at this age. I used to get some kind of visual attraction back then, but now it is just…oh, just an old guy. I can't keep dying my hair every two weeks. I'd rather have grey hair than cancer [laugh]. I have Facebook, but I barely post anything…except food. I still go to work and go straight home afterwards. I don't think I look that old, but kids just keep looking younger and younger." (GM9)

"I can't be picky these days when I meet someone. It is either that or nothing. I can't really choose. If I want to enjoy someone and be a little active about it, I need to be less picky. Someone around my age would understand." (GM2)

"I am not the same. I know guys come to me for that reason [money]. I am not in the position to choose. If I want to have a bit of something, I need to lose something." (TGW6)

Loneliness

Some respondents provided comments on being lonely as most of their heterosexual friends and family members had their own married lives with children. This resulted in the decrease of socialization and that they had to do things on their own, which in a long term could suggest an emotional health issue of loneliness.

"My good friends from school all get married and have kids. We hardly hang out. Of course, it is kind of lonely but what can I do. At least I still have a job. I can still visit them, but it is not the same anymore, you know." (TGW6)

"I live alone in our [family] old house. My siblings all have family and live separately. They live actually not far from here but for them it is better to live with their own family. My older brother hasn't really accepted my sexuality so we don't meet much." (GM4)

Another respondent addressed positivity that having a partner is important as for being an older non-heterosexual person, as well as support system one could receive from a meaningful relationship:

"Lonely? I like to keep myself busy. I am lucky I have my boyfriend. At this age, you need to value whoever sticks with you through times. I can't have a child. All I have is him, at least I can rely on him if I get sick." (TGW9)

"I was in a serious relationship for like 20 years. He passed away almost 10 years ago. I never dated again since. As a transgender, having a real partner was the best support. But I'm alone now." (TGW3)

An older gay respondent stated the reason for choosing to be alone and single due to trust issues:

"I have seen many examples of relationships that failed because of guys trying to take advantage. Especially in rural area, straight guys would pretend to love and then take everything from you. I don't want this kind of problem. I'd rather be alone and deal with loneliness, but I'm safe." (GM7)

Health Conditions

Several respondents expressed their physical health conditions which have been a barrier in enjoying their lives like they used to. Both chronic illnesses and disability at birth or accident could serve as individual reasons for losing interaction with society as well as internalized disapproval from community. A transgender respondent shared her health conditions, which were also known to be common among older transgenders:

"*One of my eyes has been completely blind for 5 years due to cataract. The other one still has 40% of vision, due to diabetes. Not so many transgenders over 60 are still around these days. Those who are still around either can't understand a thing because of hormone imbalance or are dealing illnesses like me." (TGW3)*

A few respondents also indicated their health conditions as a barrier to living their lives including working and meeting others:

"I have been living with some illness, and getting much older too, it kind of takes away my sexual desires." (TGW1)

"I was asked to leave my job because of my leg, from accident. I used to enjoy meeting guys at work. After that, it has been just me and my flower shop." (TGW7)

"I am visually impaired at birth. I don't believe guys would find this attractive. If they came, it was not from heart." (GM4)

Additionally, some transgender women addressed their challenges in hormone uptake due to ageing and physical illnesses.

"I needed to stop taking hormone because I have problems with my liver. I used to drink a lot back then." (TGW1)

"I have stopped taking hormone for years. I don't know why I stopped, or why I should continue. At this age, I am not sure what for." (TGW4)

"I was told to stop [taking hormone] due to my heart condition." (TGW5)

Interpersonal Level

Isolation

The data revealed that being alone was not by choice. As people moved on with their

adulthood, having a family somehow indirectly pushed them to isolation. Being indirectly excluded from immediate family and friends, though not intentionally, could influence isolation which also leads to negative mental well-being. A few respondents added:

"When everyone around you is busy with their own people, and you're alone…of course, you have to be by yourself. You can't go with them and be a third person. You don't want to go with your friend's family and then be an outsider. You have to learn to live by yourself." (GM2)

"They all have their lives. I can't insert myself whenever I want. You kind of hope special family holidays arrive sooner so you could meet them." (GM3)

A few transgender women respondent expressed the accepting decision of living alone as a result of her partner's passing, which also ended her need for sexual relationship:

"I was in a 30-year relationship. He passed away a few years ago. I don't want to have a new relationship. I am too old. I don't want to feel that pain again. I am alone now and it's okay. I don't care about sex anymore either." (TGW1)

"One long meaningful relationship, and that was it for me. That was enough. I'm ok now." (TGW3)

Friends and Family Support

Several respondents addressed their support from friends and family for being gay or

transgender which has been earned through time and behavioral approval. The acceptance of their sexuality/sexual orientation might not be since their first disclosure, and the data suggests that time and good behaviors could increase the acceptance and support. Some respondents indicated some kind of conditional support from family:

"Everyone in my family is ok with me being this way. It was not easy growing up, but I am older now. If you are nice and good, they will think of you and bring their kids to visit you." (TGW4)

"Everyone moved out and built their own family. I can't build a family so I am here at home with my mother. I need to take care of her; she is very old. They still come to visit and send some money to help. We still keep in touch." (GM9)

"I supported 3 of my nieces and nephews, hoping they would take care of me one day…but I don't think it would be as I had hoped. I have no savings left. Now I do everything to earn money, selling flowers, decorating, bouquet, etc." (TGW7)

"Everyone else has family and kids. I left my job in the city and moved back home to take care of mother. She has Alzheimer. They usually send money to help and visit sometimes." (TGW9)

One transgender woman stated the fortunate acceptance from her community was gained through her respectful partner:

"I guess I was lucky that my boyfriend was a respectful person in this neighborhood, so people here tended to accept me and be kind to me." (TGW1)

Sociocultural Level

Culture and Beliefs

Rich culture and tradition could put pressure on sexually diverse people in addition to obtaining acceptance from family and society. A long-lasting tradition of certain culture where male child is expected to bear the burden of extending the family and generations still exists in Thailand. An older gay man expressed his experience as a Thai-Chinese son:

"My family is half Chinese, so being gay is not really something they would easily accept. Going to places with my family back then was tough for me. I had to behave and acted straight. People kept asking about when I would form a family. So much pressure. Now I am old, and they are gone. I have done my best being their child. I didn't think it was any sin." (GM8)

Two older transgender women pointed out the homophobic culture of police where the family's male child should also continue their father's legacy of honor:

"My family didn't accept me. I came from a serious and strict police family. My father really wanted me to be one. He also beat me up. I ran away since 9th grade and moved to Pattaya. I lived there for almost 50 years. One of my childhood friends also went through the same thing with her family. Her father forced her to be in the army. So she committed a suicide." (TGW5)

"Back in the days, it was not so accepting like this. I had been bullied a lot growing up, both verbally and physically. People said to me 'how lucky are you being born a man, what a waste'. They said so much worse." (TGW6)

An older transgender woman mentioned a belief of a wheel of life and that living is a way of paying off karmic debts:

"I always talk with my friends about elderly life. Who would take care of us when we get older than this. I never have any thought of suicide in my mind. I will just have to live like this and pay off my karmic debts." (TGW6)

Some respondents suggested that in order to gain acceptance from community, one needed to well behave. Participation and dedication to community's practice and traditions could also help people to recognize them in a good way:

"I have been devoting my older life for the community. Religious ceremonies, special traditional events, you name it. I do everything though I can't see well. I participate and help them organize. They first acted strangely around me but now they love me." (TGW3)

Stigma and Discrimination

Stigma and discrimination perceived from some public places could pose challenges in life. This could very well act as a barrier to the person for practicing one's rights to enhance their physical and mental well-being. An older transgender woman explained a difficulty from enjoying her basic rights in public places that she felt discriminated against:

"There are places that I cannot really go…like a recreational facility, some gym, swimming pool. I am like this and it confuses people. It rather draws attention from people to maybe make fun of me. Maybe that is in my head but it is just not comfortable. I cannot go to the men section, and in the women section, they look at me strangely." (TGW8)

Stigma was associated with misbehaving or having some disease as being gay or transgender at a healthcare facility. A few respondents described their experience receiving healthcare services as older gay man and transgender women:

"I meet many clients and things could sometimes happen behind a closed door. I am still sexually active and I always take good care of myself and be responsible. I take PrEP. But when I go for a checkup and get a new bottle, there is always some vibes that sort of tell me that they [providers] disapprove of me having sex at this age." (GM3)

"I go for my medication and checkup routine, but the way people look at me and even some nurses question me as if I am a sex worker. I don't really care much but this is 2021. Shouldn't this be a normal thing? Couldn't they think maybe I went to get my hormones shots?" (TGW4)

Structural Level

LGBT Human Rights Policy

The lack of law to protect LGBT populations in the country restricts some human rights as anyone or any partners should freely practice. An older transgender

respondent indicated her experience from a healthcare facility that did not acknowledge same-sex partners:

"Before my boyfriend passed, we wanted to get married…but of course, impossible. There should be some kind of law for us. I went to a hospital with him when he was sick, and the nurse asked me whether I was his family member. What was I do? Like, together for 30 years but no legal support. 30 years together almost meant nothing in that situation." (TGW1)

Other older transgender women also shared a story of being treated unfairly at a hospital:

"When I first changed from taking hormones orally to injection, my body had severe reaction to it. I was taken to a hospital. The nurses didn't know what to do with me. My ID was Mr. but myself was a girl, long hair and skirt. They wheeled me to the male section but a doctor had me relocate to female. At the female, another doctor thought it was weird to have me there with other female patients." (TGW2)

"At a hospital, sometimes they called out my name like uncle or something [my ID is Mr.]. When they saw it was me, they started to apologize. I was fine with it as long as they treated me nicely." (TGW5)

Another gay man added about his experience receiving healthcare service, especially for sexuality-related services, that was not comfortable:

"I am on HIV treatment and the hospital that I go has a separate section for HIV. But still has to collect medication at the common room. When the nurse explain to me about the medication, others can hear. I don't like it." (GM2)

With the lack of basic human rights, most transgender women have been underserved and marginalized, especially in career seeking. This has been an issue in the society and it forces this community to restrain their expression of true identity and mental well-being:

"My friend is a teacher and has to secretly dress up so she can feel happy. She has been doing this for like 10 years. If she got caught, for sure she would get fired." (TGW5)

"Long hair and transgender, no one would hire me. No normal jobs anywhere would hire us. Only night job at a pub would hire us." (TGW6)

"You approached them as a transgender, they would not really give you a chance to show and prove your performance. You knew well you could do it, but you were never given that chance. We actually have been trained to be tough all our lives." (TGW9)

Social Exclusion

Older adults in certain venues can still experience discrimination on the basis of age. Additionally, it raises a deeper level of discrimination if at your own community. Some older gay men described discomfort and disappointment for the age-restricted gay recreational venue:

"Some place like gay spa or bathhouse, they charge so much more if you're older than this age. Or free membership if you are this age or discounts. It is not nice. Better just say only ages this to this up front. I understand that they want to keep younger looing clientele in their place, but it is just not nice." (GM3)

"I go to certain places but then I feel like being avoided. It's not like I would ask for sex. Maybe I wanted to just chat and make some friends, right?" (GM9)

Technological Support

Despite the barriers to interact with others freely, modern technology has become a great means facilitating older gay men and transgender women in meeting others both for general recreational purpose and sexual encounters:

"Mobile apps make my life so much easier. I can actually meet guys who actually show interest in me, because we chat first and agree up front. I am also open about my age in the apps. Unlike back then, flirting with someone was at your own risk for getting beat up." (GM1)

"*I advertise and get clients mostly through gay apps. I also provide home private massage so it is pretty much mutual agreement, you know what I mean right?*" (GM3)

Other respondents also indicated the usefulness of such mobile applications to receive sexual health information as well as reaching out for specific health services:

"Gay apps are the best way to reach at-risk (HIV) populations of all ages. We see from under 18 to very old. It's great." (GW6)

"These apps do advertise about prevention and healthcare for gay people. Without this, people might not know what to do. Where to get tested, get PrEP, like this. At least we can contact to check first and not having to feel uncomfortable because you're old." (GW7)

"Some ads on some apps are helpful even for transgender. I don't have to feel shy going to a clinic right away. I can chat with them and ask questions first. There's a lot that ageing transgender like me have to deal with, physically." (TGW8)

CHAPTER V
DISCUSSION

This study among older gay men and transgender women in Chiang Mai reveals multi-level factors contributing to their sexual health and well-being. Thai culture has been described as “tolerant but unaccepting” of sexual and gender minorities, such as transgender people and gay people (Jackson & Sullivan, 1999). One aspect of this is that sexual and gender diversity can be acknowledged in some situations and social contexts that are deemed “appropriate”. Acceptance and non-acceptance are not fixed and unchanging but depends on what is considered appropriate for a particular situation (Jackson, 2003b).

The findings suggest that at the individual level, the loss of satisfaction at own appearance contributes to loneliness and isolation. This also affects interpersonal and social activities, including having a sexual relationship with someone. This could pose a concern as a previous study also showed that gay men’s struggle through physical appearance and sexual functioning changes due to ageing contributed to loneliness and could develop risky coping strategies such as alcohol/drug use and unsafe sex (Jacobs & Kane, 2012). The findings on individual level are also subsequent consequences of those on the structural level. Several studies prove that challenges on day-to-day life of these populations, including the loss of inclusion or sense of belonging to the recreation/public facilities, are one of the roots to put them at risk of social isolation (Government of Canada, 2021).

The results also suggest that the intersecting factors at the sociocultural and interpersonal levels impact the well-being of older gay men and transgender women at the individual level. This highlights the existence of minority stress among this older

population of the study. It is also important to acknowledge that there are psychological and social costs to having to hide one's sexuality or gender identity. Although this may help someone to “pass” in a particular situation, a lifetime of having to monitor what one is allowed to say, how one is allowed to act, who someone is allowed to mention as their friends or partner, can take a psychological toll. This is referred to as “sexual minority stress” (Meyer, 2003). The socio-cultural challenges that gay men and transgender women have experienced, as well as having to adapt and respond to their social environment, can impact on their physical and mental health (Meyer, 2003).

In terms of stigma and discrimination, it is important to describe differences within LGBT people. Not all LGBT people face the same challenges, and some have greater resources to deal with these challenges. As in many other cultures, LGBT people face distinct challenges according to their socioeconomic status, education, ethnicity, family background, and health status (Ojanen et al., 2016). It is evident that stigmatization and discrimination are still apparent among healthcare services at the socio-cultural and structural levels. Previous studies in Thailand also supported that LGBT people experienced prejudice from healthcare providers (Logie et al., 2016; Newman et al., 2012). In 2016, the LGBTQ+ community was identified as a “health disparity population” by the National Institute on Minority Health and Health Disparities (National Institute on Minority Health and Health Disparities, 2016), somewhat because people who self-identify as part of this population tend to experience challenges in accessing health care. Yarns et al. also indicated that challenges and experiences of discrimination and victimization posed potential vulnerability to the person (Yarns et al., 2016). Another study similarly supported that

the experience of sexual stigma, for some people throughout their life course, could negatively affect their sexual health (Fredriksen-Goldsen et al., 2017). LGBT people include all races, ethnicities, social classes, and religions; however, they seem to experience prejudice and discrimination from providers when accessing health care services. Therefore, community-based organizations providing health services to LGBT populations play an essential role globally.

According to the American Psychological Association, a primary influence in resilience is having caring and supportive relationships within and outside the family (American Psychological Association, 2020). Resilience or coping techniques have also been addressed from this study. Some older gay men and transgender women participated in community religious and traditional ceremonies in order to stay active, gain acceptance and the sense of inclusiveness. A report on ageing LGBT also indicated that those who attended spiritual or religious activities were likely to gain protective strengths for physical and mental health (Fredriksen Goldsen et al., 2011). Technology-driven era also supports ageing individuals' resilience system. The data shows that several new mobile applications have facilitated them, unlike their younger times, in interacting and socializing with others with the same interest, including seeking information on healthcare. This is consistent with Dakin and colleagues' study that technology which facilitated social support and social networks could improve resilience among LGBT older adults (Dakin et al., 2020).

LIMITATION

Due to the specific age group of the study respondents, there was some recall bias during the data collection on some older respondents. Some questions asked

about their experience in the past or recent past, thus recollection of happenings by the participants might be accurate or complete. However, the investigation sought to capture their life experience and story, so the entire discussion proved sufficiency of the data for each participant. As the study was conducted during the second outbreak of the Coronavirus (COVID-19), strictly following the protective measure was a must. However, most qualitative interviews of this study were still conducted in person, due to the lower prevalence in Chiang Mai. Therefore, wearing face masks/face shields throughout the discussion posted some limitation in reading the respondents' facial expressions. Among these interviews, four have been conducted online due to the pandemic concern as well as travel restrictions. Another limitation of this study was the age range of the respondents. Information received by both CBO staff and several respondents, there were not many gay men and transgender adults of 65 years and older left to recruit. Many of whom had passed due to illnesses, including cancer, AIDS, and suicide.

CONCLUSION

This study is among the first qualitative studies to explore the voice of older SGM populations, and to address their challenges and needs that could contribute to their well-being, including the impact of social changes in the past years. The intersectional impact of multi-level factors on sexual health and well-being of older gay men and transgender women demonstrated that individual- and interpersonal-level experiences could contribute to their overall well-being, both physically and mentally. The results of this study also portray the resilience of SGM older adults who had a life-long event of marginalization. Coping strategies tend to differ among older

gay men and older transgender women, which depend on both individual and environmental factors. Understanding sexual health and resilience of ageing SGM individuals requires an insight perspective of the life-course challenge in an heterogenous society. The structural support—technology—has positive impacts towards older SGM in seeking in-depth information and connection without concern around identity and ageing appearance. Therefore, ageing needs to be considered as an evolving challenge for such populations. Personal and public understanding of ageing society should be taken place as Thailand is becoming one, regardless of gender. Interventions on acknowledging awareness and health needs of such marginalized communities may support understanding and improvement their health quality. Sociocultural- and structural-level factors suggest that further social policy and intervention research should be focused, in order to promote more inclusive social structure and equality for older gay men and transgender women in Thailand.

RECOMMENDATIONS

As this is not yet a popular topic to study in Thailand, more issues around ageing LGBT populations should be studied, apart from sexuality and sexual health. The findings from this study could support the need for future quantitative research to be surveyed in order to further examine possible factors associating with all aspects of well-being of these populations, especially mental health. The study of resilience of ageing SGM should also be conducted through a wider sample, with regards to possible limited literacy and reading ability. Further clinical studies which focus on sexuality of such ageing populations should also be considered, in order to understand and improve their sexual health quality. Additionally, there is a need for raising

awareness, developing training to health service providers, enhancing research attention, and advancing available resources to support and protect the ageing LGBT communities. Policy development should be inclusive of ageing LGBT populations regarding elderly care services and support, especially those individuals who live alone. Such policy should also be applied to existing and future community organizations in order to ensure adequate practice towards this marginalized populations.

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APPENDICES

APPENDIX A

Sample Flyer

Note: Most older gay and transgender women may not use online social media as much as younger population. Thus, this flyer is a sample information to be given to the community-based organization members/staff to share among their clients to help spread the invitation to the study to possible eligible candidates.

APPENDIX B

Screening Questions

*This criteria of screening for eligibility will be assessed by staff of the community-based organization serving LGBT populations in Chiang Mai.

1. Are you a Thai national?

[This can also be considerably opted out from asking by a CBO staff—that is if they know of the person or have pre-existing relationship with the person, or they are clients of the CBO]

2. What is your current sexual identity?

a) Gay man

b) Transgender woman (male-to-female)

3. In what year were you born?

= _____

*1961 (Buddhist year of 2504) or earlier → eligible

*1962 (Buddhist year of 2505) or later → ineligible

4. How long have you lived in Chiang Mai? (This can be skipped if CBO staff knows that the person is local)

= _____

5. In what part/area of Chiang Mai do you live?

= _____

Please provide your preferred means of contact for the researcher to reach you in order to schedule an interview.

= _____

APPENDIX B (*Thai version*)

คำถามสำหรับการคัดกรองผู้เข้าร่วม

องค์กรที่ทำงานเพื่อกลุ่มหลากหลายทางเพศทีจังหวัดเชียงใหม่จะมีส่วนร่วมและช่วยเหลือในการคัดกรองตามเกณฑ์ สำหรับเข้าร่วมการศึกษานี้

1. คุณเป็นคนไทยโดยกำเนิดหรือไม่

[สมาชิกขององค์กรสามารถข้ามคำถามนี้ได้ แล้วแต่การพิจารณา เช่นในกรณีที่รู้จักบุคคลนั้นมาก่อนหรือเป็นผู้ที่เคยมารับบริการขององค์กร]

2. โปรดระบุอัตลักษณ์ทางเพศปัจจุบันของคุณ

a) เกย์ (รวมไปถึงกลุ่มชายรักชาย)

b) หญิงข้ามเพศ (ทั้งแปลงเพศแล้วและยังไม่ได้แปลงเพศ)

3. เกิดในปี พ.ศ. ใด

= _____

*ต้องเกิดภายในปี พ.ศ. 2504 (หรือ ค.ศ. 1961) หรือก่อนปีนี้ ถึงจะมีสิทธิ์เข้าร่วม

4. คุณอาศัยอยู่ที่ในจังหวัดเชียงใหม่มานานหรือยัง (สามารถข้ามคำถามนี้ไปได้หากท่านรู้จักหรือรู้อยู่แล้วว่าบุคคลนี้เป็นคนท้องถิ่น**)**

= _____

5. คุณอาศัยอยู่ที่ใดในจังหวัดเชียงใหม่ (อำเภอ / ตำบล)

= _____

หากคุณสมบัติผ่านเกณฑ์เบื้องต้นนี้ กรุณาระบุช่องทางที่คุณสะดวกที่จะให้ผู้วิจัยติดต่อคุณเพื่อนัดหมายการสัมภาษณ์ (หมายเลขโทรศัพท์ / ไลน์ / whatsapp / etc.)

= _____

APPENDIX C

Semi-Structured Interview Guide

Thank you for agreeing to participate in this study to discuss about sexual health and well-being of older gay men and transgender women in Chiang Mai.

To ensure your understanding, this is entirely voluntary and the information that I seek is based on your experience and opinions. I will record our discussion, however names and any identifying information will be deleted from the transcription and analysis. If you feel uncomfortable answering any issues or you feel like you want to stop, please feel free to let me know. The information you have provided will be deleted.

- **May I ask how old you are?**
- **Are you working at the moment?**
  - *If so, what type of work do you do?*
  - *If not, what type of work did you do?*
- **What is your education background?**
- **What is your current living arrangements?**
  - Living alone, with partner, with family, with friends
- **How out are you to your family, friends, neighbors?**
- **What is your relationship with family? And with friends? (neighbors?)**
  - Receive any support from family / friends?
- **Do you feel that the neighborhood/community that you live in now is safe and friendly to you as an older gay/transgender person?**
  - Any experience/events of stigma, discrimination, including being treated unfairly? Please describe.
- **How is your personal life now?**
  - Sexual relationship
  - Health condition
  - Financial issues

  - Challenges due to COVID-19 pandemic?
- **Where do you go to seek healthcare services?**
  - Insurance coverage
  - Comfortable disclosing sexual identity? Being treated fairly?
  - Small clinics? Organizations serving gay/transgender people's health?
- **How have your life experiences influenced the course of your life as a gay/transgender person as well as how you age?**
- **Can you tell me about healthcare services you wish to receive or services that would benefit older gay men and transgender women's lives?**
- **What are your suggestions on how to age well and recommendations for other gay/transgender people (including younger ones) to promote healthy aging?**

APPENDIX C (*Thai version*)

แนวบทสัมภาษณ์เชิงลึก

ก่อนอื่นต้องขอขอบคุณที่คุณได้ตกลงร่วมการวิจัยครั้งนี้ เพื่อยืนยันความเข้าใจของคุณอีกครั้ง การสนทนานี้เกิดขึ้นด้วย ความสมัครใจ ข้อมูลทุกอย่างจะมาจากประสบการณ์และความคิดเห็นของคุณ ทางเราจะอัดเสียงบทสนทนาครั้งนี้ แต่จะไม่มีการเปิดเผยชื่อหรือข้อมูลที่จะบ่งชี้ถึงตัวคุณเด็ดขาด หากคุณไม่สะดวกที่จะตอบคำถามข้อใด คุณสามารถข้ามได้ หากคุณต้องการหยุดและยกเลิกการสนทนา คุณสามารถแจ้งได้ทันที และไฟล์เสียงที่อัดไว้จะถูกลบทันที

- **ขออนุญาติถามอายุของคุณได้ไหม**
- **ปัจจุบันนี้คุณได้ทำงานหรือเปล่า**
  - ถ้าทำ ทำงานอะไร ประเภทไหน...
  - หากไม่ได้ทำ แล้วเมื่อก่อนเคยทำงานอะไรมาบ้าง...
- **คุณได้เรียนถึงระดับไหน**
- **ปัจจุบันคุณพักอาศัยอยู่กับใคร**
  - พักคนเดียว กับคู่ชีวิต แฟน เพื่อน ครอบครัว ญาติ / บ้าน หรือหอพัก
- **แล้วครอบครัวของคุณเป็นอย่างไรบ้าง เพื่อนๆ คนแถวบ้าน**
- **ความสัมพันธ์ของคุณและครอบครัว เพื่อนๆ เพื่อนบ้าน เป็นอย่างไรบ้าง**
  - มีความเข้าใจ มีการช่วยเหลือกันไหม อย่างไรบ้าง
- **คุณรู้สึกว่าชุมชน ละแวกที่คุณพักอาศัยอยู่ตอนนี้ปลอดภัยดีไหม เป็นมิตรกับคุณดีหรือเปล่า ในฐานะที่คุณเป็นเกย์ / ผู้หญิงข้ามเพศสูงวัยคนนึง**
  - คุณเคยมีประสบการณ์เกี่ยวกับการตีตรา ถูกแบ่งแยก กีดกัน ไม่ได้รับความเท่าเทียมไหม อย่างไรบ้าง
- **ชีวิตส่วนตัวของคุณเป็นอย่างไรบ้าง**
  - ความสัมพันธ์ทางเพศ
  - สุขภาพ
  - การเงิน
  - สถานการณ์โควิด-19
- **คุณไปรับบริการทางการแพทย์ที่ใด**
  - มีประกันหรือไม่
  - สามารถเปิดเผยหรือระบุตัวตนทางเพศได้อย่างสบายใจไหม ได้รับบริการที่เท่าเทียมคนอื่นไหม
  - คลินิคเล็กๆ องค์การเฉพาะกลุ่ม
- **จากประสบการณ์ชีวิตของคุณนั้น คุณคิดว่าอะไรที่เป็นอุปสรรคในการดำรงชีวิตในฐานะเกย์หรือผู้หญิงข้ามเพศรวมไปถึงการที่มี อายุเพิ่มขึ้น**
- **คุณคิดว่าบริการด้านสุขภาพแบบใดที่คุณต้องการ และเหมาะสมกับสุภาพชีวิตของเกย์และผู้หญิงข้ามเพศสูงวัย**
  - สิ่งที่ได้รับ และมีอยู่ตอนนี้ / สิ่งที่ไม่เคยได้รับ และควรจะมี
- **คุณมีอะไรจะแนะนำกลุ่มเกย์และผู้หญิงข้ามเพศคนอื่นๆไหม ทั้งวัยรุ่น กลางคนและสูงวัย ในการใช้ชีวิตเพื่อเข้าสู่การสูงวัยอย่างมีสุขภาพดี**

APPENDIX D

Consent Form

Research Study: A Social Ecology of Sexual Health and Well-being among Older Gay Men and Transgender Women in Chiang Mai, Thailand: A Qualitative Study

Researcher: Mr. Suchon Tepjan, College of Public Health Sciences, Chulalongkorn University

Research Objectives:

This study aims to explore experiences, attitudes, and challenges in life that are associated with sexual health and well-being of older gay men and transgender women in Chiang Mai, using the social ecological theory to understand the intersectionality of factors in individual, interpersonal, sociocultural and structural levels.

What will Happen during the Study:

If you volunteer to participate, you will be asked to take part in an approximately 40-minute to 1 hour one-time interview. The interview will be audio-recorded. The discussion during the interview will be about your experiences and opinions, attitudes, ideas as well as challenges of being a gay man or transgender woman. Questions will also ask about your experiences in supporting and dealing with the challenges.

Possible Benefits:

You will not directly benefit from your participation in this study. The findings from this research may provide information to relevant academic research, as there has not yet been many studies done among this populations. Moreover, this could help to support the lives of ageing gay men and transgender women in your community.

Confidentiality:

The discussion will be audio-recorded, however, all information collected from this interview will be held in strict confidence. No names or specific identifying

information will be collected or used in the reports, publications, or presentations. The report/publication will refer to the speaker of conversation by using a code or respondent number.

The interview transcript will be sent to you, soon after completing the interview, in order for you to review for authenticity and correctness of what has been said. You may contact the researcher immediately if you see any misinterpretation of your words and/or any parts where you wish to delete in respect to your privacy.

Voluntary Participation and Early Withdrawal:

Your participation in this study is completely voluntary. You don't have to answer any question if you don't want to. You can just skip any question that you don't want to answer. It is also okay for you to stop answering questions whenever you want and to leave the interview if you do not want to keep going. If you wish to withdraw from the interview, data collected up to the point of withdrawal will be destroyed, including audio-recordings, notes and transcriptions. You will retain your compensation if you choose to withdraw from the study.

Compensation:

You will receive THB400 in this one-time interview to compensate you for your time or your transportation cost. You can keep the money if you choose to withdraw from the study.

Copy of Final Report:

You may request a copy of the final report as well as this informed consent at no cost by contacting the person mentioned above.

For an online interview, if you understand and consent to participation of this study, kindly verbally state your consent acceptance to the researcher.

APPENDIX D (*Thai version*)

เอกสารชี้แจงความยินยอม

หัวข้อการวิจัย: การศึกษาเชิงคุณภาพเกี่ยวกับแนวคิดนิเวศสังคมด้านสุขภาพทางเพศและสุขภาวะของเกย์และหญิงข้ามเพศสูงวัยในจังหวัดเชียงใหม่ ประเทศไทย

ผู้วิจัย: นายสุชน เทพจันทร์ นิสิตปริญญาโท วิทยาลัยวิทยาศาสตร์สาธารณสุข จุฬาลงกรณ์มหาวิทยาลัย

ติดต่อ: 086-363-5522

จุดประสงค์:

งานวิจัยนี้จึงต้องการที่จะศึกษาและทำความเข้าใจเกี่ยวกับทัศนคติ ปัญหา การใช้ชีวิต ที่ส่งผลถึงสุขภาพโดยรวมและสุขภาพทางเพศของเกย์และหญิงข้ามเพศสูงวัยในจังหวัดเชียงใหม่ ซึ่งจะใช้ปัจจัยแนวคิดนิเวศน์สังคมหรือปรัชญาความสัมพันธ์ของสังคมและสิ่งแวดล้อม เข้ามาเป็นกระบวนการทำความเข้าใจ โดยจะศึกษาถึงความสัมพันธ์ของปัญหาในแต่ละระดับ (ระดับบุคคล ระดับระหว่างบุคคล ระดับสังคม/วัฒนธรรม และระดับโครงสร้าง) ที่สามารถส่งผลกระทบต่อกัน

การเข้าร่วมการศึกษาครั้งนี้:

หากคุณตกลงที่จะเข้าร่วม คุณจะได้รับการสัมภาษณ์เชิงลึกซึ่งจะใช้เวลาประมาณ 45 นาที ถึง 1 ชั่วโมง และสัมภาษณ์เพียงครั้งเดียว โดยจะมีแนวคำถามที่เตรียมไว้แล้ว ซึ่งจะเป็นการสอบถามเชิงสนทนาเกี่ยวกับชีวิตความเป็นอยู่โดยรวม สุขภาพอนามัย พฤติกรรมทางเพศ สภาพแวดล้อม การยอมรับทางสังคมและครอบครัว รวมไปถึงการเข้าถึงระบบการรักษาสุขภาพต่างๆ ในฐานะเกย์หรือหญิงข้ามเพศสูงวัยคนหนึ่ง

ประโยชน์ที่จะได้รับ:

ผู้เข้าร่วมวิจัยอาจจะไม่ได้รับประโยชน์โดยตรงจากการเข้าร่วมครั้งนี้ แต่ผลการศึกษานี้จะเป็นประโยชน์ต่องานวิจัยวิชาการที่เกี่ยวข้องในอนาคต เนื่องด้วย ณ ปัจจุบัน ยังไม่มีการศึกษาด้านนี้มากนัก และอาจจะเป็นประโยชน์โดยรวมต่อประชากรสูงวัยที่มีความหลากหลายทางเพศได้ เช่นในการพัฒนาการเข้าถึงระบบการบริการด้านสุขภาพ ด้านโครงสร้างนโยบายของกลุ่มที่เกี่ยวข้องในการปรับการบริการเพื่อให้สอดคล้องและรองรับความต้องการของประชากรสูงวัยที่มีความหลากหลายทางเพศ

การรักษาความลับและข้อมูล:

การสัมภาษณ์นี้จะถูกอัดเสียงไว้และข้อมูลที่ได้ทุกอย่างจะถูกเก็บเป็นความลับ ผู้วิจัยจะไม่มีการเปิดเผยชื่อ หรือข้อมูลใดๆที่จะบ่งชี้ตัวบุคคลของผู้เข้าร่วมวิจัยได้ หากผู้เข้าร่วมมีการเอ่ยชื่อ หรือเอ่ยถึงบุคคลใดๆในระหว่างการสนทนา ข้อมูลเหล่านั้น ก็จะถูกตัดออกเพื่อความปลอดภัย รายงานผลการวิจัยเชิงคุณภาพจะมีการอ้างถึงบทสนทนาระหว่างผู้วิจัยและผู้เข้าร่วม แต่จะมีการนำเสนอโดยรวม และใช้การอ้างถึงด้วยรหัส เช่น "ผู้เข้าร่วมคนที่ 1 กล่าวว่า..."

หลังจากผู้วิจัยได้สัมภาษณ์แล้ว และมีการถอดเทปเสียงบทสนทนา ผู้วิจัยจะส่งบทสนทนาให้ผู้เข้าร่วมดูเพื่อตรวจสอบความถูกต้องของการตีความของผู้วิจัย หากมีส่วนใดที่ผิดเพี้ยน ไม่ถูกต้อง หรือไม่ต้องการที่จะเผยแพร่ก็แจ้งให้ผู้วิจัยแก้ไขได้ทันที เพื่อความน่าเชื่อถือของข้อมูล

ความสมัครใจและการถอนตัว:

การเข้าร่วมการวิจัยเป็นโดยสมัครใจ สามารถปฏิเสธที่จะเข้าร่วมหรือถอนตัว จากการวิจัยได้ทุกขณะ โดยไม่ต้องให้เหตุผล ไม่สูญเสียประโยชน์ที่พึงได้รับ และไม่มีผลกระทบใด ๆ ต่อผู้เข้าร่วมวิจัย หากคุณต้องการยกเลิก บทสัมภาษณ์และไฟล์เสียง ที่ได้อัดไว้จะถูกทำลายทันที

ค่าตอบแทน:

หลังการสัมภาษณ์เสร็จสิ้น ผู้เข้าร่วมจะได้รับค่าชดเชยการเสียเวลาหรือค่าพาหนะในการมาเข้าร่วมครั้งนี้ให้จำนวน 400 บาท

รายงานผลงานวิจัย:

หากคุณต้องการสำเนาสรุปของผลการวิจัยในครั้งนี้ คุณสามารถแจ้งผู้วิจัยได้ ทางผู้วิจัยยินดีที่จะส่งสำเนาให้ โดยไม่มีค่าใช้จ่ายใดๆ

****กรณีที่การสัมภาษณ์ครั้งนี้ทำผ่าน zoom / Line call / phone / whatsapp / Skype แล้วแต่ที่ผู้เข้าร่วมสะดวก ฉะนั้นหากคุณตกลงในกระบวนการยินยอมนี้ กรุณาเอ่ยความยินยอมเป็นเสียงให้ผู้วิจัยได้รับรู้**

VITA

NAME	Suchon Tepjan
DATE OF BIRTH	11 April 1984
PLACE OF BIRTH	Chiang Mai, Thailand
INSTITUTIONS ATTENDED	College of Public Health Sciences, Chulalongkorn University
PUBLICATION	Peer-reviewed Journals

Newman, P. A., Reid, L., Tepjan, S., & Akkakanjanasupar, P. (2021). LGBT+ inclusion and human rights in Thailand: A scoping review of the literature. BMB Public Health. [Accepted].

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AWARD RECEIVED

Outstanding Poster Presentation Award, The 12th International Graduate Students Conference on Population and Public Health Sciences (IGSCPP), 12 July 2021, Chulalongkorn University, Bangkok Thailand.

Outstanding Oral Presentation Award, The 20th International Conference of Public Health Sciences “Inno-Tech in Public Health in Public Health” on 6 November 2020, Chulalongkorn University, Bangkok Thailand.