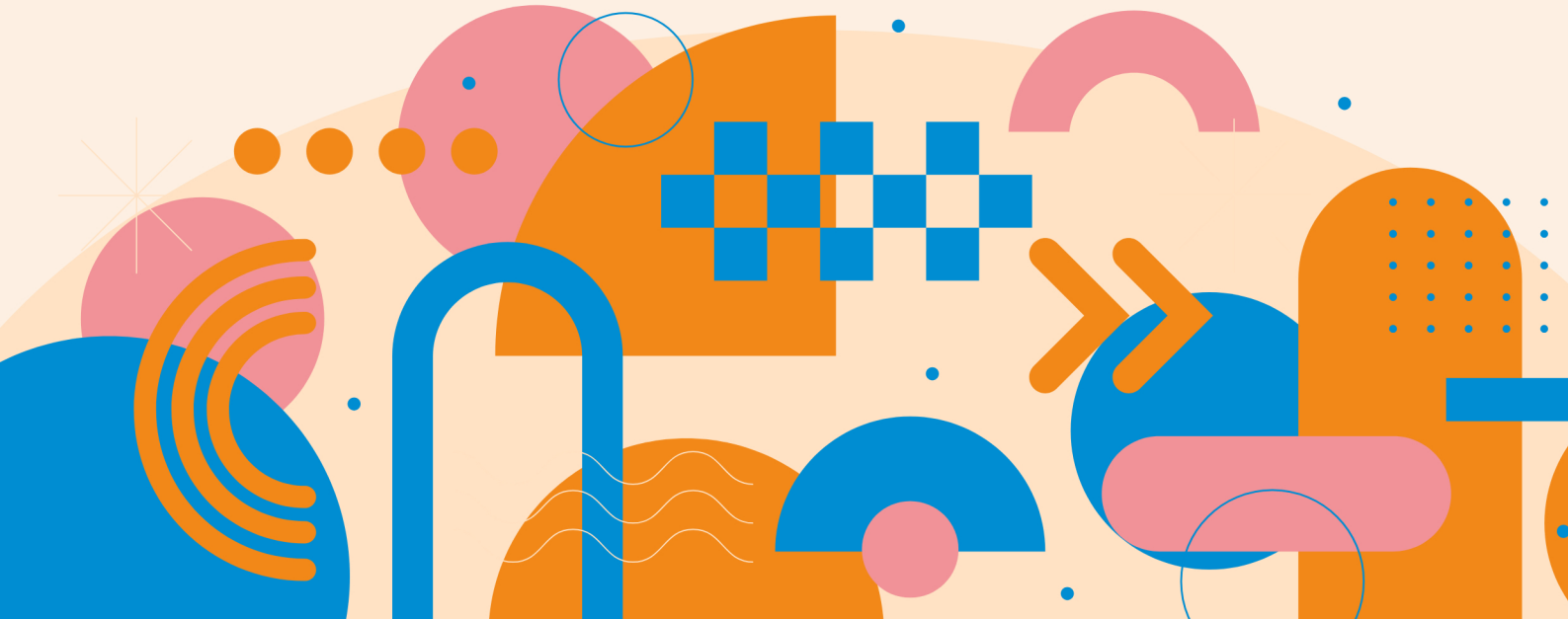
ECOM

EXPLORING THE SRHR NEEDS, BARRIERS, AND PERSPECTIVES OF LGBTQI+ YOUTH IN EASTERN EUROPE, SOUTH CAUCASUS, AND CENTRAL ASIA: INFORMING INCLUSIVE POLICY DEVELOPMENT



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DISCLAIMER:

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EXECUTIVE SUMMARY

Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex individuals, and plus (LGBTQI+) youth in Eastern Europe, the South Caucasus, and Central Asia (EECA) face significant obstacles in accessing their sexual and reproductive health and rights (SRHR). Across the region, political repression, restrictive legal frameworks, widespread social stigma, and discrimination in healthcare settings severely limit their ability to access inclusive, affirming health services. These barriers increase the vulnerability of LGBTQI+ youth to HIV infection, negatively affect their mental health, and reduce their opportunities for safe, informed engagement with sexual and reproductive healthcare systems. This study explores the SRHR needs of LGBTQI+ youth

AGED 18-28

ACROSS 14 EECA COUNTRIES

and aims to generate evidence to inform more inclusive health policies. Conducted between June and December 2024, the research combined a quantitative online survey completed by 1,033 youth and 14 qualitative focus group discussions (FGDs) with LGBTQI+ activists and community leaders. Participants were recruited through purposive and snowball sampling methods, with careful attention to capturing diverse experiences across gender identities, sexual orientations, socio-economic backgrounds, and rural or urban locations.

Findings from the study reveal significant gaps in access to sexuality education, HIV prevention, and gender-affirming care. Only 22% of respondents had received comprehensive sexuality education, and more than half had no access to formal programs at all. While awareness of PrEP for HIV prevention was relatively high, actual usage remained extremely low, with only 7.9% of respondents reporting current use. Access to gender-affirming healthcare was challenging, with 52% of participants describing it as “not easy” or inaccessible, and only a small minority finding SRHR services fully inclusive and respectful of their identities. Transgender, non-binary, and rural youth reported the highest

levels of exclusion, discrimination, and negative healthcare experiences. Moreover, many respondents indicated they relied on informal networks and social media to access essential health information, reflecting the lack of safe, trusted, and publicly available resources. The research shows that country of residence, urban versus rural living conditions, income level, and education significantly impact young people's access to SRHR services. In many cases, legal frameworks and social attitudes continue to criminalize or marginalize LGBTQI+ identities, further isolating youth and limiting their ability to seek care without fear of stigma or retribution.

The findings emphasize the urgent need for inclusive and youth-centered reforms. Comprehensive sexuality education that affirms diverse identities must be expanded across the region. Access to HIV prevention tools like PrEP and PEP should be made widely available and affordable. Healthcare providers require improved training to address LGBTQI+ youth with sensitivity, competence, and respect. Additionally, strengthening legal protections and empowering community-led initiatives are essential to ensure sustainable improvements in health outcomes

for marginalized youth. This report provides clear evidence that LGBTQI+ youth in EECA continue to be systematically excluded from SRHR frameworks. If no action is taken, health disparities and social exclusion will persist. However, with concerted policy changes, investment in youth leadership, and the expansion of inclusive health systems, it is possible to create a future where all young people—regardless of gender identity, sexual orientation, or place of residence—can access the care and rights they deserve.

METHODS:

The study employs a mixed-methods approach, combining a cross-sectional quantitative survey (n=1,033) with qualitative focus group discussions (FGDs) across 14 countries in Eastern Europe and Central Asia. Survey participants were LGBTQI+ youth aged 18–28, self-identifying across a range of sexual orientations and gender identities, including lesbian, gay, bisexual, transgender, queer, intersex, and other identities. The FGDs involved young LGBTQI+ activists and community leaders with direct experience navigating SRHR systems. The analysis integrates statistical modeling and thematic coding to assess SRHR accessibility, inclusivity, and policy barriers affecting LGBTQI+ youth across diverse social and legal contexts.

Results:

Findings highlight significant disparities in SRHR access:

- **Sexuality Education:** Only 22% of respondents received comprehensive sexuality education, whether in school or through other sources, while 52% had no access to any

sexuality education. LGBTQI+ topics were largely absent from both formal school curricula and informal education settings.

- **HIV Prevention:** 60% knew about PrEP, but only 7.9% had access. Cost remains a major barrier, with prices reaching €200–300/month in Russia. According to respondents, 58% reported that anonymous HIV testing was available to them, although privacy concerns often deterred its use.
- **Gender-Affirming Care:** 52% reported difficulty accessing services. Only 16% found SRH services fully inclusive, with transgender and non-binary individuals facing the most discrimination.
- **STI & HPV Screening:** 52% were unsure about HPV vaccine availability; 35% had access to free STI testing, while 32% could only access paid services.
- **Legal and Social Barriers:** 62% of respondents reported being aware of restrictive laws affecting LGBTQI+ access to healthcare, particularly in Russia, Belarus, and Uzbekistan. In addition to legal restrictions, social stigma, fear of discrimination from healthcare providers, and lack of family

or community support were significant barriers that deterred LGBTQI+ youth from seeking care. Rural populations and transgender youth faced the greatest disparities in accessing inclusive and nonjudgmental health services. Urgent policy interventions are needed to integrate LGBTQI+ topics into sexuality education, expand access to HIV prevention and gender-affirming care, and reform discriminatory laws. Strengthening inclusive SRHR policies is crucial to improving health outcomes for LGBTQI+ youth in EECA.

KEY WORDS

LGBTQI+ youth, SRHR, Eastern Europe, Central Asia, healthcare access, discrimination, gender-affirming care, sexuality education, HIV prevention, inclusivity policies.

Key messages:

- LGBTQI+ youth in EECA face systemic discrimination and legal barriers to SRHR services.
- Sexuality education is inadequate, and access to HIV prevention tools remains limited.
- Transgender and non-binary youth face the most severe healthcare discrimination.
- Legal reforms and inclusive policies are essential for equitable SRHR access.

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INTRODUCTION:

SRHR of LGBTQI+ YOUTH

The human rights and healthcare access landscape for Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and other (LGBTQI+) individuals in the world is fraught with challenges. Deeply ingrained societal norms and legislative frameworks often fail to protect sexual and gender minorities and can create a significant threat to their health and well-being (Kovtun & Tilek kyzy, 2023). These issues create a complex environment where LGBTQI+ individuals struggle to access necessary healthcare and face significant barriers to their rights and well-being. World Health Organization (WHO) highlights that despite significant strides in enhancing sexual and reproductive health and rights (SRHR) in the European Region, there remain considerable challenges, including inequalities in SRHR outcomes (2023). In the EECA region, LGBTQI+ youth encounter numerous challenges that vary significantly across different countries due to political, cultural, and legislative differences. According to a study conducted by

ECOM (Khabibulina & Yourski, 2021), these challenges lie in four main areas: political problems, access to healthcare, workplace discrimination, and educational barriers.

WHO defined sexual rights as the right to equality, non-discrimination, privacy, access to the highest health services, right to marry a desired person freely, right to identify the number of children desired to bear, right to information, education, freedom of expression, and protection from violations of fundamental rights. While reproductive rights are advancing with no political opposition, sexual rights are facing strong opposition from the far-right and populistic politics throughout the world, as it includes the rights of not only heterosexual men and women, but also the youth, LGBTQI+ people and youth, people with positive HIV, and others (Lazdane, 2013)

For the purpose of this research, 'youth' refers to individuals aged 18 to 28, with a particular focus on those categorized as Most at Risk Young People (MARYP) or Especially Vulnerable Young People (EVYP). Researching youth as a separate socio-economic group is crucial because of their vulnerabilities in access to health and education services, somewhat careless behavior, and age

differentiation (Khabibulina & Yourski, 2021; Zarbailov & Esin, 2014). Most importantly, they do not have stable income nor access to the networks and are in the process of obtaining an education degree, if this is the case. Young people 15-24 make up 35% of people with HIV, but the attention to youth, transgender girls, MSM, girls and boys who are forced to sell sex, or those who use drugs, is not given as much (Melles & Ricker, 2018). Power distribution imbalance and its influence on the vulnerable youth is crucial to understand. Physically, financially weak, and mentally not prepared as much, youth could be a subject of domestic, sexual, and physical violence from parents, peers, and relatives.

LGBTQI+ youth, in turn, is more vulnerable because of intersecting forms of all forms of violence and the social stigma in the majorly heteronormative and patriarchal society of the world we live in. While there is some progress made in Western Europe, the Americas, and some countries of Asia, the populations of the Global South and East and, more vitally, LGBTQI+ youth suffer from the stigma and discrimination, exclusive laws, lack of sexual and reproductive health rights and education (Greene et al., 2015). Adolescence and youth is a time of puberty, trying sexual

intercourse, alcohol, psychoactive substances, and other risky activities, making them the most vulnerable to issues like human immunodeficiency virus (HIV) - (Zarbailov & Esin, 2014). The SRHR services for LGBTQI+ youth should be part of the fundamental dignity and gender-affirming treatment, including access to contraception, HIV testing and prevention through PreP, etc. Fight for general access and realization to SRHR services has been hardly won in general, but now are in specific danger because of greatly funded contestation of the right-wing and populist politics in the world. This puts the LGBTQI+ individuals in a great danger (Pugh, 2019).

The provision of mental health and psychosocial support is also integral, addressing challenges related to sexual orientation, gender identity, and experiences of stigma and discrimination. Community empowerment and participation are crucial. It ensured that SRHR services are not only accessible but also inclusive and responsive to the specific health concerns, cultural contexts, and lived experiences of LGBTQI+ youth (UNFPA & IPPF EN, 2017). There are many unmet challenges to the SRHR needs of young and adolescent people on contraception, cancer, gender

equality, and abortion (Temmerman et al., 2014). But what requires attention and rapid attention are the needs of middle or low-income countries, which EECA makes up in general.

LGBTQI+ YOUTH IN EECA

This research specifically focuses on LGBTQI+ youth of Eastern Europe and Central Asia (EECA). Countries like Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Russia, Tajikistan, Ukraine, and Uzbekistan, exhibit significant variability in their approach to SRHR, often reflecting broader geopolitical and cultural dynamics. These countries were selected because they are part of the Eastern Europe, South Caucasus, and Central Asia (EECA) region and represent diverse political, legal, and social environments affecting LGBTQI+ youth's access to SRHR services. Still identified as “post-Soviet,” these countries are linked through institutions and economic dependence on Russia as Eurasian Customs and Economic Unions, Commonwealth of Independent States (CIS), oil and gas pipelines, trade relations, and security military bases

(Kirey-Sitnikova & Kirey, 2019). Out of 14 countries, only Georgia, Moldova, and Tajikistan have developed a National SRHR action plan. Maternal deaths per 100,000 women are 24 in the region. Even though the EECA region has improved their situation with abortion access and early pregnancy by at least more than 50%, dilatation, and curettage are still one of the main methods of abortion, which is not recommended by the World Health Organization (WHO). Adolescents and youth in this region face a rapid and regular increase in HIV infections because of various reasons, including adolescent sex work, both voluntary and forced, early pregnancy, lack of contraceptives, and hesitation to get them because of high stigma. There are the highest ratios of HIV transmissions in Russia and Ukraine. According to UNAIDS data, Russia and Ukraine have the highest ratios of HIV transmissions in the EECA region. Central Asia also experienced a significant spike in HIV cases in the early 2000s (UNAIDS, 2023) Because of it being in the middle of major drug trafficking, cases of HIV transmission through drug usage, MSM, and sex work have been on the increase. However, there has been improvement in the region by getting funding, and education, a decrease in early unprepared sexual acts, availability of more contraceptives and

sexual education, and lessened stigma in society. Local and regional non-governmental organizations have been channeling most of the information and resources to the local population and vitally to the most vulnerable populations of youth.

Many LGBTQI+ youth in the region are disproportionately affected by structural poverty, which limits their access to healthcare, education, and stable housing. In addition, healthcare systems in most EECA countries continue to operate under binary gender norms, making it difficult for transgender, non-binary, and gender-diverse youth to receive inclusive and appropriate care. Because of high policing government apparatuses in EECA, the data on LGBTQI+ youth needs is rarely collected. They encounter systematic challenges in law and provision, education, and health—all of which are combined with societal stigma and discrimination in healthcare settings. UNFPA in EECA highlighted that even though many countries have made progress in decreasing maternal mortality levels, the issues of maternal health, cervical cancer, and low use of modern contraceptives persist. To combat this, advocacy for legal reform and policies that decriminalize LGBTQI+ identities and behaviors are paramount

(IPPF, 2016; UNFPA & IPPF EN, 2017). Despite ICPD +25's new approach takes into consideration low-income countries and families, structural poverty, and gender inequality, Belarus, including 10 other countries, did not participate in ICPD +25 because the government does not think the terms "sexual and reproductive health and rights" should be used (Mahmood & Bitzer, 2020; Rowlands, 2020). Therefore, this study seeks to provide data into the lived realities of LGBTQI+ youth in Eastern Europe and Central Asia through mixed-method research. It seeks to make three important contributions.

In countries like Russia, Belarus, Uzbekistan, and Turkmenistan, restrictive legal and political frameworks limited the availability of accessible and comprehensive literature on LGBTQI+ health and rights. While Turkmenistan is not included in this research due to very limited data and criminalization of voluntary same-sex relations among men (similar to Uzbekistan), other countries generally have a repressive attitude towards civil society, especially those who have or fighting for the foreign, i.e. Western, funding. As the region is mostly known for its degrading development against freedom of speech, assembly, and gender

diversity, there is a lack of disaggregated data, which this research aspires to fulfill.

First, it is aiming to identify the specific SRHR needs of LGBTQI+ youth in Eastern Europe and Central Asia. It is viable to divide the region into 4 general categories Eastern Europe (Belarus, Moldova, Russia, Ukraine), Central Asia (Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan), South Caucasus (Armenia, Azerbaijan, Georgia), and Baltic States (Estonia, Latvia, Lithuania).

EECA

EASTERN EUROPE	CENTRAL ASIA	SOUTH CAUCASUS	BALTIC STATES
Belarus	Kazakhstan	Armenia	Estonia
Moldova	Kyrgyzstan	Azerbaijan	Latvia
Russia	Tajikistan	Georgia	Lithuania
Ukraine	Turkmenistan		
	Uzbekistan		

However, the research contextualizes the experiences of LGBTQI+ youth within the broader legal, educational, and healthcare frameworks across the EECA region. Some countries are more progressive, and others are less. There are no specific divisions according to subcategories. It is also crucial to mention an ongoing full-scale invasion of Russia in Ukraine, recent wars and conflicts of Armenia and Azerbaijan, Kyrgyzstan and Tajikistan, Russian politicians' claim on the land of Kazakhstan, and the peculiarities of SRHR needs for the LGBTQI+ of the oppressed minorities. Ukrainian gay soldiers are affected disproportionately, with their partners having no right to decide where to bury them in the heterosexual military state apparatus. Russian gay soldiers and migrant ethnic and racial minorities are sent to war and occupied territories with no support for sexual and reproductive rights while targeting them through far-right anti-migrants discourse and claiming white "Russianness" (Aidarbekova, 2023; Eraliev & Urinboyev, 2020). Second, it examines the barriers that LGBTQI+ youth face in accessing SRHR services. Third, it explores the perspectives of community leaders and LGBTQI+ activists on policy challenges and opportunities.

PROBLEM STATEMENT

While international standards emphasize the importance of inclusive sexual and reproductive health and rights (SRHR) for all young people, there remains a significant gap in evidence regarding the specific needs and experiences of LGBTQI+ youth in Eastern Europe, the South Caucasus, and Central Asia (EECA). In particular, little is known about how existing legislation, education systems, and healthcare services in the region align with the realities and rights of LGBTQI+ youth. The limited visibility of LGBTQI+ experiences in public health research and policy frameworks risks perpetuating access barriers, health inequities, and social exclusion. Given the diverse and often restrictive legal, social, and political contexts of EECA countries, there is an urgent need for research-driven advocacy to better understand and address these gaps. By centering the voices and lived experiences of LGBTQI+ youth, this study aims to contribute to building a more inclusive and equitable SRHR landscape in the region.

JUSTIFICATION

This study is driven by the urgent need to generate empirical evidence on the sexual and reproductive health and rights (SRHR) challenges faced by LGBTQI+ youth across Eastern Europe, the South Caucasus, and Central Asia (EECA). Despite international calls for inclusive health systems, LGBTQI+ youth in the region remain largely invisible in public health data, policy frameworks, and service design. Existing research tends to either overlook young LGBTQI+ populations or fail to capture the intersecting barriers they face across education, healthcare, and legal systems.

The EECA region presents a particularly pressing context for this research. Restrictive legal environments, limited sexuality education, rising HIV rates, and widespread social stigma converge to create serious barriers for LGBTQI+ youth. Political shifts in recent years have further constrained civil society spaces, reduced opportunities for advocacy, and increased the risks associated with openly identifying as LGBTQI+. Without timely, locally grounded research, there is a risk that these youth will

remain excluded from national SRHR strategies and HIV prevention efforts.

By documenting the lived realities of LGBTQI+ youth and highlighting the discrepancies between current policy frameworks and actual experiences, this study seeks to inform policy revisions, strengthen youth-led advocacy, and contribute to the creation of a more equitable and supportive healthcare environment for all young people, regardless of sexual orientation or gender identity.

YOUTH-PARTICIPATORY RESEARCH APPROACH

This study adopted a youth-led research approach, positioning LGBTQI+ youth in the EECA region as active contributors to the research process. By embedding young people directly in the research design and implementation, this approach ensured their voices were not only heard but also actively shaped the research outcomes. This framework aimed to validate the lived experiences of LGBTQI+ youth, empower them to advocate for meaningful change, and develop more inclusive and effective SRHR policies. A total of 14 young LGBTQI+ activists from targeted countries

across the EECA region were recruited and trained in both quantitative and qualitative research methodologies, including survey dissemination and conducting focus group discussions (FGDs). These specialized trainings strengthened their research capabilities, provided practical skills in data collection, and enhanced their confidence in advocacy. As peer facilitators, these activists played a vital role in ensuring the study authentically reflected the lived realities of LGBTQI+ youth, overcoming barriers often faced by marginalized groups. Notably, the principal investigator was 25 years old, underscoring the study's commitment to youth leadership and its philosophy of "youth-to-youth" engagement. Youth participation in research and decision-making has been widely recognized as essential for fostering empowerment and improving program outcomes. Melles and Ricker (2018) highlight that meaningful engagement of youth in HIV and SRHR decision-making improves self-efficacy and leads to more inclusive program designs. However, they also identify persistent challenges such as tokenism, age-based hierarchies, and limited access for marginalized groups, including transgender individuals and young people who engage in sex work or use drugs. To address these barriers, this study incorporated

capacity-building initiatives tailored specifically to LGBTQI+ youth, ensuring their effective and meaningful participation. Cahill and Dadvand (2018) further emphasize that youth engagement is most impactful when it is purpose-driven and contextually grounded, addressing power imbalances and creating spaces for authentic collaboration. Their framework identifies interconnected domains—purpose, positioning, perspective, power relations, protection, place, and process—that are crucial for ensuring participatory practices are more than symbolic gestures. This study adopted these principles by fostering inclusive spaces, providing training, and prioritizing the voices of LGBTQI+ youth in the research process. Capacity-building efforts were integral to the study's approach, as marginalized youth often face systemic barriers to participation, including discrimination and lack of representation in decision-making spaces. By equipping young LGBTQI+ participants with tools and skills for research and advocacy, the study not only enhanced the quality of the findings but also empowered participants to challenge societal norms and advocate for policy changes. This youth-participatory approach aligns with global calls for investing in youth leadership and promoting equity in policy development. By

prioritizing meaningful engagement, the study ensured that LGBTQI+ youth were not merely participants but active partners, bridging representation gaps and fostering sustainable solutions to SRHR challenges. These efforts contributed to advancing SRHR policies that reflect the needs of LGBTQI+ youth and set a precedent for more inclusive and participatory research practices.

OBJECTIVE(S) AND RESEARCH QUESTIONS

RESEARCH QUESTION

What are the sexual and reproductive health and rights (SRHR) needs, barriers, and perspectives of LGBTQI+ youth in Eastern Europe, South Caucasus, and Central Asia, and how can these insights inform the development of inclusive and youth-friendly policies?

OBJECTIVES

- To identify the specific SRHR needs of LGBTQI+ youth in Eastern Europe and Central Asia.
- To examine the barriers that LGBTQI+ youth face in accessing SRHR services.
- To explore the perspectives of community leaders and LGBTQI+ activists on policy challenges and opportunities.

METHODOLOGY AND SAMPLING

Mixed Methods Approach

This research employs a mixed methods approach to explore the SRHR needs of LGBTQI+ youth across Eastern Europe and Central Asia (EECA), specifically targeting Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Russia, Tajikistan, Ukraine, and Uzbekistan. This research employs a mixed methods approach, combining a quantitative survey to gather broad, generalizable data with qualitative focus group discussions (FGDs) to gain deeper insights. This approach, supported by Creswell & Plano Clark (2018), allows for a comprehensive understanding of the SRHR needs and barriers faced by LGBTQI+ youth. This methodology integrates the statistical breadth of quantitative analysis with the contextual depth of qualitative insights, offering a robust framework for exploring complex issues.

Quantitative Component: Survey

Design: A cross-sectional survey designed to capture a wide range of experiences and needs related to SRHR among LGBTQI+ youth, informed by regional trends that highlight the critical transition from adolescence to adulthood. This design allows for the analysis of various factors influencing SRHR in a snapshot format, providing a broad overview of the current state of affairs.

Participants: The study included LGBTQI+ youth aged 18–28 living in 14 EECA countries. Participants self-identified as part of the LGBTQI+ community, were within the target age range, and had sufficient digital access to complete an online survey or participate in a focus group discussion (FGD). Individuals outside this age range, those not identifying as LGBTQI+, or living outside the EECA region were excluded. A total of 1,033 youth completed the survey, and approximately 120 young activists and community leaders participated in 14 FGDs. Participants were recruited through purposive and snowball sampling via LGBTQI+

organizations and social media networks. This age group is critical as they represent a transition from adolescence to full adulthood, a period where individuals solidify their identities and sexual behaviors and where they may encounter specific barriers to accessing SRHR services (UNFPA & IPPF EN, 2017).

Sampling Strategy: Non-probability sampling methods, specifically snowball and purposive sampling, were employed, facilitated through social media platforms and collaborations with community organizations. These methods are particularly effective for reaching hard-to-reach populations, as discussed by Patton (2015), and are ideal for this study's focus on a marginalized group.

Data Collection: The survey was administered using ZOHO SURVEY, a reliable and accessible online survey platform that allowed for the efficient collection and management of data. This tool supported the creation of a structured questionnaire that probed into SRHR needs, healthcare encounters, and policy perceptions. The data collection process adhered to the General Data Protection Regulation (GDPR) guidelines to ensure the

confidentiality, security, and ethical handling of respondents' personal information. Participants were informed about the purpose of the survey, and their consent was obtained prior to participation, with data stored securely and anonymized to protect their identities.

To systematically address the research questions, the following quantitative indicators were collected through the survey instrument:

Socio-Demographic Characteristics:

Age Distribution: Participants' ages were categorized into brackets (18–19, 20–21, 22–23, 24–25, 26–28) to analyze age-related trends.

Country of Residence: Participants' countries of residence were recorded to understand geographic distribution and regional differences.

Gender Identity Distribution: Participants' gender identities were categorized (Cisgender Male, Cisgender Female, Transgender Male, Transgender Female, Non-binary, Other, Prefer not to say) to assess diversity.

Sexual Orientation Distribution: Participants identified their sexual orientation (e.g., Gay, Lesbian, Bisexual, etc.) to capture diverse experiences.

Urban vs. Rural Residence: Participants indicated whether they lived in the capital city or elsewhere to explore urban-rural disparities.

Access to Information and Education Variables:

- **Sexuality Education:** Whether participants had received sexuality education that included LGBTQI+ topics.
- **Quality of Sexuality Education:** Participant ratings of the quality of sexuality education received (from Poor to Excellent).
- **Missing Topics in Sexuality Education:** Identification of key topics missing from sexuality education curricula.
- **Ease of Accessing Sexual Health Information:** Participant-reported ease of accessing LGBTQI+-relevant sexual health information (categorized as Very Easy or Not Easy).

HIV Prevention and Care Variables:

Awareness of HIV Prevention Services: Whether participants were aware of HIV prevention services specifically for LGBTQI+ youth.

Comfort with Accessing HIV Services: Participants' reported comfort levels (Very Comfortable to Very Uncomfortable) when accessing HIV prevention services.

Awareness of PrEP (Pre-Exposure Prophylaxis): Awareness of PrEP as a method for preventing HIV infection.

Availability and Use of PrEP: Whether PrEP was available and participants' use or willingness to use it.

Availability of Anonymous HIV Testing: Awareness of anonymous HIV testing options in participants' local areas.

Confidentiality in HIV Care: Participant ratings of confidentiality practices in HIV services (from Excellent to Poor).

Sexual and Reproductive Health Services Variables:

- **Accessibility of Gender-Affirming Healthcare:** Reported ease of accessing gender-affirming services for transgender youth.
- **Inclusivity of SRHR Services:** Evaluation of whether SRHR services were inclusive and respectful of participants' gender identities.
- **Availability of HPV Screening and Vaccination:** Availability of HPV screening and vaccination services.
- **Availability and Cost of STI Testing:** Availability of free STI testing and participants' awareness of it.
- **STI Testing History:** Whether participants had been tested for STIs in the past year.
- **Satisfaction with STI Treatment:** Participant satisfaction ratings with STI treatment services.
- **Ease of Access to Contraceptive Methods:** Participant-reported ease of accessing contraceptive methods and related counseling.
- **Barriers to Safe Abortion Services:** Participant experiences regarding barriers to accessing safe abortion services.

Comfort Discussing SRHR Needs: Comfort levels when discussing SRHR needs with healthcare providers.

Legal and Social Barriers Variables:

Awareness of Discriminatory Laws: Awareness of laws negatively affecting LGBTQI+ individuals' access to SRHR services.

Perceived Barriers Faced by LGBTQI+ Youth: Frequency and type of barriers identified (e.g., discrimination in healthcare, employment, education).

Perceived Causes of Barriers: Participants' views on causes of these barriers, including governance, economic development, service quality, and societal prejudice.

Priority Areas for Advocacy: Identification of up to three national-level advocacy priorities (e.g., healthcare accessibility, legal protections, public awareness).

Perceptions of Healthcare Providers' Understanding: Participant views on whether healthcare providers understood LGBTQI+ youth needs effectively.

Experiences with Stigma and Discrimination Variables:

- **Experiences of Discrimination by Healthcare Providers:** Whether participants felt discriminated against by healthcare providers because of their LGBTQI+ identity.
- **Refusal of SRHR Services:** Whether participants had been denied SRHR services based on their LGBTQI+ identity.
- **Suggested Actions to Reduce Stigma:** Actions identified by participants as strategies to reduce stigma in healthcare settings.
- **Experiences of Judgment by Healthcare Providers:** Whether participants felt judged when accessing SRHR services.

Analysis: These indicators were systematically collected through the survey tool and analyzed using descriptive and inferential statistics to answer the research questions. The data provided a comprehensive understanding of the access, quality, and inclusivity of SRHR services for LGBTQI+ youth across different regions. By identifying these indicators, the study aimed to inform targeted interventions and policy recommendations to improve SRHR outcomes for LGBTQI+ populations. Quantitative

data were analyzed using R, where descriptive and inferential statistics were applied to map out the data landscape and uncover patterns and associations among various variables.

Qualitative Component: Focus Group Discussions (FGDs)

Design: Semi-structured FGDs were designed to create an environment conducive to open discussion and deep reflection on SRHR challenges and policy gaps. This format allowed participants to express their views freely, providing rich qualitative data.

Participants: Focus groups consisted of LGBTQI+ community leaders and activists aged 18–28, known for their advocacy and insight into the community's needs. Inclusion criteria required participants to self-identify as LGBTQI+, be within the target age range, actively engage in LGBTQI+ advocacy or community work, and have direct knowledge of sexual and reproductive health and rights (SRHR) challenges faced by LGBTQI+ youth. Individuals outside the specified age range, not engaged in community or advocacy work, or without relevant

SRHR experience were excluded. A total of approximately 120 youth participated across 14 focus groups, with each group comprising between 6 and 10 participants. Participants were recruited through purposive sampling in collaboration with local LGBTQI+ organizations.

Sampling Strategy: Purposive sampling was used to ensure a diverse range of perspectives across sexual orientations, gender identities, socio-economic backgrounds, and geographic locations. Participants were recruited through partnerships with local LGBTQI+ organizations, regional networks, and online platforms, including social media outreach targeting LGBTQI+ youth communities. National partners in each country supported recruitment efforts by sharing the survey and focus group invitations through their networks. Efforts were made to include participants from both urban and rural areas, different income levels, and a range of LGBTQI+ identities. Snowball sampling was also employed, encouraging participants to share the study invitation with peers to extend the reach, particularly in contexts where visibility and public organizing are restricted.

Data Collection: FGDs were held online, utilizing digital platforms such as Zoom and Google Meet to facilitate remote communication. This approach ensured broader accessibility while respecting participants' need for privacy and security. Trained moderators (national youth researchers) facilitated the FGDs, guiding conversations in the national language and ensuring a safe and respectful environment. Moderators were equipped to handle sensitive topics and provide support as needed during the discussions.

Analysis: A thematic analysis, as described by Braun and Clarke (2006), was conducted to extract key themes from the discussions. This qualitative method involved several human-centered steps:

1. **Familiarization:** Immersion in the participants' stories was achieved by reading and re-reading the transcripts to deeply understand their experiences.
2. **Generating Initial Codes:** The data was systematically reviewed, highlighting interesting points and recurring issues.

3. **Searching for Themes:** Codes were grouped into potential themes, identifying patterns in participants' narratives.
4. **Reviewing Themes:** Themes were checked against the data as a whole to ensure they accurately reflected participants' voices.
5. **Defining and Naming Themes:** Themes were refined, with clear names and definitions that captured the essence of participants' experiences.
6. **Producing the Report:** Themes were woven into a narrative that highlighted the systemic barriers participants faced and their suggestions for improvement.

Recruitment of Study Participants

Recruitment Strategy:

Participants for both the survey and the focus group discussions were recruited through targeted outreach efforts, utilizing multiple channels to ensure a diverse and representative sample of LGBTQI+ youth in Eastern Europe and Central Asia.

1 Social Media Recruitment:

ECOM leveraged its social media platforms to reach out to potential participants. These platforms provided a direct and engaging way to connect with LGBTQI+ youth, allowing for broad dissemination of the recruitment message. Social media campaigns were tailored to resonate with the target demographic, using culturally and socially nuanced language and imagery to ensure inclusivity and relevance.

2 Collaboration with National Partners and Members:

Recruitment efforts also extended through ECOM's network of national partners and members. These organizations, deeply embedded within local LGBTQI+ communities, facilitated the recruitment process by sharing study information with potential participants. This strategy not only broadened the outreach but also added a layer of trust and credibility, as the recruitment messages came from known and respected sources within the community.

Sample Size Distribution

Country	Population (million)	Estimated LGBTQI+ Population	Quantitative Sample Size	Qualitative Sample Size (FGDs)
Armenia	2777979	111,119	76	1 FGD, 6 participants
Azerbaijan	10462904	418,516	35	1 FGD, 5 participants
Belarus	9455037	378,201	15**	0**
Estonia	1319041	52,762	104	1 FGD, 5 participants
Georgia	3717425	148,697	105	1 FGD, 9 participants
Kazakhstan	19828165	793,127	65	1 FGD, 6 participants

Kyrgyzstan	6839606	273,584	65	1 FGD, 7 participants
Latvia	1810240	72,410	102	1 FGD, 5 participants
Lithuania	2692798	107,712	67	1 FGD, 6 participants
Moldova	3329865	133,195	67	1 FGD, 5 participants
Russia	143957079	5,758,283	136	1 FGD, 5 participants
Tajikistan*	10331513	413,261	57	1 FGD, 5 participants
Ukraine	37937821	1,517,513	81	1 FGD, 5 participants
Uzbekistan*	35673804	1,426,952	58	1 FGD, 5 participants
TOTAL			**1033**	**64**

** Due to the challenges associated with accessing LGBTQI+ individuals in these countries, the projected number of survey participants has been adjusted downward following recommendations from national community organizations.*

***Excluded from the analysis due to limited number of participants*

The total population estimates for each country were based on the most recent census data and statistical updates provided by authoritative bodies such as national statistics offices and international databases like the World Bank and the United Nations. This approach secured a factual baseline essential for population-based studies. The estimated that 4% of the population identifies as LGBTQI+ drew from scholarly work by the Williams Institute, which suggests a consistent demographic proportion across diverse geographical contexts (Gates, 2011).

For the quantitative component of the study, sample sizes were carefully calculated to align with the estimated LGBTQI+ youth population, ensuring that the data collected could provide statistically significant insights. This method followed the

recommendations outlined in Cochran's work on sampling techniques, which supports creating scalable sample sizes based on the population estimate, balancing statistical requirements with practical constraints (Cochran, 1977).

Additionally, the qualitative aspect, involving focus group discussions (FGDs), was structured to include 5-10 participants per group, as recommended by Morgan (1996). This group size was optimal for maintaining dynamic conversations that allowed for in-depth discussions and meaningful participation, facilitating a nuanced exploration of the SRHR needs faced by LGBTQI+ youth.

ETHICAL CONSIDERATIONS

Protecting Vulnerable Populations

Participant Safety and Confidentiality: Given the vulnerability of LGBTQI+ youth in Eastern Europe and Central Asia, the study prioritized participant anonymity and confidentiality. Data, particularly concerning sexual orientation, gender identity, and SRHR needs, was handled with utmost sensitivity. No personal identifiers, such as names or email addresses, were collected in the survey. Participants were identified solely by a unique ID number assigned by the researchers during the data analysis phase, ensuring anonymity from the point of collection. Similarly, participants in FGDs were not required to provide their names or any other personal identifiers. Each participant was assigned a unique ID during data analysis to maintain confidentiality throughout the discussions and subsequent processing.

Informed Consent: Informed consent was meticulously obtained from all participants. Efforts were made to ensure participants

fully understood the study's aims, their voluntary participation, the confidentiality of their responses, and their right to withdraw at any time without consequence.

Cultural and Regional Sensitivities: The research team approached the topic with deep respect for the cultural and social nuances of LGBTQI+ youth's experiences in the region. Engaging with community leaders and activists ensured that the study's design and implementation were sensitive to local contexts and the diverse needs within the LGBTQI+ community.

Ethical Approval and Oversight

Research Ethics Board Approval: The study was reviewed and approved by the Institutional Review Board (IRB) of the International Charitable Foundation “Alliance for Public Health” (Registration #IORG0010394). The first approval was granted on June 18, 2024, with recommendations to refine certain aspects of the study protocol. Following the implementation of these recommendations, the updated protocol received final approval on October 3, 2024. Both approvals emphasized adherence to ethical standards and participant protection.

Risk Mitigation Measures: Participants were thoroughly briefed on the sensitive nature of the survey and FGDs before their participation. This briefing emphasized their right to withdraw from the study at any point without consequence. Surveys and discussions were conducted under strict confidentiality to protect participant identities and sensitive information. Trained moderators, equipped with protocols to manage distress and provide emotional first aid, oversaw all FGDs. Participants were provided with a list of accessible mental health resources, including crisis hotlines and contacts for psychological support services supportive of the LGBTQI+ community. Follow-up procedures included optional debrief sessions facilitated by mental health professionals to help participants process their experiences and mitigate any potential long-term distress. The research team regularly monitored the effectiveness of these risk mitigation measures and adjusted practices based on participant feedback and IRB guidelines.

Data Protection: Data protection followed the General Data Protection Regulation (GDPR) standards. All qualitative and quantitative data collection platforms adhered to high-security

protocols to ensure participant privacy. Data collectors signed a Pledge of Confidentiality and never stored any materials on their personal devices. Instead, all data was directly uploaded to the principal investigator's secure systems. This approach minimized risks of data breaches and ensured stringent confidentiality measures.

Benefit-Risk Assessment: The potential benefits of the study, including contributing to more inclusive SRHR policies and services for LGBTQI+ youth, were carefully weighed against the risks. By providing a platform for participants' voices, the study aimed to empower individuals while minimizing risks associated with their involvement.

Data Handling and Dissemination

Data Security and Privacy: All collected data, including survey responses and voice recordings, was securely stored on the lead researcher's encrypted laptop. Access to the laptop was restricted to the lead researcher, with strong password protection and biometric access controls in place. Secure cloud backup services were used to safeguard data integrity, with

backups encrypted and accessible only to the research team. Voice recordings from FGDs were anonymized and deleted post-analysis to protect participant identities and adhere to data protection standards.

Funding

The study was funded by UNFPA EECA RO and UNAIDS EECA RO. The funding supported incentives for data collectors in 14 countries, as well as qualitative and quantitative analysis. The funding agencies did not influence or involve themselves in the study design, data collection, analysis, or interpretation of the results.

RESULTS:

1.1. Methodology of inclusivity index calculation

To estimate the overall level of inclusive health policies by country of residence, a composite inclusivity index was calculated. For this purpose, all binary and ordinal-scale questions were used in the index calculation. For ordinal-scale questions, weights were assigned to each response level: 1 for the best outcome, 0.5 for the average outcome, and 0 for the worst outcome. Where additional intermediate responses were present, proportional weights (e.g., 0.25) were applied. The inclusivity index for each country of residence was obtained by calculating the mean of the outcome values across all questions.

1.2. Methodology of Regression-Based Deviance Analysis

The study applied logistic and ordinal regression models to determine the relationships between demographic, and socioeconomic factors with various indicators of SRHR needs. For

binary answers, the logistic regression model was built. For categorical variables, the ordinal regression models were built.

The initial set of independent variables included age, country of origin, country of residence, urban or rural living area, income, and education level.

To assess the strength of the relationship between pairs of predictor factors and ensure the reliability of the models, a Cramer's V-based correlation matrix for categorical variables was built. Looking at associations between variables, Cramer's V coefficients (which fall between 0 and 1) were calculated. The analysis found that Cramer's V exceeded 0.5 when examining the relationship between "Country of residence" and "Country of origin" variables. Given how tightly these geographic variables overlapped, only 'Country of residence' was used in model development as a factor reflecting the relevant geographic context.

To make the remaining independent variables compatible with the regression models, they were transformed into factors. The same was done for response variables, which were transformed into factors with appropriate reference categories.

Each model was estimated using maximum likelihood estimation,

which is a conventional statistical method for fitting regression models that have categorical outcomes. The model included all explanatory variables, making it possible to estimate their individual variations while accounting for other predictors.

The significance level was assessed through a second type of analysis of variance (ANOVA). This method required computing the chi-square likelihood ratio statistic for each predictor factor allowing for estimating their individual effects without interference from other variables. It contains the chi-square statistics, p-values, and levels of significance for each predictor factor. If the p-values were below 0.05, predictor variables were considered statistically significant. The significance levels ***, **, and * were representing highly significant ($p < 0.001$), moderately significant ($p < 0.01$), and poorly significant ($p < 0.05$) results, respectively.

1 Descriptive Analysis of the Data

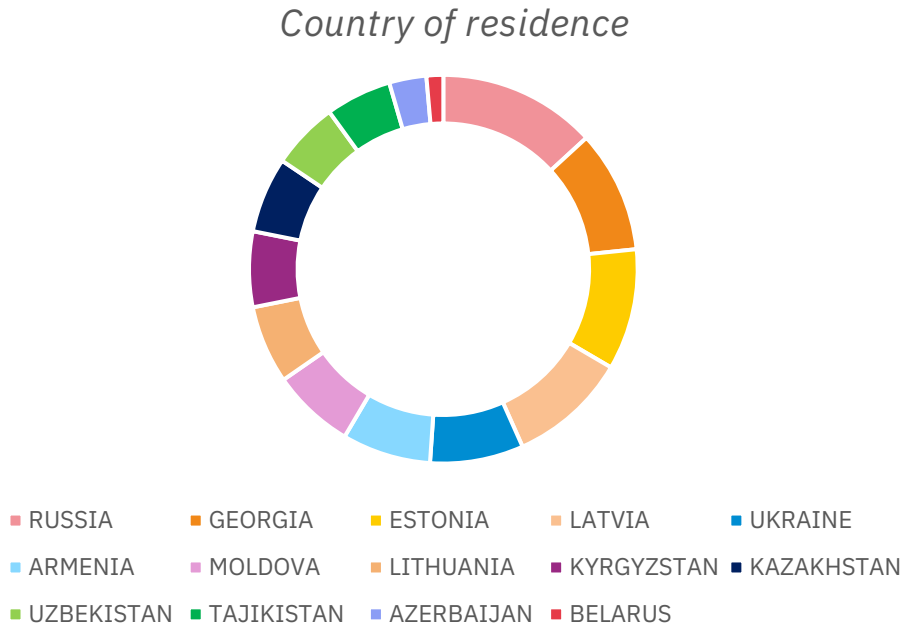
The initial dataset contains survey answers from 1,277 LGBTQI+ youth across 14 countries in Eastern Europe and Central Asia. In addition to the survey participants, basic socio demographic information was collected from focus group participants. This included age, gender identity, sexual orientation, and country of residence. Focus group participants reflected a diverse range of identities and backgrounds, although the sample primarily consisted of individuals actively engaged in LGBTQI+ community advocacy. Participants were asked to provide information about their main demographic and socioeconomic characteristics (age, gender identity, sexual orientation, income and education levels, their living situation in urban or rural areas, as well as their country of origin and residence). To evaluate the SRHR needs of LGBTQI+ youth, the participants were questioned regarding different aspects of their sexual and reproductive health (SRH) experiences. 244 participants did not respond to any of the SRH-related questions. Therefore, they were removed from further analysis. As a result, the final dataset contains 1,033 responses.

The sample is categorized into five age categories: 18–19, 20–21, 22–23, 24–25, and 26–28. The sample distribution across age categories is relatively equal. Although the youngest (18–19) and the oldest (26–28) groups have the biggest percentage accounting for 23.1% and 22.2%, respectively. They are followed by the 20-21 age group (20.3%), the 22-23 age group (18.2%), the 24-25 age group (16.2%).

The highest proportion of respondents originates from Russia, Georgia, and Latvia, accounting for 13.8%, 10.4%, and 9.3% of the sample, respectively. Countries such as Estonia, Ukraine, Kazakhstan, Armenia, Moldova, Lithuania, Kyrgyzstan, Uzbekistan, and Tajikistan have moderate representation, each falling within the range of 5–10%. Azerbaijan and Belarus have the smallest share of respondents accounting for 3.4% and 1.5% respectively.

The data on the country of residence is slightly different from the country of origin. The majority of respondents live in Russia (13.2%), reflecting the highest concentration among these countries. It is followed by Georgia (10.2%) and Estonia (10.1%). Latvia accounts for 9.9%. Ukraine, Armenia, and Moldova represent 7.8%, 7.4%, and 6.9% of respondents, respectively.

Lithuania (6.5%), Kyrgyzstan (6.3%), and Kazakhstan (6.3%). Uzbekistan (5.6%) and Tajikistan (5.5%) showed moderate representation. Azerbaijan (3.1%) and Belarus (1.4%) have the lowest proportions in the sample.



The dataset covers a wide range of gender identities. The largest share of respondents identify as cisgender men (28%), followed by cisgender women (27%). 16% of respondents identify as non-binary, 10% - as transgender men and 9% as transgender women. 6% chose the option “I prefer not to answer” and 5% identified themselves in the category “Other”, which covers gender identities not listed among the predefined options.

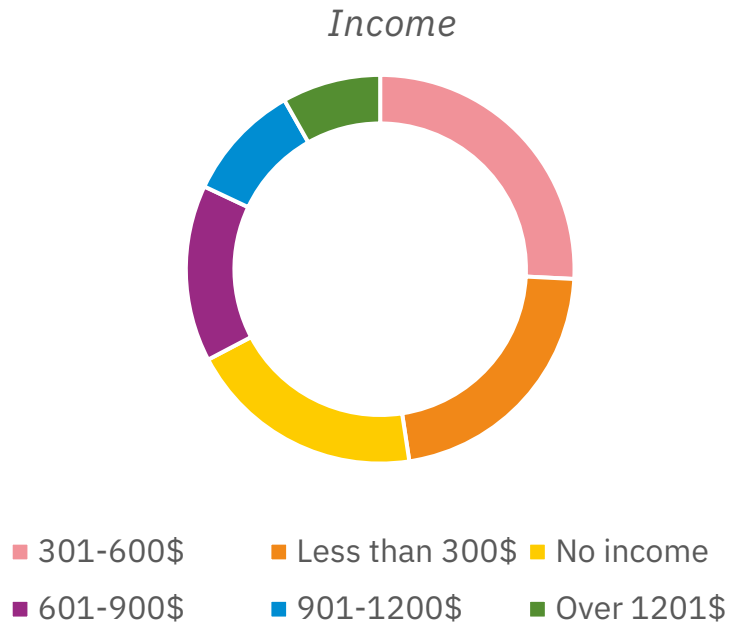
In terms of sexual orientation, the largest percentage of respondents identified as gay (30%) and bisexual (26%). They were followed by pansexual (16%), lesbian (10%), and asexual (6%) respondents. Participants who preferred not to disclose their sexual orientation in the survey accounted for 6%. The remaining 6% of the respondents were classified as "Other".

Only 9% of respondents live in rural regions in contrast to 91% who live in cities. Considering that the sample is primarily urban, it could impose some constraints on accurately representing the experiences of LGBTQI+ youth in rural areas. Consequently, such distribution could influence how the results are interpreted as a whole. The findings may not accurately represent the challenges, availability of healthcare services, and social dynamics that LGBTQI+ youth face in rural areas.

The largest percentage of respondents falls into such income categories: "$301–$600/month" (25.8%), "Less than $300/month" (21.8%), and "No income" (19.7%).

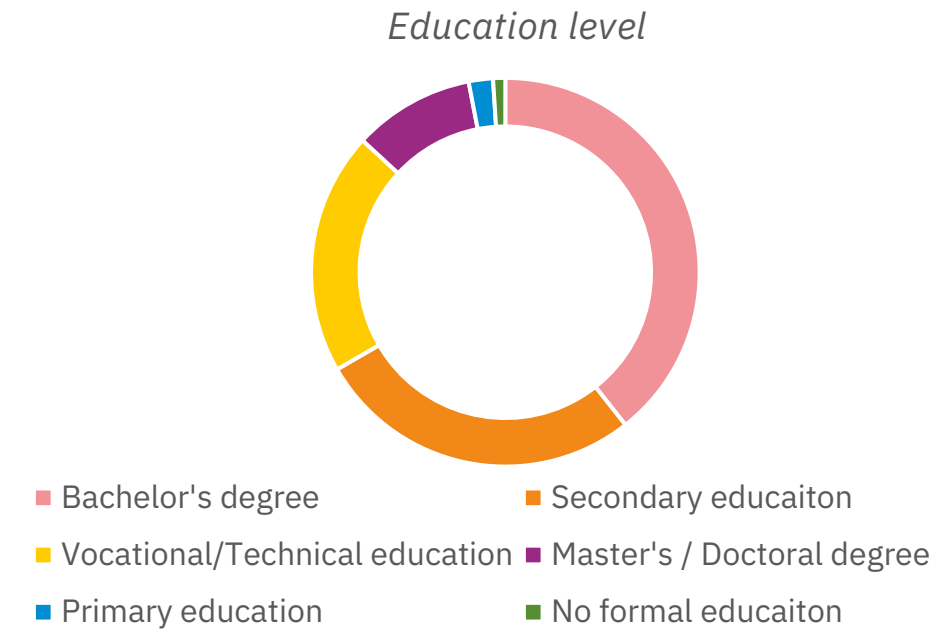
In the middle-income group, 14.7% of interviewees reported earning at the level of $601-$900 /month. 9.8% fell into the "$901-$1200 /month" range. The highest income group, “Over $1201 /month" is represented by the smallest share of

respondents (8.2%), which indicates a limited representation of high-income participants in the sample. This distribution demonstrates a bias toward lower income levels, with the share of respondents decreasing as income increases.



The largest share of respondents (39%) has a higher education (bachelor's degree). They are followed by 27% of respondents who have completed secondary education. The next most common education is vocational or technical education, which was completed by 20% of respondents. Those who have earned a master's or doctoral degree account for less of the sample (10%), suggesting that there is a comparatively small number of individuals with higher education. The remaining groups - primary

education (2%) and no formal education (1%) - account for a minor portion of the population. This preference for more education could make it more difficult to analyze the requirements and difficulties faced by people with less education.



This section presents the findings of the study on the accessibility, quality, and inclusiveness of sexuality education and sexual health services for LGBTQI+ youth in Eastern Europe and Central Asia. In addition, the study analyzes the impact of legal and social barriers, including discriminatory policies and healthcare restrictions that limit the sexual and reproductive health rights of LGBTQI+ people. The study also explores experiences of stigma

and discrimination from healthcare providers and reveals that many respondents suffer from stigmatization, denial and lack of inclusive services.

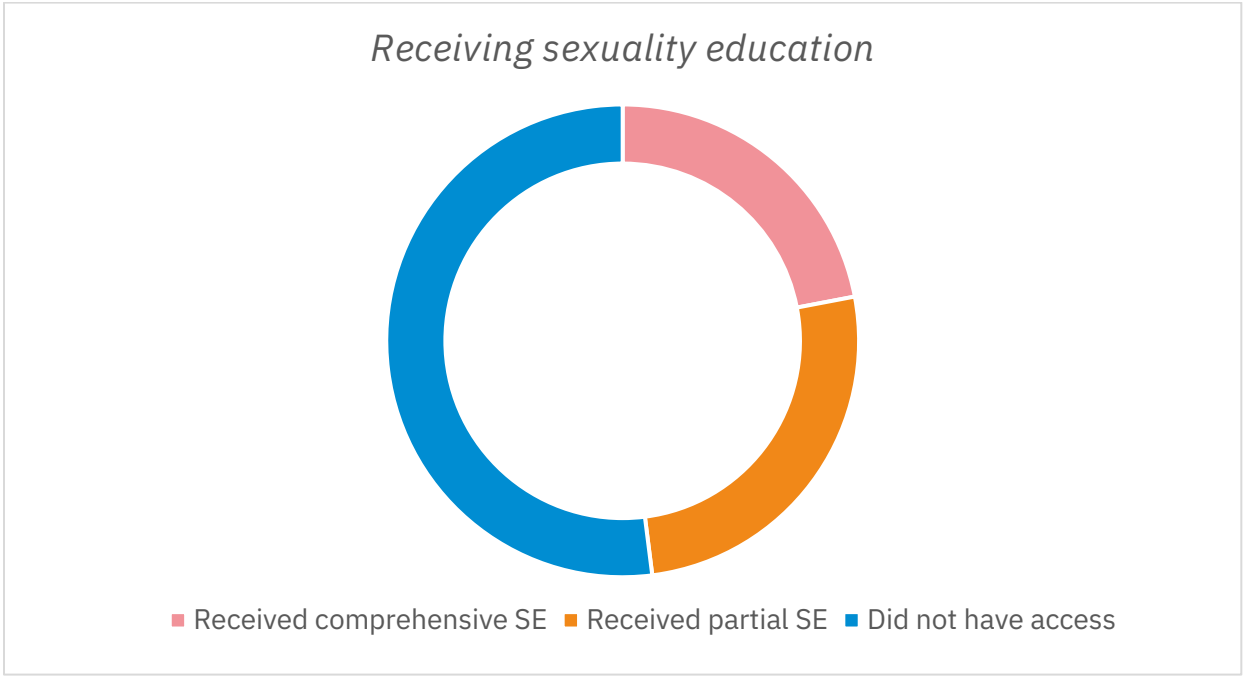
According to statistical assessments, it outlined significant disparities in sexuality education, access to sexual health resources, and health care. Across all aspects examined, including availability and access to education and healthcare services, legal and social barriers, and experiences of discrimination, country of residence was found to be a consistently significant factor that reflects differences in policies, health infrastructure, and social attitudes country-by-country. Other predictor factors such as urban-rural area, gender identity, sexual orientation, income, and educational level showed statistical significance only in some aspects.

Outlines the composite Inclusivity Index, which reflects the general level of inclusive health policies by each country of residence. The methodology for calculating the index is presented in Section 1.1. According to the index results, the highest levels of inclusivity in health policies are in Ukraine, Georgia, Armenia,

Kyrgyzstan, and Estonia, while the lowest levels are observed in Lithuania, Russia, Tajikistan, Uzbekistan, and Kazakhstan.

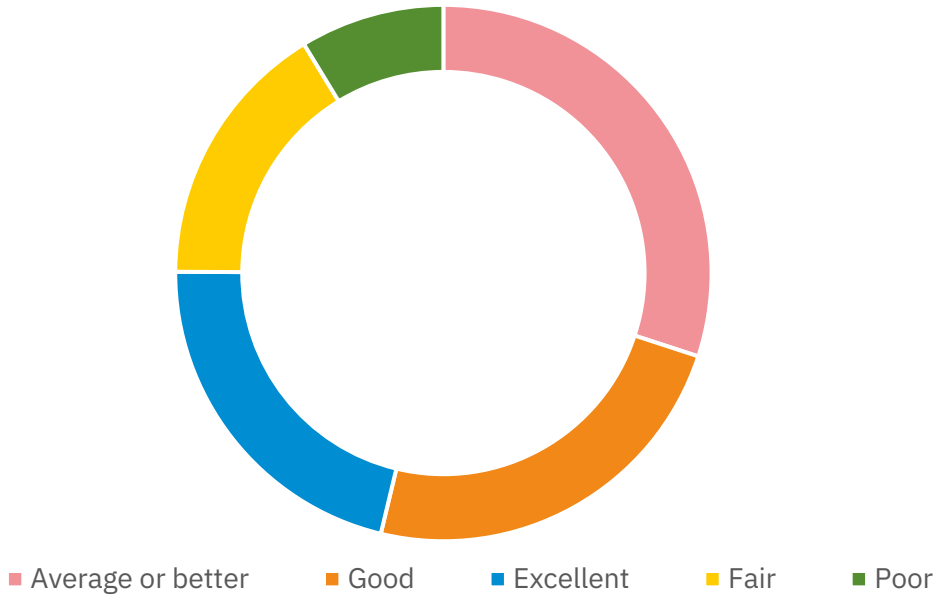
2.1. Access to Information and Education

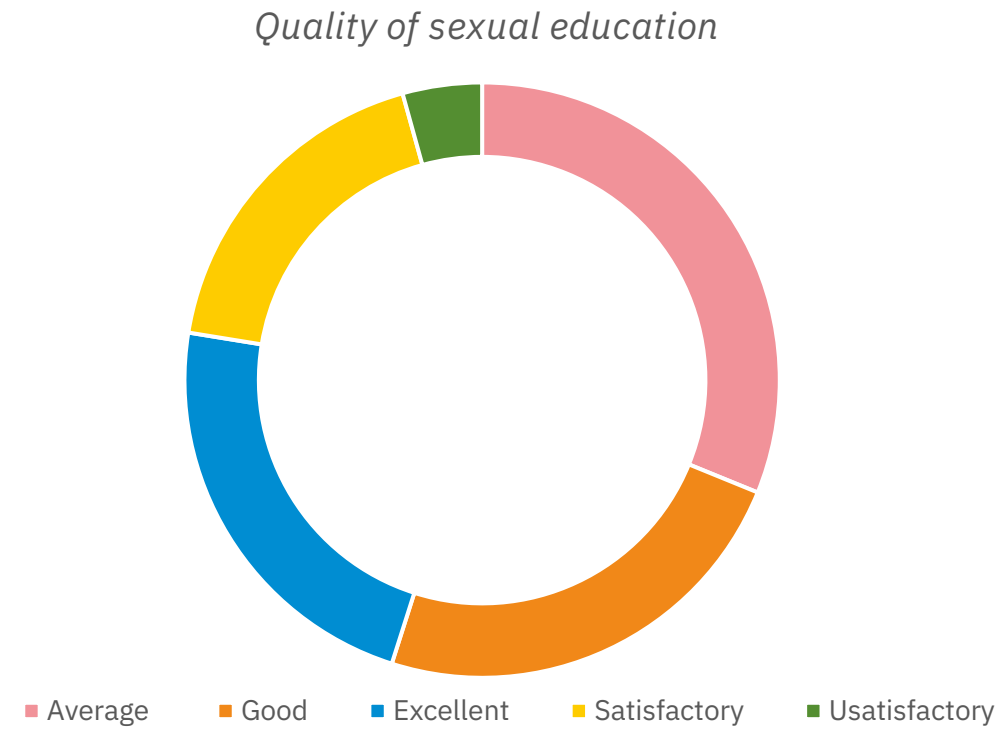
An analysis of data on the provision and coverage of sexuality education among LGBTQI+ youth in Eastern Europe and Central Asia revealed significant discrepancies. Only 22% of respondents reported receiving comprehensive sexuality education, 26% received partial education, and 52% did not have access to such education at all.



Despite these limitations, the overall access to sexual health information relevant to LGBTQI+ youth was assessed by the majority of respondents as “average” or better, with 30% rating it as “average”, 23.7% as “good”, and 21.3% as “excellent”. In contrast, 16.2% rated their access as “fair,” and 8.7% as “poor.” Similarly, when assessing the quality of sexual education received, 31.1% described it as “average,” 24% as “good,” and 22.6% as “excellent.” However, dissatisfaction remained notable, with 18.1% rating it as “satisfactory” and 4.3% as “unsatisfactory.”

Accessibility to sexual health information





Further analysis of omitted topics in sexuality education indicates a systemic deficit, as all proposed topics received similar percentages (10%-12.3%). This pattern suggests that the current curricula do not cover a wide range of necessary aspects, including legal issues, LGBTQI+-friendly services, safe sex, mental health, family planning, and overcoming discrimination.

Further statistical analysis shows that the reception of sexuality education among LGBTQI+ youth differs significantly depending on gender identity ($p = 0.047$), urban or rural area ($p = 0.015$), and level of education ($p = 0.035$), as confirmed by the results of

analysis of variance (ANOVA). At the same time, factors such as age, income, and sexual orientation did not demonstrate a statistically significant impact in this context. Respondents from countries such as Kyrgyzstan, Ukraine, and Georgia reported higher levels of comprehensive or partial sexuality education, while Lithuania, Azerbaijan, Belarus, Russia, Moldova, Latvia, Kazakhstan, and Uzbekistan mostly reported no sexuality education. In addition, respondents living in urban areas were more likely to have received comprehensive education, while in rural areas, partial or complete lack of education was more common. In general, the level of comprehensive or partial sexuality education increased with the level of education, except for respondents who had completed only primary school, as they had the highest level of such education.

Regarding access to sexual health information relevant to LGBTQI+ youth, Sexual orientation was also a statistically significant factor ($p = 0.007$), indicating differences in access depending on the sexual orientation of respondents. Gender identity was close to statistical significance ($p = 0.089$), which may indicate its potential impact, which requires further research. The highest percentage of respondents who rated access to

information as “fair” or “poor” was observed in Armenia, Belarus, Kyrgyzstan, Moldova, and Azerbaijan. At the same time, factors such as age, urban or rural residence, income, and education level did not have a statistically significant impact on access to sexual health information.

One of the key obstacles in accessing such information is its limited availability and reliance on informal networks rather than publicly accessible sources. As a participant of Latvian FGD responded, “A major issue is the lack of accessible information. Thanks to the people in the national trans NGO chat and to _ (board member of this NGO), who compiled and edited the Google spreadsheet with trans-friendly doctors, we have some resources. But it’s really inconvenient that you can’t just search for this information online; instead, it’s shared by word of mouth. I can’t even imagine where an LGBT-friendly marker could be established. In the field of psychology and psychotherapy, there are local directories with descriptions, but it seems like no one has updated or checked these listings in years.” This highlights the ongoing challenge of accessing reliable and up-to-date information, underscoring the need for publicly available and regularly updated LGBTQI+ inclusive sexual health resources. In

the absence of institutional support, many turn to social media or informal networks to fill the gap. However, this reliance on unverified sources presents another challenge. As another respondent from Moldova noted,

> "The biggest problem is the lack of a centralized source of information. People rely on social media, but the information is often inaccurate or outdated."

Without reliable, centralized resources, misinformation can spread and consequently it can leave young people with incomplete or misleading knowledge about their sexual health.

The highest percentage of respondents who rated the quality of sexuality education as "poor" or "fair" was observed in Latvia, Estonia, Lithuania, Tajikistan, and Uzbekistan. In contrast to the reception of sexuality education and access to sexual health information, age ($p = 0.023$) and urban or rural area ($p = 0.021$) were significant predictors in determining the quality of sexuality education. Older respondents reported lower ratings for sexuality education quality, which may reflect growing expectations for its content over time. In rural areas, the share of respondents who

rated the quality of education as “poor” or “fair” was about twice as high as in urban areas. These findings suggest that perceptions of sexuality education quality vary by demographic factors, with younger respondents and urban residents reporting more positive experiences than older and rural participants.

In the results of the focus group discussion (FGD), participants widely indicated the big disparities in the access to sexual education that is consistent with the survey indicators that only 22% of the respondents received comprehensive sexual education. Respondents from multiple countries expressed frustration in regards to the lack of LGBTQI+ inclusive content in the school programs. A focus group participant from Latvia shared their experience,

“I want to touch on an aspect beyond simply making information accessible through aggregators like Google. There’s also a critical need for education and awareness in schools—for pupils, teachers, and parents. And there’s a massive problem here: on paper, it all seems to be in place. I spoke with the Minister of Culture, and they assured me that everything is included in the curriculum, everything’s great, we’re in Europe. But here I am, and in 12 years of school, I only heard the word “gay” once—and that

was when my teacher was using it as an insult. Sexual education and awareness? We never heard a word about it, because it's suppressed—mainly by parents."

This account highlights the disconnect between formal sexuality education policies and lived experiences, where school culture and societal attitudes often override official regulations in shaping access to information

The findings of this analysis highlight the urgent need to improve sexuality education for LGBTQI+ youth, especially in rural areas where access and quality remain inadequately lower. Education campaigns should focus on raising awareness of what constitutes quality sexuality education, with a particular focus on the younger generation.

2.2. HIV Prevention and Care

In addition to sexuality education, ensuring access to HIV prevention and care services remains a significant challenge for LGBTQI+ youth. The survey showed that 53% of respondents

were aware of services that offer HIV prevention specifically targeting LGBTQI+ youth. Most respondents reported feeling 'good' or better about accessing these services, while 9.1% rated their experience as 'fair' and 11% as 'poor'. A major challenge lies in the lack of specialized training among healthcare providers, which often leads to misinformation and inadequate support for LGBTQI+ youth. Large institutions often fail to address the unique needs of LGBTQI+ youth, leading to misinformation or inadequate support. A focus group participant from Ukraine shared their experience:

> “These problems are also caused by the fact that large institutions do not have specialized knowledge or experience in working with LGBTQI+ youth. When I was still working as a social worker and testing people, we also worked with hospitals. I came and tested people in hospitals. And one young man told how he turned to a doctor for advice on HIV prevention, and the doctor advised him "just not to engage in sexual relations."

It's more of a hindrance than a knife.” This testimony underscores a critical gap in healthcare services: while awareness and comfort

levels in accessing HIV prevention may seem relatively high, the quality of information and support provided by medical professionals remains inconsistent. Awareness of HIV prevention services was highest in Armenia, Kyrgyzstan, and Georgia, while the lowest levels were reported in Lithuania, Russia, Uzbekistan, Estonia, and Latvia. Additionally, LGBTQI+ respondents in Kyrgyzstan, Belarus, Azerbaijan, Kazakhstan, and Russia were most likely to rate their access to services as 'poor' or 'fair'.

Whether an area was urban or rural was a statistically significant factor in awareness. Respondents from rural areas were significantly less aware of these services compared to those living in urban centers. A participant of FGD in Kyrgyzstan notes,

"As a client, someone who has accessed various healthcare services in different areas, I've never faced any issues. Whenever I needed services, I received them without any problems. Perhaps this is more common in major cities. I'm not sure how widespread this is in rural regions, but, for example, I currently work in Issyk-Kul, far from urban centers. However, I manage to travel once a month to get the services I need and then return. So, to be honest, I don't see significant issues—at least not in my experience. There

are queer-friendly doctors, albeit few in number, but the queer community isn't overwhelmingly large either. We can visit them and get the help we need. That's my perspective."

However, despite these personal experiences, rural-urban disparities in awareness did not significantly affect overall comfort levels in accessing healthcare. Therefore, it is crucial to mention that limited awareness of available services, combined with logistical and financial constraints, often prevents individuals from seeking the care they need. Even though queer-friendly doctors exist, their small numbers and concentration in urban centers create accessibility challenges.

Age and income level significantly influenced individuals' comfort in accessing HIV prevention and care services. The percentage of participants who rated comfortable access to HIV prevention and care services as 'average' or higher gradually increased from ages 18–19 to 22–23 before declining in the 26–28 age range. Higher income was generally associated with greater comfort in accessing services, except among those earning over $1,200 per month, who reported the lowest satisfaction. This finding

highlights a research limitation, indicating the need for further studies to explore underlying factors influencing these patterns.

The study revealed that 60% of participants were knowledgeable about PrEP (pre-exposure prophylaxis) as a method to prevent HIV, while 40% lacked information. PrEP awareness was highest in Kyrgyzstan, Armenia, and Russia. In contrast, over 50% of participants in Lithuania, Azerbaijan, Kazakhstan, and Latvia were unaware of PrEP. For some, obtaining PrEP and other preventive measures is straightforward, especially in settings where medical professionals are well-trained and provide a sense of comfort to patients. As a participant from Kyrgyzstan noted,

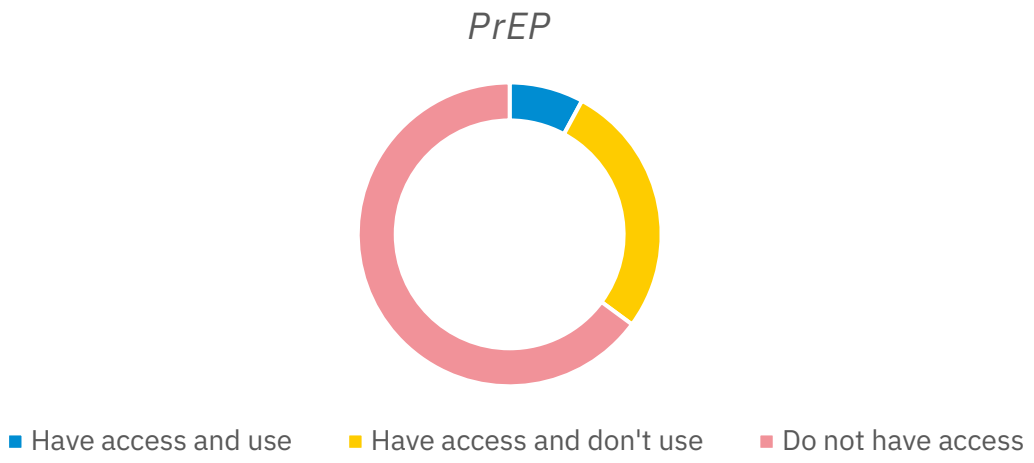
"I understand the general mindset of those seeking services—there are people who avoid any contact with organizations and instead look for alternative routes, like obtaining PrEP or self-testing kits from acquaintances who somehow have access to them. However, in practice, I haven't encountered any issues. Doctors act professionally, make patients feel at ease, explain everything clearly."

This suggests that while informal networks are sometimes preferred, professional healthcare environments can still offer positive experiences for those who seek them.

Conversely, structural barriers in other countries limit access despite high awareness.

Statistical analysis indicated that awareness levels were significantly influenced by age, sexual orientation, and whether individuals lived in urban or rural settings ($p < 0.01$). Awareness was higher among older respondents and in urban areas, while more than 50% of rural respondents were unaware of PrEP.

Although most respondents were aware of PrEP, only 7.9% reported having access to and using it, while another 27.2% had access but did not use it.



Statistically significant factors that influenced accessibility were age, urban-rural area, and level of education. Income level was not a significant factor for either awareness of or accessibility to PrEP. PrEP availability and usage were higher among older respondents, although this trend was also observed among those who had access but chose not to use it. PrEP was most accessible in Kyrgyzstan, Georgia, and Armenia, whereas the highest unmet demand was reported in Uzbekistan, Tajikistan, and Russia, where many respondents wished to use PrEP but could not access it. In Russia, financial barriers rather than lack of awareness were the primary obstacles to PrEP access. As one participant explained in the FGD conducted in Russia,

> “There’s a general issue with access to PrEP in Russia. Everyone understands what PrEP is, so I won’t elaborate. PrEP is theoretically available for personal purchase at pharmacies without a prescription, but it’s costly—around 200-300 euros per month.”

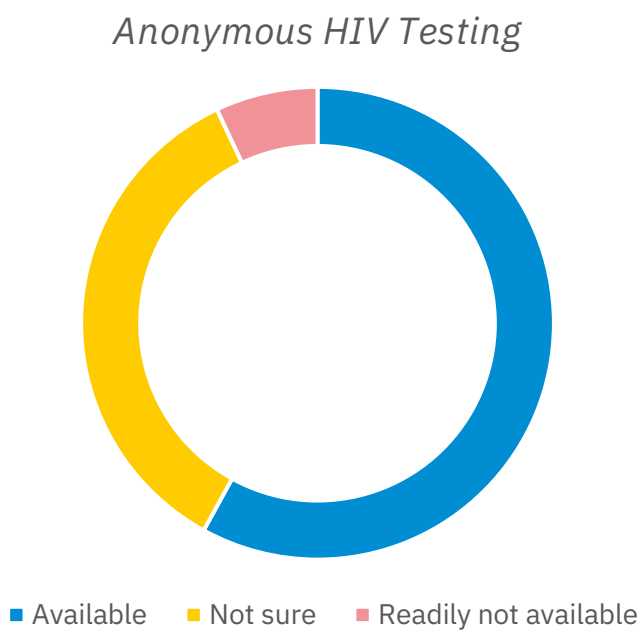
Another respondent from Estonia highlighted the financial state as a barrier for frequent usage of PrEP, “PrEP is kind of a problem.

You get a 50% discount, so usually it costs around 50 euros, but if you get a prescription you're gonna get it for 25. It would be of course better if it was completely free, then people would use it more. And especially, It's kind of a problem that when people are young they probably need PrEP more, but since it's not free, they usually don't have money. So in the end they skip it.”

This highlights a major accessibility barrier, as affordability limits its widespread use despite general awareness about the PrEP. Participants from urban areas reported better access to PrEP, yet the rate of usage among both urban and rural respondents remained nearly the same. Rural respondents, however, were more likely to report a lack of availability while expressing a willingness to use it. These disparities suggest that while structural factors such as location and education influence access, financial limitations—especially in countries like Russia—continue to restrict the widespread adoption of PrEP as an HIV prevention tool.

Educational differences were found. Respondents without formal education most often reported that PrEP was not available and they were not interested. At the same time, graduates of vocational schools were the largest group that expressed willingness to use PrEP if it was available. Respondents with primary education and those with higher education often reported having PrEP but not using it.

The study found that anonymous HIV testing was available to 58% of survey participants, 35% were not sure about its availability, and for 7% of the respondents it was readily not available.



The greatest availability rates were observed in Kyrgyzstan, Uzbekistan, and Belarus. The lowest rates were reported in

Tajikistan, Georgia, and Moldova. According to statistical analysis, age, sexual orientation, and whether one lived in an urban or rural area were significant factors affecting the availability of anonymous HIV testing. Respondents from older age groups tended to experience greater access to such services. Individuals living in urban areas reported a higher level of access to anonymous testing than those from rural areas.

Regarding confidentiality practices in HIV care, the majority of respondents rated the services as “average” or better, with 34.7% giving an “excellent” rating. Geographically, the best scores were recorded in Ukraine, Uzbekistan, and Georgia, while respondents from Azerbaijan, Kyrgyzstan, and Russia were more likely to rate the level of privacy as “poor” or “fair”. However, experiences with confidentiality varied significantly, with some individuals reporting breaches of privacy despite assurances of anonymity.

A participant from Armenia highlighted concerns about confidentiality violations, particularly during HIV testing:

“The main problems arose because of confidentiality because people always came for testing, and then imposed some kind of monitoring. During the monitoring, they came from the ministry,

from NCID (National Center for Infectious Diseases), from NGOs—some kind of monitoring—bringing people, etc., etc. That was the main problem, which has always been and still is. We are told that the tests are confidential and anonymous, but these people are brought to sit down and asked questions with five people: who have you been with, how many times have you been with, have you been with a boy, have you used a condom, etc., etc."

This illustrates a fundamental contradiction in confidentiality policies—while tests are officially claimed to be anonymous, intrusive questioning and external oversight can compromise privacy.

In contrast, some organizations successfully uphold confidentiality standards. A participant from Moldova shared a different perspective: "Regarding testing, in our organization, for example, everything is done anonymously and confidentially, but this is much rarer in medical institutions, where there is no established mechanism. Thus, some institutions respect this, while others do not." This suggests that while confidentiality measures exist in certain settings, their implementation remains inconsistent, with some institutions lacking clear privacy

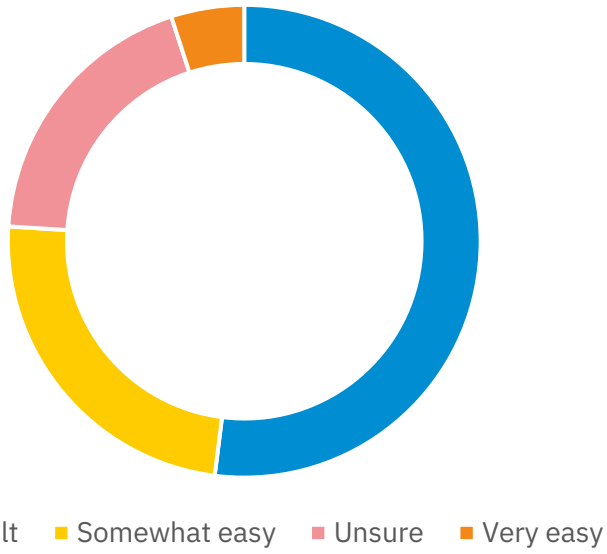
protections. The statistical analysis showed that age had a significant impact on the perception of confidentiality. Participants aged 24-25, 26-28, and 22-23 gave the highest privacy ratings, while the group of 20-21-year-olds had the highest number of respondents who rated privacy as “fair” or “poor”.

In the results there should be more efforts to increase awareness of HIV services and PrEP they should be focused primarily on rural populations, where awareness remains significantly lower. Expanding PrEP availability and encouraging its use requires targeted interventions, especially among young people and those with lower levels of education, who demonstrate lower awareness and frequency of use. In addition, the comfort of accessing HIV prevention services should be improved among people with lower incomes, who have higher levels of dissatisfaction. The findings of this research highlight the need to increase PrEP use in urban areas, where accessibility is relatively higher but uptake remains low, and among lower-income respondents who may face barriers beyond accessibility.

2.3. Sexual and Reproductive Health Services Experience

LGBTQI+ youth face significant accessibility constraints in broader sexual and reproductive health services. A majority (52%) of respondents found access to gender-affirming care difficult. Around 24% reported access as 'Somewhat easy,' while 19% were unsure. Only 5% of participants answered that access was ‘Very easy’ for them.

Access to gender-affirming care



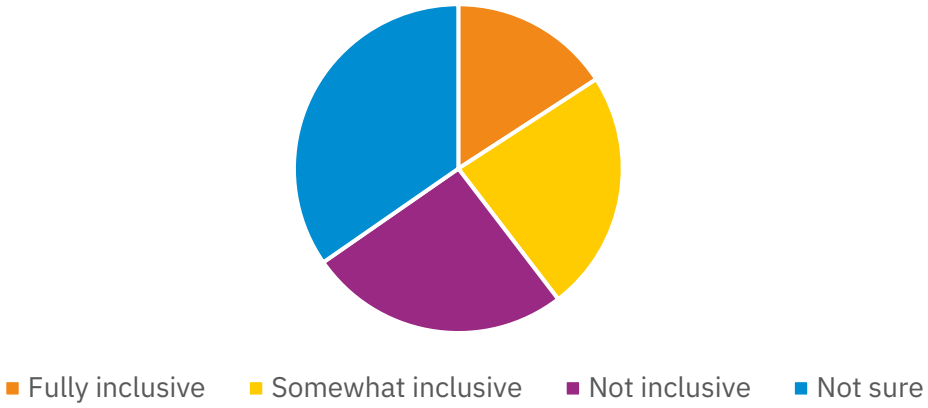
The highest percentage of respondents reporting "Not easy" access was found in Estonia, Russia, Lithuania, Azerbaijan, and Moldova. Level of education, urban-rural area, and sexual orientation were statistically significant factors affecting

accessibility rate. Although the percentage of respondents reporting “Very easy” access was similar in urban and rural areas, “Somewhat easy” access was more common for urban areas, while “Not easy” access was more widespread in rural areas. Interestingly, the level of accessibility (“Very easy”) decreased with the level of education. The highest percentage of “Not easy” responses was observed among those who had completed only primary school. Although this rate decreased slightly with the education level increasing, it remained significantly higher than for those with only primary education or no formal education. This unexpected observation requires further investigation of possible factors influencing the level of accessibility, such as differences in expectations and awareness of available services across different education levels.

The inclusivity and respectfulness of sexual and reproductive health services toward respondents' gender identity was also assessed. Only 16% of participants reported that SRH services were fully inclusive, while 24% found them as “Somewhat” inclusive. At the same time, 26% of respondents indicated that these services were not inclusive, and 35% were not sure,

indicating significant gaps in the health care system in terms of affirming diverse gender identities.

Inclusivity of health services



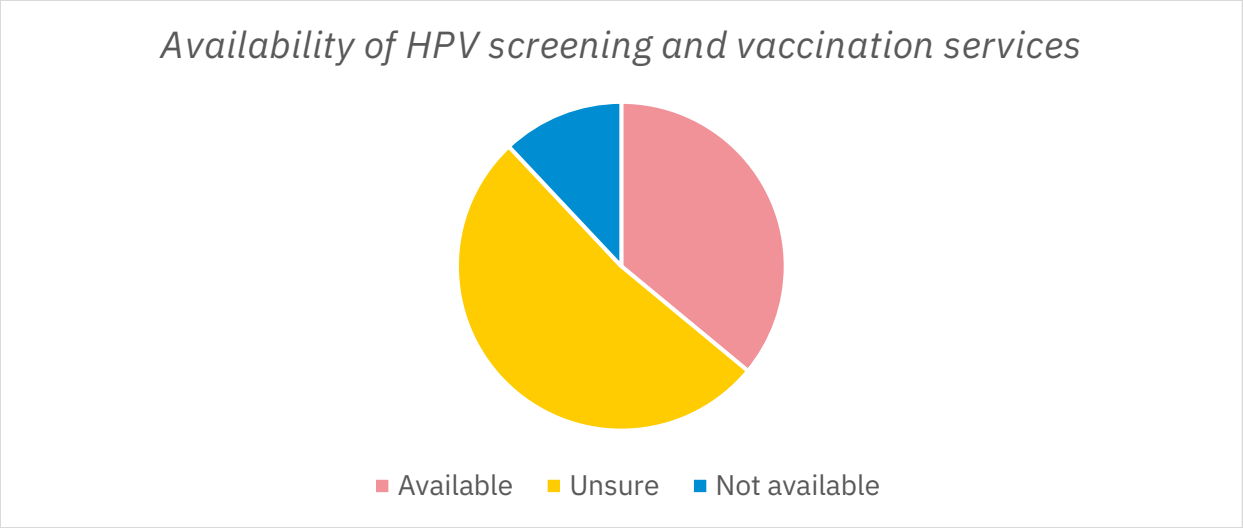
This lack of inclusivity reflects broader systemic challenges in recognizing and accommodating diverse gender identities within healthcare frameworks. As a participant from Ukraine highlighted,

"I believe that the main political obstacles are legislative support for LGBTQI+ youth who want to receive sexual health services. Very often, LGBTQI+ funds are simply forgotten during the development of medical protocols, and this creates the feeling that they are 'unknown' to the healthcare system."

This statement underscores how the exclusion of LGBTQI+ individuals from policy and medical guidelines further

marginalizes them, reinforcing the need for intentional, inclusive reforms in healthcare services. This issue is particularly observed in countries such as Russia, Belarus, Estonia, Uzbekistan and Tajikistan, where respondents reported the lowest level of inclusivity and respect in SRH services. Further analysis revealed that age, gender identity, and urban or rural residence were statistically significant factors that influence perceptions of inclusive SRH services. Inclusiveness and respect for gender identity tended to improve with age. People who identified themselves as transgender men, transgender women and non-binary people were more likely to report less inclusive and less respectful attitudes in health care facilities compared to cisgender respondents. Respondents living in rural areas reported lower levels of inclusiveness and respect in SRH services compared to those living in urban areas.

Although 12% of respondents reported that HPV screening and vaccination services were not available to them, as opposed to 36% who confirmed their availability, the majority-52%-were unsure about the availability of these services in their region.



The highest percentage of respondents who reported the absence of such services was recorded in Uzbekistan, Armenia, Azerbaijan, Kyrgyzstan, and Georgia. At the same time, the highest level of uncertainty about the availability of HPV screening and vaccination services was observed in Uzbekistan, Latvia, Tajikistan, Lithuania, and Moldova. This widespread uncertainty suggests a significant gap in public awareness and education regarding HPV prevention. As one respondent of FGD highlighted,

"Yes, no one talks about this. The information exists, but there is a severe lack of education in this field. If you really need it, yes, you can find this information on the internet, but there have been no campaigns on this topic. I only recently learned about this

myself, and when I talked to other girls in the community, I found out that no one knew about this vaccine."

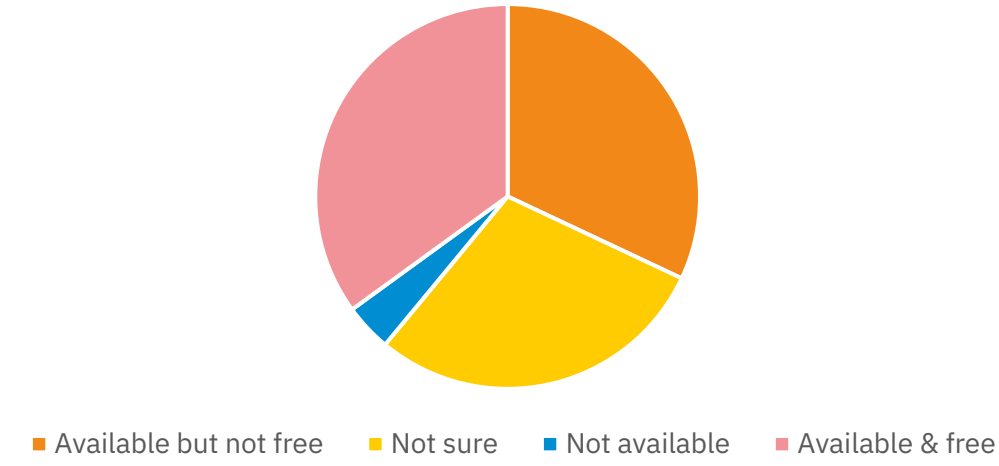
This statement emphasizes the necessity of proactive public health measures to enhance outreach and guarantee that all communities have access to information regarding HPV screening and vaccination.

The results indicate that the absence of organized awareness campaigns and education on HPV prevention is a significant obstacle, in addition to the availability of services. In order to ensure that people can make educated decisions regarding their sexual and reproductive health, this issue necessitates focused public education campaigns, especially in areas where ambiguity is still strong.

Statistical analysis showed that urban versus rural area and gender identity had a significant impact on these differences. A higher percentage of respondents in urban areas reported the availability of HPV screening and vaccination services compared to respondents in rural areas.

Awareness of the availability of free testing for sexually transmitted infections (STIs) was higher than that of HPV screening and vaccination. 29% of respondents were not sure about its availability, 4% reported that free STI testing was not available in their region, while 32% said that testing was available but not free, and 35% confirmed that free testing was possible.

Availability of testing for STI



The highest percentage of respondents who reported a complete lack of STI testing was recorded in Azerbaijan, Tajikistan, Georgia, Uzbekistan, and Latvia. The highest level of uncertainty about the availability of such services was observed in Azerbaijan, Lithuania, Estonia, Latvia, and Moldova. At the same time, the highest proportion of respondents who said that STI testing was available

but not free of charge was in Belarus, Ukraine, Kyrgyzstan, Kazakhstan, and Uzbekistan.

Statistical analysis shows that urban or rural residence has a significant impact on the level of awareness of the availability of STI testing. Approximately equal percentages of respondents in urban and rural areas knew that testing was available, but not free of charge. However, in urban areas, a higher percentage of respondents reported that free testing was available, while in rural areas there was more uncertainty about its availability. 57% of respondents took a test for sexually transmitted infections (STIs) in the past year. The lowest percentage of interviewees was in Lithuania, Estonia, Latvia, Kazakhstan, and Russia. Age group, urban or rural area, and income level showed a significant influence on the likelihood of having been tested for STIs in the past year. Particularly, the level of STI testing increases with age and income. In addition, respondents living in rural areas were less likely to be tested.

Most respondents rated their experience with health care services for STI treatment as average or above. 25% of participants rated their experience as “fair” or “poor”. The highest percentage of such respondents were residents of such countries as Kyrgyzstan,

Kazakhstan, Russia, Azerbaijan, and Moldova. In addition to accessibility challenges, many LGBTQI+ individuals face further barriers due to assumptions made by healthcare professionals. As a participant from Estonia explained,

“I'm sure there are also some sort of Facebook communities that keep track of these doctors that you can be comfortable with, but there are, at the same time, people who just don’t understand. As you said, older generations, for instance. For example, my boyfriend went to a hospital for an STI check-up or PrEP. They by default think of you as a heterosexual. And that makes things a bit more complicated. You have to come out to them.”

This highlights how heteronormative assumptions within healthcare settings can create discomfort and additional emotional burdens for LGBTQI+ individuals seeking STI-related care. Beyond issues of inclusivity, financial barriers also prevent many from accessing STI testing and treatment. A participant from Kazakhstan noted,

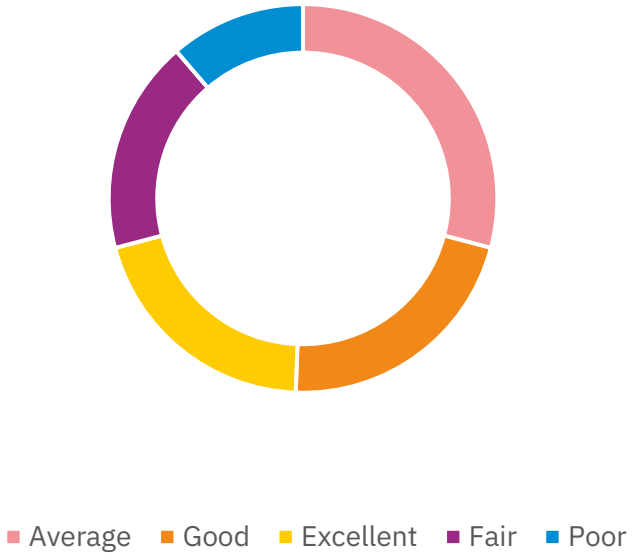
“But, for example, for STI or for STD, as it is called, it is very expensive, inaccessible. I don’t know about you guys, but to pay 30-40 thousand for 5-6 tests each time, you have to...”

This testimony emphasizes how expensive STI screening is, rendering it an unaffordable service for many, especially in nations where insurance does not cover or subsidize healthcare costs. Together, these issues that are ranging from the assumption of healthcare workers to budgetary limits—illustrate the systemic barriers that continue to impede STI testing and treatment among LGBTQI+ people. To solve such issues, along with more cost-efficient and mass test services, more inclusive and bias-free health environments are necessary.

The perceived inclusiveness and respectful treatment of gender identity by healthcare professionals showed a positive correlation with age, with older respondents reporting more favorable experiences. However, transgender men and women, and non-binary people were more likely to report less inclusive and less respectful treatment. Respondents from rural areas were more likely to experience less inclusive and less respectful attitudes in

health care. Respondents also assessed the accessibility of different contraceptive methods and related counseling. 29.1% characterized access as “average,” 21.5% and 20.3% rated it as “good” and “excellent” respectively. 17.8% of participants rated access to such services as “fair” and 11.3% as “poor”.

Accessibility of contraceptive methods



The lowest quality of accessibility, rated as "poor" or "fair" was recorded in Russia, Kyrgyzstan, Kazakhstan, Azerbaijan, and Latvia. One common barrier to access is the requirement for medical consultations before obtaining contraception. As a participant from Estonia noted, “Birth control pills and other hormonal contraceptives that you can only get through going to a gynecologist.” This adds an extra layer of difficulty for those

seeking contraceptive options, particularly for individuals who may face stigma or financial constraints when accessing gynecological services.

In Russia, accessibility issues have been exacerbated by external factors such as the war and economic instability. A participant explained,

> “We work on strategic litigation, advising on these cases and redirecting them to migration pathways when necessary. This situation exists alongside shortages of contraception and reproductive healthcare in pharmacies, which began with the onset of the war. These shortages allow commercial pharmacies to inflate prices unlawfully, making contraception even less accessible.”

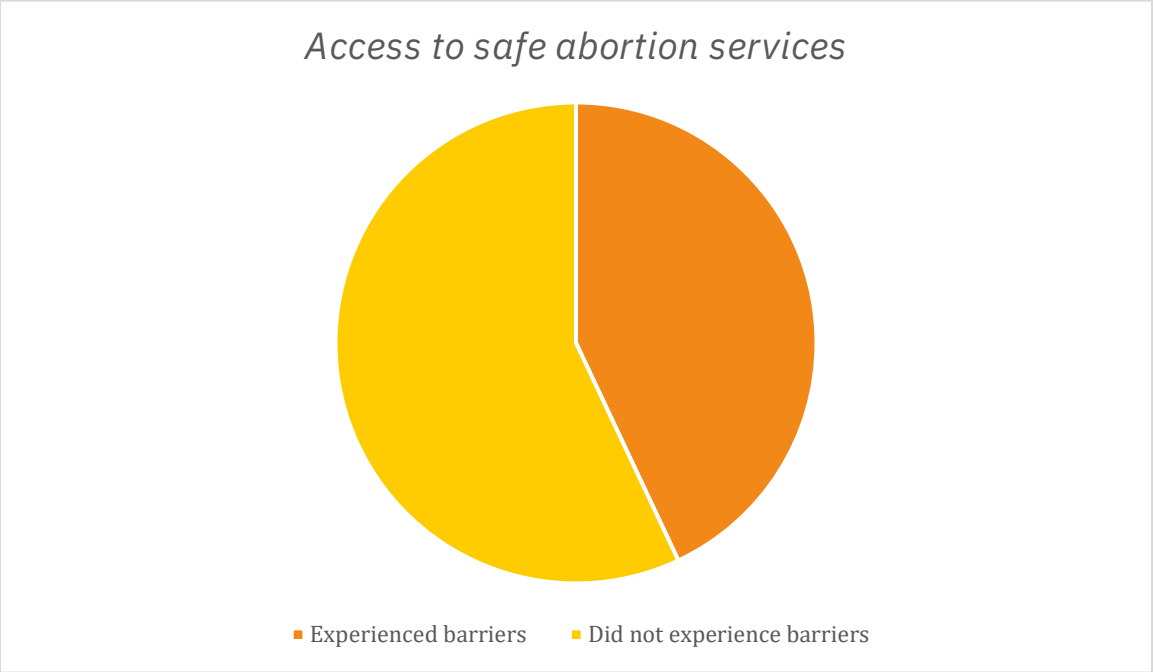
Geopolitical issues can further limit access to reproductive healthcare, disproportionately affecting vulnerable groups, as this evidence demonstrates. On the other hand, some respondents noted advances in access to contraceptives when compared to ten years ago, despite persistent obstacles. A participant from

Kyrgyzstan reflected, “It seems to me that changes... I don’t know if you can call it a change, but I think that ten years ago, it was definitely not possible to get so many services, directions, like contraceptives and HIV tests.” While access remains limited in many regions, this perspective suggests gradual progress in expanding reproductive health services over time.

Together, these findings demonstrate how hard it is to get contraception in many countries. Despite the fact that access to reproductive healthcare may be improving in some areas, persistent barriers such as economic instability, geographic disparity, and medical gatekeeping continue to make it challenging for everyone to have equitable access. Accessibility, affordability, and public awareness must be given top priority in policy interventions to address these problems and ensure that everyone can make informed decisions about their reproductive health.

When asked about barriers to accessing safe abortion services, a significant majority (80%) answered that they had never required access to such services, which limits the applicability of this question to a wider sample of respondents. Among those who

needed to access safe abortion services, 43% experienced barriers to accessing safe abortion services, and 57% said they had experienced none of them.



One of the key challenges identified was the lack of privacy and the bureaucratic hurdles associated with accessing abortion services. As a FGD participant from Estonia described,

"There was also talk about abortions. I wanted to add the fact that there are cases of violence in Armenia, and what concerns abortion, there is a big problem in Armenia. The drugs are not freely available, you have to go to the polyclinic, where they register you, they pressure you, all this is recorded in your questionnaire, mainly in the electronic database. There is no

privacy, and even now, there is a centralized ArMeds system, which one of your acquaintances or parents, especially when you are a minor, could see and cause big problems."

It states how systemic documentation practices and lack of confidentiality can deter individuals from seeking abortion care, particularly in restrictive environments. Moreover, access is also severely restricted by cultural and ideological viewpoints inside the medical industry, in addition to practical and privacy-related obstacles. A participant from Lithuania stated,

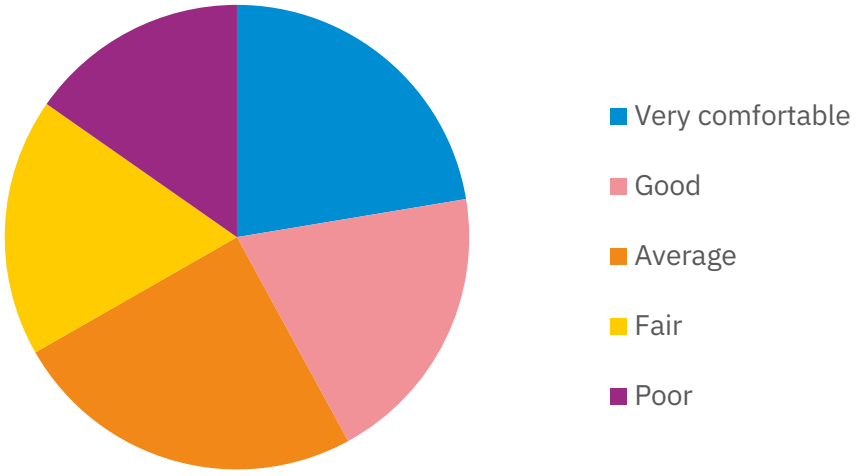
"Abortion is murder in the eyes of gynecologists."

We can see how deeply ingrained stigma surrounding abortion in some regions, where personal or religious beliefs among healthcare providers influence medical decisions and create additional barriers for those seeking reproductive healthcare. As a result, access to safe and private abortion treatment is nevertheless hindered by systemic barriers, varying from biased medical personnel to bureaucratic registration procedures, even though abortion services may be legally permitted in some areas.

Reforms that put confidentiality first, lower administrative obstacles, and guarantee that healthcare providers follow patient-centered, nonjudgmental care practices are necessary to address these issues.

Regarding the level of comfort in discussing SRHR needs with healthcare providers, 22.4% of respondents feel “very comfortable” and 19.7% reported a “good” comfort level. Another 24.7% rated their comfort as “average”. At the same time, 18% and 15.3% of respondents expressed “fair” and “poor” comfort levels, respectively.

Level of comfort in discussing SRHR needs



A higher percentage of respondents from Latvia, Lithuania, Estonia, Belarus, and Kazakhstan rated their comfort in communicating SRHR needs as “poor” or “fair”. The factor

influencing the level of comfort was the "urban/rural" area. Urban citizens were more likely to report “excellent” and “good” comfort in discussing SRHR issues compared to respondents from rural areas. In summary, the findings suggest that eliminating inequalities in access to gender-affirming health care is especially critical for those living in rural areas or with lower levels of education. However, further research is required to understand the underlying determinants of such inequalities, including the impact of social expectations, and other factors. In order to create focused interventions that guarantee inclusive and equitable healthcare services for everyone, it is also necessary to investigate how policy frameworks, public awareness initiatives, and healthcare infrastructure influence access to gender-affirming care.

In rural areas, increasing awareness and access to HPV screening, vaccination services, and STI testing remains a critical public health priority. In addition, it is important to encourage STI testing every year, with a particular focus on people in rural areas. Annual STI testing should also be promoted particularly among younger groups and populations with a low income level. Younger age

groups and low-income populations should also be encouraged to get tested for STIs annually, since they are frequently the most vulnerable yet the least likely to do so because of financial constraints, stigma, and confidentiality concerns. Public health outcomes in underprivileged communities can be improved by bridging this gap and promoting early identification and treatment through the implementation of free or subsidized testing programs and focused educational campaigns. Similarly, efforts to improve inclusivity and respectful attitudes toward gender identity among healthcare professionals should primarily focus on addressing barriers and challenges LGBTQI+ youth face in rural regions. In particular, it is essential to ensure the right of transgender and non-binary individuals to receive appropriate and affirming care that meets their SRHR needs. Ensuring the right of transgender and non-binary people to get adequate, affirming care that satisfies their SRHR needs is especially crucial. This includes having access to reproductive healthcare treatments catered to a range of gender identities, gender-affirming hormone therapy, and mental health support programs that value and acknowledge their experiences. Systemic obstacles including the lack of legal recognition for gender-diverse people, the high cost

of gender-affirming procedures, and the lack of precise medical recommendations for transgender healthcare must also be addressed by healthcare legislation. ensure that medical facilities implement inclusive policies and increasing access to specialist doctors will be essential to ensure that everyone, regardless of gender identity, receives fair and respectable healthcare.

2.4. Legal and Social Barriers

Exploration of legal and social barriers showed that 62% of respondents are aware of laws in their countries that negatively affect the access of LGBTQI+ people to sexual and reproductive health and rights (SRHR) services, while 38% are not aware of the existence of such laws. The highest percentage of respondents unaware of such laws was recorded in Estonia, Moldova, Tajikistan, Latvia, and Belarus. Statistical analysis indicates that awareness levels are significantly influenced by urban or rural residence, with urban respondents demonstrating a higher level of awareness compared to those in rural areas.

When obtaining SRHR services, LGBTQI+ people are frequently at a disadvantage due to legal constraints and institutional prejudice. The legal system occasionally limits minors' capacity to make their own healthcare decisions by upholding parental authority over them. One participant from Latvia explained these difficulties by saying,

> "We're going against the grain here, and, as they say, pissing against the wind is risky. Until age 18, only the parents are responsible for a child—no one else, not the state, just the parents. That's the law; that's how things are structured."

These legal restrictions put LGBTQI+ kids at risk of social stigma or rejection from family members by preventing them from discreetly receiving sexual health care. Access to healthcare is further hampered by privacy and medical ethics issues in addition to legislative limitations. An Armenian participant related an instance where a gay guy seeking medical attention experienced a breach of confidentiality:

“I had a gay beneficiary in the REACT project who went to the polyclinic, they took blood from him, tested and found HIV without informing him, then the local doctor called one of his family members and told him the results of the blood test, and big problems arose. That guy contacted me, he was at one of Artashat's polyclinics, I called the doctor, but it didn’t give any results. I took the phone number of the director and talked to him, but the doctor was punished and dismissed from his job according to the law.”

This episode serves as a reminder of the ongoing prejudice and ethical transgressions that many LGBTQI+ people encounter, even when they seek necessary medical care. These results highlight how urgently stronger protections and legal changes are needed to guarantee that LGBTQI+ people can use SRHR services without worrying about prejudice or confidentiality violations. Reducing these social and legal hurdles requires enforcing stringent medical privacy laws and increasing awareness, especially in rural areas.

Figure 5 shows the distribution of the main barriers identified by the respondents that LGBTQI+ youth face in their countries. Among them: discrimination related to civil and political freedoms (22%), discrimination in healthcare facilities (19.3%), low or no availability of necessary healthcare services adapted for LGBTQI+ youth (19%), and discrimination in employment (17.3%). Together these barriers account for approximately 80% of responses, with each of them making up about 20% of the total. Despite legislative protections in several countries, LGBTQI+ people continue to face discrimination in the workplace. An Estonian participant of FGD described how, in reality, anti-discrimination legislation frequently fall short of protecting people: “We have some general laws about discrimination at the workplace but if an employer decides that they don't want you to work for them, then they find the other reasons that are within the law.” This demonstrates how employers can circumvent legal protections by creating false grounds for dismissal or refusal to hire, putting LGBTQI+ people at risk of systematic exclusion from the workforce. In numerous countries, institutional and legislative frameworks actively support the marginalization of LGBTQI+ people in addition to workplace discrimination, especially when it

comes to healthcare. One Uzbek participant explained the impact of discriminatory laws on HIV-positive individuals:

"If we are talking about discriminatory legislation that is attached, then we can talk about HIV/AIDS, about AIDS centers that are obliged to transmit information about cases of HIV infection, including if SOGI is disclosed in a person who has been diagnosed with HIV infection, after which the information can be transferred to law enforcement agencies, which investigate the causes of HIV infection using various methods of pressure."

In addition to violating medical confidentiality, this practice puts LGBTQI+ people at risk of legal scrutiny and perhaps persecution, which discourages them from getting the care they need. It is possible to observe how widespread prejudice against LGBTQI+ people is in many areas of life. Enforcing employment protections, maintaining confidentiality in healthcare settings, and increasing access to LGBTQI+-inclusive medical services are all made possible by complete legal reforms. In the absence of such reforms, LGBTQI+ youth's marginalization in society would be

strengthened as institutional discrimination continues to restrict their rights and possibilities.

For 21.6% of respondents prejudice, stereotypes, and social prejudice against LGBTQI+ people is the most common reason for barriers faced by LGBTQI+ youth. Additional reasons for barriers identified include weak representative bodies (such as parliaments and local councils), poor quality of educational services at all levels (primary, secondary, and higher education), authoritarian executive bodies (including presidents, prime ministers ministries, and subordinate structures), weak civil society organizations and initiatives aimed at realizing the full potential of young people, including LGBTQI+ youth, low economic development of the country, and poor quality of healthcare services in both public and private institutions. Each of these factors accounts for approximately 10-14% of the responses. It illustrates the distribution of priority areas where national-level LGBTQI+ youth advocacy organizations could most effectively improve conditions for LGBTQI+ youth in the respondents' country, according to survey participants' perspectives. To improve the situation of LGBTQI+ youth at the

national level, respondents identified the following priority areas for advocacy organizations: protection of rights, including freedom of speech, self-expression, peaceful assembly, choice and the right to be elected (21.5%); raising public awareness of the challenges faced by LGBTQI+ people (18.4%); and legalizing a non-discriminatory procedure for changing gender identity (14.3%).

The exploration of legal and social barriers showed that targeted interventions should be aimed at raising awareness of laws affecting LGBTQI+ people's access to sexual and reproductive health and rights (SRHR) services, especially in rural areas. An important challenge is to address underlying barriers, such as discrimination in civil and political freedoms, healthcare, and employment.

To overcome these barriers, it is necessary to reduce social prejudice, prejudice and stereotypes against LGBTQI+ persons, strengthen representative bodies, improve the quality of educational services, promote democratization of governance, increase civil society participation, stimulate economic development, and improve the quality of healthcare services.

Advocacy organizations are encouraged to focus their efforts on protecting fundamental rights, raising public awareness of the challenges faced by LGBTQI+ persons, and implementing non-discriminatory gender reassignment procedures.

2.5. Experiences with Stigma and Discrimination

Analysis of the experience of discrimination and stigma of LGBTQI+ individuals within healthcare facilities reported that 55% of respondents had experienced instances of discrimination by healthcare providers based on their identity. 45% reported that they had never experienced such attitudes.

Discrimination by healthcare providers

These findings highlight a significant divide in healthcare experiences, with a substantial portion of LGBTQI+ individuals facing bias, stigma, and inadequate medical treatment. Legal advocacy and direct interaction with healthcare practitioners to encourage responsibility are two strategies for tackling these issues. One Armenian attendee underlined the importance of paralegals in the fight against discrimination:

"I work with paralegals and I can say that it is a great help, because the paralegal can communicate, get in touch, provide explanations, invite the discriminating doctor to a course, etc. Likewise, the victim can start a process without a paralegal. Health workers must understand that they are responsible for their behavior. Ordinary talking, explaining can bring great changes. If we all do that, we can make a big difference."

This implies that discriminatory attitudes can be changed and more accountability in the healthcare industry can be fostered through legislative and educational initiatives. The stigma and fear of being judged, however, continue to be significant obstacles to LGBTQI+ people seeking care in spite of these initiatives. When

seeking medical care, many young people feel pressured to conceal their gender identity or sexual orientation, according to a Moldovan participant:

> “Regarding internal stigma and discrimination, when young people go to a specialist, they often don’t talk about their sexual or gender identity due to fear of judgment or not receiving appropriate and respectful treatment.”

The fear may keep people from getting the care they require, which could result in insufficient medical care and delayed diagnoses.

In addition to overt discrimination, stigmatization in hospital settings is further reinforced by social beliefs. One Lithuanian participant brought attention to the frequent rejection or invalidation of same-sex relationships, especially those between women:

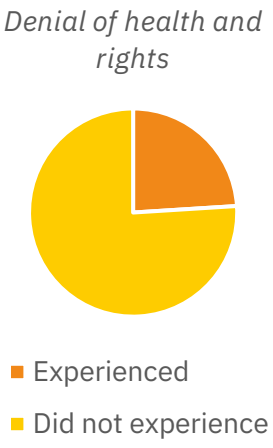
> “The stigma is high if, for example, a woman is said to be in a relationship with a woman. On the one hand, this is not treated as

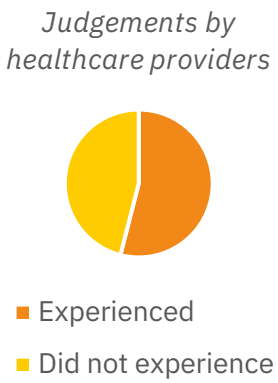
a real relationship. It is not read as, I don't know, having already lost your virginity."

These views influence how healthcare professionals approach and comprehend patients' demands, which helps to erase LGBTQI+ identities from medical discourse.

The findings highlight the pressing need for structural changes in healthcare organizations, such as more stringent enforcement of ethical standards, comprehensive anti-discrimination laws, and LGBTQI+-inclusive medical education. LGBTQI+ people will continue to experience stigma and prejudice in healthcare settings if these changes are not made, which will eventually affect their general well-being and ability to access necessary medical services.

Regarding denial of sexual and reproductive health and rights care, 24% of respondents confirmed that there were instances where healthcare providers had denied care on LGBTQI+ identity grounds, while 76% reported that there were no cases of denial of care on this ground.





Additionally, the majority of respondents, i.e., 54%, indicated that they had experienced judgments by healthcare providers while seeking SRHR services, while 46% indicated no experience of that kind.

Discrimination in access to sexual and reproductive health and rightsse rvices remains a widespread issue, with the highest rates of reported discrimination recorded among respondents from Uzbekistan, Tajikistan, Belarus, Armenia, and Lithuania. In these countries, barriers were beyond general discrimination since respondents from Tajikistan, Armenia, Azerbaijan, Uzbekistan, and Ukraine also reported the highest instances of healthcare providers denying SRHR services based on LGBTQI+ identity. Furthermore, stigmatization by healthcare professionals was particularly in Uzbekistan, Tajikistan, Armenia, Lithuania, and Azerbaijan and it highlights a broader image of exclusion and bias within medical settings. These findings suggest that in certain countries, discrimination is not only systemic but also reinforced by healthcare providers. Additional to that the statistical analysis

revealed that gender identity is a significant factor associated with discrimination as well as with stigmatization by healthcare workers. Findings indicate that transgender men and women are among the most affected groups.

The denial of SRHR services by health care workers was significantly related to the gender identity, and level of education. Again, the most vulnerable groups were transgender men and women. In addition, respondents with little or no formal education reported the highest rates of denial of health care services.

Participants were surveyed in terms of different actions that could reduce stigma and discrimination towards LGBTQI+ youth within healthcare. The most supported solutions included: training for healthcare providers (12.3%), strict non-discrimination policies (12.2%), legal reforms (12%), enhanced support and resources for LGBTQI+ youth (11.9%), and improved access to SRHR services (10.7%). Other suggested measures (each supported by about 10% of respondents) included increasing LGBTQI+ visibility in SRHR education materials, creating safe spaces within healthcare settings, involving LGBTQI+ community members in SRHR program development and evaluation, and launching public awareness campaigns.

Another potential approach to addressing accessibility issues is leveraging technology to provide critical resources to LGBTQI+ youth. A participant from Ukraine suggested the development of an online platform or mobile application where young people can access information about available services, seek advice, and find verified doctors. “This would be especially useful in regions where there are no specialized medical centers.” Such a platform could bridge the gap in areas where LGBTQI+-inclusive healthcare remains limited or inaccessible.

Beyond technological solutions, advocating for systemic change through reliable connections within political and medical institutions was also emphasized. A participant from Latvia noted that

“The key is to make sure you don’t have a bad reputation. From experience, writing to unknown people is useless for reaching our goals—they either don’t respond or give vague, unhelpful answers. You need to go to acquaintances in the ministry, in the parliament, or to doctors you know, preferably offline. In this way, you push your agenda through reliable channels to the leadership.”

This highlights the importance of strategic advocacy, where personal networks play a critical role in influencing policy and institutional change. In Estonia, participants specifically pointed out the bureaucratic hurdles that transgender individuals face when accessing gender-affirming care.

Recommendations included “a complete overview of bureaucracy (do we need a committee to decide if a person is trans?),” eliminating outdated terminology such as “transgenderism,” and implementing self-identification for trans people. Other proposed solutions included streamlining the process of changing gender markers, ensuring access to hormone therapy on informed consent, and increasing education on gender identity in school curricula. These suggestions reflect the urgent need to simplify and depoliticize the legal recognition of transgender identities, making healthcare services more accessible and affirming.

In addition to policy changes, breaking taboos around sexual and reproductive health education remains crucial in combating stigma. A participant from Kyrgyzstan emphasized that “Young people are generally more open to communication about things that adults would call ‘shameful,’ and I think these activities help

young people lift the taboo labels from topics like sex, menstruation, and health." This underscores the role of education in fostering open discussions and normalizing conversations around sexual and reproductive health, ultimately reducing stigma in healthcare settings. Together, these insights reinforce the need for a multifaceted approach to addressing discrimination and stigma in healthcare. Whether through digital solutions, political advocacy, legal reforms, or education, the goal is to create a healthcare environment that is inclusive, accessible, and respectful of LGBTQI+ identities and needs. Moreover, to address discrimination in health care against LGBTQI+ individuals, particular attention should be paid to transgender men and women, as they face the highest levels of discrimination, denial of services and stigmatization. Besides that, targeted measures are needed to support people with lower levels of education, as they disproportionately face denial of health care services. Addressing these inequalities through targeted policies and inclusive health care reforms is critical to ensuring equal access to SRHR services for LGBTQI+ individuals.

DISCUSSION:

LEGAL BARRIERS

EECA region is known for the systemic barriers in violations of the freedom of assembly and association, which limits the creation of NGOs and supporting working groups for the LGBTQI+ community. Except for Georgia, Moldova, Ukraine, Estonia, Latvia, and Lithuania, there is no law about anti-discrimination, let alone a direct formulation of it based on sexual orientation and gender identity (SOGI). Uzbekistan and Turkmenistan are the countries that criminalize same-sex sexual voluntary contact between men and have the highest violations from law enforcement workers (Eurasian Coalition on Health, Rights, Gender and Sexual Diversity, 2024b; Federovich, 2023).

One of the most significant barriers to LGBTQI+ advocacy in the region stems from restrictive legislation originating in Russia, which has influenced neighboring states. Russia’s "foreign agents" law, initially designed to regulate organizations receiving

international funding, has been replicated in Georgia and Kyrgyzstan. This law imposes bureaucratic hurdles on LGBTQI+ organizations, restricting their ability to register, receive funding, or operate freely (Crotty et al., 2014; Iskender, 2024). Similarly, so-called "LGBT propaganda" laws, originally introduced in Russia and subsequently adopted in Belarus, Georgia, Kyrgyzstan, and Turkmenistan, were identified by participants as contributing to widespread censorship. Although framed as measures to protect minors, these laws effectively criminalize positive or even neutral representations of LGBTQI+ identities, curtail public education efforts, and foster a hostile societal climate (Arik et al., 2022; Human Rights Watch, 2023). Participants noted that the spread of Russia-inspired legislative models has had a chilling effect on LGBTQI+ activism across the region, further limiting access to SRHR services and reinforcing stigma at both institutional and community levels.

Furthermore, these restrictive laws intersect with corruption and systemic discrimination within legal and healthcare institutions, creating additional barriers for LGBTQI+ individuals seeking medical and legal assistance. Healthcare professionals, for

example, may refuse treatment, disclose confidential patient information, or discriminate against LGBTQI+ individuals, knowing that legal protections are either weak or nonexistent (Kovtun & Tilek kyzy, 2023; ECOM, 2023f). This intersection of legal oppression and institutional discrimination not only marginalizes LGBTQI+ communities but also exacerbates existing inequalities in healthcare access, economic opportunities, and fundamental rights.

The widespread implementation of restrictive legislation in many countries further marginalizes LGBTQI+ populations by institutionalizing discrimination in the legal and medical systems as well as codifying societal biases. For example, the Supreme Court's classification of the "international LGBT movement" as an extremist group in Russia has legalized widespread discrimination, resulting in a rise in raids, arrests, and the closure of venues that support the community. This has forced the community into the shadows and discouraged people from getting the medical care they need (The Wall Street Journal, 2024). Similar to this, Georgia's severe anti-LGBTQ+ legislation has increased concerns about an increase in hate crimes and violence

against the LGBTQI+ community, further isolating people and limiting their ability to engage in social and economic activities. In the result, a cycle of marginalization is maintained by such institutionalized discrimination, where people's socioeconomic standing, health, and well-being are jeopardized because they are afraid of being persecuted for seeking necessary services.

Anti-discrimination Law:

Legislative restriction of discrimination based on the human rights of people is a must. But only 7 countries in EECA (Georgia, Moldova, Tajikistan, Ukraine, Estonia, Latvia, and Lithuania) have an anti-discrimination law, whereas both Georgia and Moldova include anti-discrimination based on SOGI and have a criminal liability for the violation of it. Despite their importance, anti-discrimination laws in the EECA region are uneven, with only a few countries providing substantial protections and enforcement remaining inconsistent. This legal recognition translates into tangible benefits, as Estonia, Latvia, and Lithuania are the only 5

countries in the EECA region, where LGBTQI+ cases and hate crimes are properly reported and LGBTQI+ community members have less fear of reporting it (Eurasian Coalition on Health, Rights, Gender and Sexual Diversity, 2024a; Frolov & Tilek, 2024; Gogul & Tilek, 2024; Plakhotnik et al., 2021). However, recent political backsliding in Georgia's ruling party is claiming to drop gender identity and expression from the Law on Gender Equality (*Annual Review 2024 | ILGA-Europe*, 2024). In Estonia, the Gender Equality Act does not provide protection based on sexual orientation but on gender identity (Karsay, 2018, p. 107).

Persistent discrimination and legal barriers continue to hinder LGBTQI+ individuals, sex workers, and people who use drugs from accessing healthcare, HIV prevention, and SRHR services across the EECA region. Many avoid seeking medical help because they fear mistreatment, legal trouble, or being forced to disclose personal information. As SWAN (2024) points out, these challenges are made worse by restrictive policies, biased healthcare providers, and a general lack of legal protections. Without meaningful legal reforms, better funding for inclusive healthcare programs, and efforts to reduce stigma in medical

settings, these groups will continue to struggle with limited access to the care they need.

Even in countries with existing anti-discrimination laws, LGBTQI+ individuals often hesitate to report incidents of discrimination due to fear of retaliation or lack of trust in law enforcement. This hesitancy is well documented in Armenia, where only 12 out of 51 documented violations against people with diverse SOGI have been officially reported, largely due to past experiences of police violence (Vardanyan, 2024). In 2017, representatives of RightSide Armenian NGO were harassed by a member of the city council and physically attacked by unidentified men (Karsay, 2018). In other countries LGBTQI+ persons are afraid to be forced to disclose their SOGI, and it highlights the ongoing legal and social obstacles LGBTQI+ people encounter in the area, the criminalization of same-sex relationships in Uzbekistan and Turkmenistan feeds a culture of fear and repression that transcends legal frameworks and into other forms of discrimination in society (Federovich, 2023; M.F.I., 2019). Widespread societal intolerance exacerbates the dread of outing and the consequences that follow, making it almost hard for

LGBTQI+ people to seek justice or medical care without running further risks. LGBTQI+ populations are effectively silenced by this systemic discrimination, which is supported by social and legal norms. This further marginalizes them and limits their access to vital legal and health safeguards. LGBTQI+ people continue to be at risk of systemic abuse and exclusion from essential rights and services in the absence of thorough legal frameworks and effective enforcement mechanisms.

The findings of this study underscore the urgent need for robust anti-discrimination laws to protect LGBTQI+ individuals from systematic bias in SRHR services. While some EECA countries have made progress in legal recognition and enforcement, many continue to uphold legal barriers that exacerbate health inequities among LGBTQI+ populations. . A diversified strategy that incorporates public awareness campaigns, policy enforcement, legal reforms, and the strengthening of LGBTQI+ advocacy organizations is needed to close these gaps. Without these initiatives, LGBTQI+ kids will continue to face prejudice in healthcare settings, which will further marginalize them and restrict their fundamental right to health and well-being.

Freedom Of Assembly, Expression, and Association:

The listed freedoms are fundamental human rights, and LGBTQI+ youth deserve to enjoy them fully. However, only 7 countries—Armenia, Moldova, Kyrgyzstan, Ukraine, Estonia, Latvia, and Lithuania —have been relatively democratic. To organize a peaceful event, the governments of these countries do not require permission but require advance notice and provide police protection if needed. Only Kyrgyzstan and Moldova do not issue a liability for organizing a peaceful event without notice. Although these provisions, following democratic reversals have resulted in more limitations on nonviolent protests, especially for underrepresented groups. In many of these nations, local courts have started to restrict the venues of public gatherings and postpone or completely forbid nonviolent protests in urban areas. Consequently, since 2022, the number of public protests, including marches and protests by LGBTQI+ individuals, has drastically decreased. (Beyer & Kojobekova, 2019; Imanaliyeva, 2023).

This change is a reflection of larger worries about the region's declining democratic standards and freedom of assembly. Even if legislative frameworks may still protect the freedom to protest, civil activism is stifled by their uneven application and judicial restrictions. It is becoming harder for LGBTQI+ groups in particular to claim public spaces for activism because of social backlash in addition to administrative obstacles. The future of civic involvement in these nations is called into doubt by the government's inconsistent backing of nonviolent protests. The question stays open whether the more limitations will weaken the voices of underrepresented groups, or will democratic institutions bolster safeguards for peaceful assembly. The direction of these regulations will have a big impact on how freedom of expression and human rights are viewed in the area.

The government of Kazakhstan does not limit rallies and assemblies on LGBTQI+ but there is a constant backlash the government-organized NGOs (GONGO). On March 8 event, the state union organized a public meeting on the vulnerability of women and the necessity for them to get married earlier to be

protected under heterosexual men (Levitanus & Kislitsyna, 2024; Volk, 2016).

It is crucial to mention The Union of Parents, one of the busiest government-organized NGOs, consistently disrupts LGBTQI+ events, both private and public, especially those headed by LBT women. Protests, red tape, and pressure on event planners are common ways that this meddling shows itself. Recently, Kazakhstani government-organized NGO “Union of Parents” actively interferes with any public and private LGBTQI+ event mostly organized by LBT women. Moreover, Kazakhstan had a public working group hearing about “propaganda law” once again; the representatives of the Union of Parents and other activists of traditional values showed up, but the law was not adopted, prohibiting the spread of homosexuality among children (Mamikomyan, 2024).

Although there aren't any official legislative prohibitions, the resistance supported by the government and social forces make Kazakhstan an unfriendly place for LGBTQI+ advocacy. The

existence and power of government-organized NGOs (GONGOs) act as an indirect form of repression, even though the state does not specifically forbid LGBTQI+ events or meetings. Under the pretense of civil society, these groups—like the Union of Parents—largely support state narratives that uphold conventional family structures and restrict LGBTQI+ presence in public discourse.

Lithuania has restricted freedom of expression and assembly in ways that have an indirect impact on the LGBTQI+ community, even though it has not specifically targeted LGBTQI+ rights. Lithuania avoids direct international criticism by limiting LGBTQI+ activism without overtly discriminating by imposing ambiguous legal limits on public gatherings and talks. This strategy is in line with a larger pattern in various Eastern European nations, where governments repress underprivileged people by using legal ambiguity and administrative obstacles rather than explicit prohibitions. Georgia, on the other hand, has suffered severe defeats in defending LGBTQI+ rights, primarily due to a failure to enforce protections rather than overt government restrictions. LGBTQI+ people's freedom of assembly has been essentially restricted by the state's unwillingness to enforce laws against

anti-LGBTQI+ violence and to guarantee police security for them. LGBTQI+ youth in Georgia regularly experience threats and violence while having the legal right to express themselves, and law enforcement either does nothing or actively discourages activity. An atmosphere of fear and exclusion is reinforced when the government remains silent in the wake of violent incidents, giving anti-LGBTQI+ actors more confidence. Georgia's adoption of an "LGBTQI+ propaganda" law, modeled after similar Russian policies, marks a significant regression in human rights protections. Such laws encourage discrimination in society at large in addition to limiting media and educational discourse on LGBTQI+ concerns. Georgia's ruling party's convergence with hardline Russian-style policies raises fears about the country's civil freedoms and wider democratic backsliding. This law's passing is reminiscent of Russia's previous attempts to repress LGBTQI+ communities by designating LGBTQI+ organizations as "terroristic" and "foreign agents," which resulted in the widespread persecution of activists and systemic bans on LGBTQI+ websites (Karsay, 2018, p. 12,42). After adopting that law first and proclaiming LGBT organizations as “terroristic” and “foreign agents,” Russian authorities have continuously banned

LGBT websites and oppressed organizations. Many individuals, particularly trans women, fled Russia to other countries (Chernova & Kottasová, 2022). Correspondingly, activists and LGBTQI+ people of Belarus continue fleeing the country and seeking asylum. While the community is highly oppressed, some countries like Moldova do not provide asylum falsely claiming that Belarus' does not have issues with human rights (*Annual Review 2024 | ILGA-Europe*, 2024).

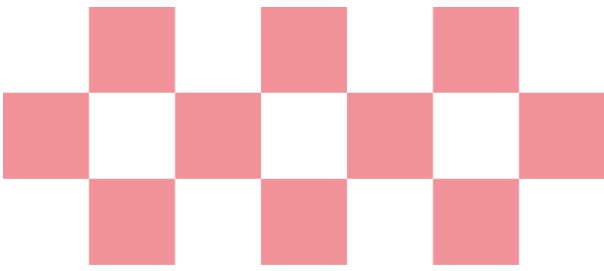
The disparity in these nations' regulations demonstrates the complex connection between domestic politics, global impact, and public perceptions of LGBTQI+ rights. Some governments use less obvious types of repression, limiting liberties through legislative loopholes, inaction, and indirect obstacles while others impose outright restrictions on LGBTQI+ advocacy. It is impossible to ignore how pro-Russian laws have influenced the development of LGBTQI+ rights in the area because they are frequently used as instruments to promote conservative viewpoints and repress opposition. Both domestic opposition and global advocacy initiatives will be crucial to the future of LGBTQI+ rights as regional political dynamics continue to change.

These changes demonstrate that there is no effort to revoke the increasing restrictions on LGBTQI+ rights in nations like Georgia and Lithuania. Serious persecution and the need for stricter regional asylum policies are highlighted by the growing number of LGBTQI+ people escaping Russia and Belarus. However, obtaining protection is made more difficult by dispersed reactions, such as Moldova's refusal to provide asylum to LGBTQI+ migrants from Belarus. Civil society and activists continue to play a crucial role in protecting rights and resisting limitations in this difficult environment. The lives of those impacted as well as the larger human rights situation will be shaped by the future of LGBTQI+ rights in the area.

So far, Georgia, Moldova, Lithuania, Latvia, Estonia, and Ukraine have all hosted pride marches, which have been significant occasions for raising awareness of and support for LGBTQI+ rights. However, over 200 anti-LGBTQI+ extremists invaded the event in 2023, tearing down banners, burning rainbow flags, and

verbally and physically attacking attendees, violently disrupting Georgia's Pride march. Police found it challenging to stop the violence because the attackers outnumbered security forces and were emboldened by far-right rhetoric and conservative resistance. Despite the presence of law police, the attackers were able to harass and threaten the LGBTQI+ community with minimal repercussions because of their delayed and often ineffectual response. Later, a number of activists attacked the government for not protecting the protesters and for not prosecuting the offenders more severely (Gogul & Tilek, 2024). Since 2002, Moldova has held Pride celebrations, honoring more than 20 years of LGBTQI+ activity in the nation. However, politicians, religious leaders, and organizations connected to the government still firmly oppose these events. Every year, state-sponsored groups and conservative groups try to outlaw, postpone, or drastically curtail Pride marches, frequently on the grounds of moral, religious, or alleged public safety concerns. Threats against organizers and participants, verbal abuse, and counter-protests are commonplace, even in cases where Pride celebrations are legal. Despite these obstacles, LGBTQI+ organizations in Moldova are still fighting for societal acceptability and more robust

legislative protections for equal rights. However, the continuous fight for LGBTQI+ visibility and safety in the nation is highlighted by the political and religious establishments' steadfast resistance as well as the absence of responsibility for those who harm Pride participants (*Annual Review 2024 | ILGA-Europe*, 2024). Estonia is one of few countries which allows Pride marches. But physical, and verbal assaults are ongoing, for which the activists are fighting to get hate speech and laws against LGBTQI+ persons. The country introduced marriage equality in June 2024, becoming the first in the EECA to adopt such legislation (Laizans & Sytas, 2024). In Lithuania, the government hindered the organization of Pride marches with the grounds of protecting public health and morality. Authorities delay and are hesitant to investigate cases involving attacks on LGBTQI+ persons and organizations. In cases of investigations, they only cover sexual orientation, not gender identity and expression (Karsay, 2018). The recent backlashes and contradictions even in the countries with existing legislation are directly connected to the transnational anti-gender and anti-human rights movement in the world.



The dynamics of Pride marches throughout the EECA region show a larger conflict between resistance and development, as social attitudes and legal frameworks continue to be closely entwined. Although several states ostensibly allow Pride celebrations, the ongoing institutional resistance—from conservative ideas to government-affiliated organizations—indicates that legal recognition is insufficient to provide true equality. Even in nations where marches are legally permitted, authorities frequently employ administrative obstacles, ambiguous morals provisions, or selective law enforcement to gently discourage LGBTQI+ visibility, which perpetuates an atmosphere of uneasiness. The result is a landscape created by conflicting forces of institutional neglect, legislative reform, and ideological resistance, where LGBTQI+ activism is both growing and under attack. Legal protections are only one aspect of the issue; another is whether or not these protections result in actual, lived freedoms. LGBTQI+ communities will continue to function in a realm of conditional recognition—visible but vulnerable—as long as governments are unwilling to uphold current rights or deliberately undermine them in the name of public order.

Anti-gender discourse has spread around the world, and countries of Eastern Europe and Central Asia are adopting laws exported from Russia. Yet not identifying gender equality and feminism, LGBTQI+ as a topic of instrumentalization in EECA, the discussion and the registration of organizations was not a problem until the late 2000s. Ultimately, anti-gender, anti-NGO, anti-LGBTQI+, and anti-migration movements should not be seen in isolation. As an opposing product against the neoliberal politics of the so-called West, mostly the European Union and the United States, the movements, with Russia being an exporting power force, started spreading around and claiming to protect the "public morals" and children's safety. This comes along with low fertility, the development of feminism and bodily autonomy, and greater sexual education (Kirey-Sitnikova & Kirey, 2019).

There is an obvious democratic backsliding in Georgia and Kyrgyzstan, especially after the start of Russia's full-scale invasion of Ukraine. The government of the Kyrgyz Republic has been unstable before the latest government, which is actually

right-wing and populistic. However because of the previous instability the change of the cabinet of ministers and the lack of representation of women in leadership, the ICPD platform implementation has been slow and uncertain (Lazdane, 2013). Similarly, after several attempts to pass the law on “Foreign agents” or the ability of NGOs and NCOs to receive foreign funding and the rallies of thousands of people across Georgia, the parliament accepted the law in May 2024, hindering Georgia’s EU accession efforts Cases of threat and violations from the police have been happening before (Kasianczuk & Djuma, 2023). In September 2024, Georgia also adopted the law on “gay propaganda” or «On Family Values and Protection of Minors» which touches upon all spheres of life, including education, health, media, advocacy, etc (Gogul & Tilek, 2024). The leading pro-Russian political party in Georgia with its proxy groups like far-right groups and Georgian Orthodox Patriarchate spread anti-LGBTQI+ statements, allowing and exacerbating the hate speech and crime against the LGBTQI+ community.

In Eastern Europe, the right-wing political party of Hungary has been vocal against gender equality and SRHR, diminishing its

importance (Fodor, 2022; Graff & Korolczuk, 2022; Kot, 2023). Russia is known for its repressive anti-gender anti-LGBTQI+ mechanisms. Known for its ultra-masculine and traditional rhetoric, Chechnya, one of the Muslim republics in the Russian Federation has been publicly persecuted for men who have sex with men (MSM). In 2017 and 2019, after public accusations, illegal detentions, and physical harassment, dozens and hundreds of LGBTQI+ people left. This comes along with draconian laws against independent media and non-governmental organizations (NGOs). Russia adopted a law “On the prohibition of LGBTQI+ propaganda,” “On the protection of children from information harmful to their health and development,” “On Foreign agents” and other initiatives that are always backed up by the political or media actors and are actively copy-cited in other “post-Soviet” countries, including Kyrgyzstan, Kazakhstan, Georgia, Armenia, and at least attempted in other countries (Guz et al., 2021; Iskender, 2024; Levitanus & Kislitsyna, 2024).

In Armenia, Azerbaijan, Georgia, Moldova, Russia, and Ukraine, civil society working on SOGI has been facing legal and structural barriers to continue their work. Russia and Azerbaijan

had limitations on foreign funding for NGOs, where LGBTQI+ organizations are obligated to register as such, from 2013 and 2018, while Kyrgyzstan and Georgia adopted similar legislation in 2023 and 2024 (Karsay, 2018). Compared to its neighboring countries, Lithuania has more dynamics in LGBTQI+ rights, both positive and negative. It adopted an “anti-gay propaganda” and family morals protection legislation back in 2009. After some efforts of the European Court to amending this law, the Parliament of Lithuania did not adopt the changes. Moldova adopted “an LGBT propaganda” ban, too. Additionally, Lithuanian politics are concerned about “child sexualization,” adoption of legislation on sex education in religious institutions, and comparisons of homosexuality to pedophilia (*Annual Review 2024 | ILGA-Europe*, 2024).

A larger ideological change driven by conservative political forces, frequently heavily influenced by Russia, is reflected in the rise of anti-gender speech throughout Eastern Europe and Central Asia. Although feminism, LGBTQI+ rights, and gender equality were not historically controversial in many EECA nations, the late 2000s saw a shift in the political discourse as these topics became

central to opposition to Western liberalism. This movement is part of a multinational attempt to change social standards under the pretense of defending "public morals" and "traditional family values." It combines anti-LGBTQI+, anti-NGO, and anti-migration narratives.

In Kyrgyzstan, Georgia, Moldova, Armenia, Kazakhstan, and Uzbekistan the legal definition of marriage is changed from “as a voluntary union based on the equal rights of the spouses” to “marriage is the union of a [genetic] man and a [genetic] woman.” Most of the change comes from Russia, along with the prohibition of “LGBT propaganda.” Armenia does not have a propaganda law but still formulates marriage as a heterosexual unit (Frolov & Tilek, 2024; Gogul & Tilek, 2024; Kusayinkyzy & Jumagazieva, 2024; Suvorova, 2024; Vardanyan, 2024).

Kyrgyzstan, Georgia, Moldova, Armenia, Kazakhstan, and Uzbekistan are among the Eastern European and Central Asian nations that have recently changed their legal definitions of

marriage to define it as a union between a man and a woman alone. This change is consistent with a larger pattern stemming from Russian legislative models, particularly the 2013 law outlawing "LGBT propaganda," which has been imitated in different ways throughout the region. The government of Kyrgyzstan has passed legislation that targets the dissemination of LGBTQI+ identities, thereby stigmatizing the community and conforming to regional trends of limiting LGBTQI+ rights (ILGA-Europe, 2024). Similar to this, Georgia's parliament has passed legislation restricting the rights of LGBTQI+ people, indicating a notable shift toward conservative policies influenced by Russia, Georgia's neighbor (Reuters, 2024). On the other hand, Similar "gay propaganda" laws have also been pushed for in Moldova, albeit the precise legislative results have differed (Human Rights Watch, 2016). Armenia retains a legal definition of marriage as a heterosexual partnership, reflecting conservative societal standards, although not having passed explicit "LGBT propaganda" laws. Although not specifically noted in the materials cited, Uzbekistan is in a region where LGBTQI+ rights are frequently restricted and traditional definitions of marriage are common. As part of a regional tendency to limit LGBTQI+ rights,

Kazakhstan has attempted to enact anti-LGBT "propaganda" legislation.

In a result, a wider regional alignment with conservative values influenced by Russia is shown in the recent legal changes in Kyrgyzstan, Georgia, Moldova, Armenia, Kazakhstan, and Uzbekistan that define marriage solely as a union between a man and a woman. Governments in these nations are intentionally limiting the legal acceptance of various family configurations by enshrining certain definitions in their laws, in addition to promoting traditionalist beliefs. A conscious attempt to marginalize LGBTQI+ people and stifle discussion of gender and sexual variety is indicated by the passage of these policies, which are frequently coupled with "LGBT propaganda" bans. Armenia's legal system maintains a strictly heterosexual definition of marriage even though it hasn't passed any official propaganda laws. This shows that institutionalized exclusion can serve as an effective legislative tool to restrict LGBTQI+ rights without necessarily requiring outright legal prohibitions. In some instances, such as Georgia and Moldova, changing political environments have made LGBTQI+ rights a crucial area of conflict,

with laws reflecting the escalating conflict between the influence of conservative, frequently Russian-backed organizations and European integration attempts.

This development demonstrates how LGBTQI+ rights are becoming more politicized throughout Eastern Europe and Central Asia, as legal limitations are employed as ideological control mechanisms. These laws legitimize wider discrimination against LGBTQI+ people and foster an environment of exclusion in addition to upholding traditional gender norms. The overall effect is a gradual reversal of rights under an appearance of defending cultural and national values, even though the precise legal ramifications differ from nation to nation. Such regulations' continuous existence emphasizes the necessity of ongoing international campaigning and monitoring in order to oppose restrictive legal frameworks and assist LGBTQI+ people in the area. These legislative tendencies run the risk of strengthening prejudice and hindering future advancements in equality and diversity if civil society and international human rights organizations do not oppose them.

TRANSGENDER OPPRESSION

Transgender* people have been subjects of structural and physical violence, unable to receive proper gender recognition, education, job, or health services. Legal gender marker change or recognition is complicated in almost all countries. While 4 countries (Azerbaijan, Armenia, Moldova, and Georgia) do not require psychiatric diagnosis, 8 countries (Azerbaijan, Armenia, Kyrgyzstan, Tajikistan, Uzbekistan, Ukraine, Georgia, and Kazakhstan) do require surgical intervention to change the gender marker (Kirey-Sitnikova, 2023, 2024; Kot, 2023).

In Uzbekistan, for instance, trans* people need to undergo a lengthy process of doctor's observation or have hormonal therapy for several years to receive a certificate, enabling them to legally change their gender mark (Eurasian Coalition on Health, Rights, Gender and Sexual Diversity, 2024b). In Georgia, transgender people can change their full name but not gender marker. It does require expensive surgery but not a psychiatrist diagnosis. A recently passed against "LGBTQI+ propaganda" might ban gender

change surgeries and the use of hormonal change medication, as well as general gender marker change, like already in Russia (Kasianczuk & Djuma, 2023). In Moldova, although medical diagnosis assessment and surgery requirements were amended, there is still a bureaucratic court process and document to change the gender for trans* people (Frolov & Tilek, 2024). There were 59 recorded cases against trans* people in Kazakhstan in 2023. A trans woman's business was seized and she was threatened to be expelled from the city, with perpetrators coming to her house. However police did not take any actions, which leaves the LGBTQI+ community under constant threat of systemic abuse (Kusayinkyzy & Jumagazieva, 2024).

Estonia, Latvia, and Lithuania have slightly better policies to hold people accountable for their hate crimes or speech, but the public discourse is still quite homo and transphobic. Trans people in Estonia can identify gender marker change in only non-state documents while facing structural violence in changing the national ID. Critically, the birth certificate remains unchanged, even after legal gender recognition (Karsay, 2018, pp. 13, 51). In Lithuania, transgender people needed to undergo sterilization

abroad and claim the Supreme Court for legal gender recognition, but starting in 2017, the procedure did not have to include sterilization (Karsay, 2018, p. 53). In Estonia, a man murdered a black migrant transgender woman, for which the killer was sentenced to 12 years of imprisonment (*Annual Review 2024 | ILGA-Europe*, 2024)

Though part of the Council of Europe, Azerbaijan and Armenia have severe violations against LGBTQI+ people. Azerbaijan, for instance, accepted Law on Ensuring Gender Equality in 2006, but it only represents the heteronormative image of males and females, not talking about homonormative, transgender, or genderqueer or fluid. A trans woman was tortured and murdered with violence; others were often insulted, arrested by the police for "hooliganism," and harassed by unidentified people (*Annual Review 2024 | ILGA-Europe*, 2024). In Armenia, trans people face harassment and violence at school, facing hardships to enter high school and later be hired for a job. They also frequently face discrimination and non-acceptance for the medical workers because their ID does not match their identification (Karsay, 2018). Two trans women were brutally

murdered in 2023, and the legal gender mark change process is extremely difficult administratively and surgically as there are no services offered. Usually, the surgery/operation would be claimed as a “correction” of bodily deformities (Vardanyan, 2024).

With all the violence and hardship, it is crucial to aid through NGOs or inclusive policies. But in most countries, similar to Russia, the foreign funding legislation made it even more complicated to register organizations to assist MSM or trans* people with PLHIV (Guz et al., 2021)

Transgender people suffer significant obstacles in obtaining legal recognition, healthcare, and safety from assault, as evidenced by the systemic oppression they experience throughout Eastern Europe and Central Asia. While some nations no longer require a psychiatric diagnosis in order to change a gender marker, others continue to require invasive and expensive surgical procedures, making the procedure practically unaffordable for many. Trans rights are nevertheless threatened by discriminatory laws and administrative roadblocks, even in situations when legal gender recognition is theoretically feasible. While state policies in Georgia, Moldova, and Armenia do not

provide adequate protections, leaving trans people vulnerable to social and institutional violence, transgender people in countries like Uzbekistan and Kazakhstan are subjected to extended medical surveillance or are completely excluded from legal gender recognition. As demonstrated in Kazakhstan, police inactivity simply serves to strengthen the climate of impunity for hate crime perpetrators, feeding a vicious circle of insecurity and terror. Structural impediments still exist that hinder transgender identities from being fully integrated and recognized, even in comparatively more progressive governments like Estonia, Latvia, and Lithuania where hate crimes are penalized by law. The issue is especially concerning in Armenia and Azerbaijan, where transgender people face severe violence, including murder, and have little to no legal protection. These nations' failure to provide even the most basic protections for transgender individuals in spite of international human rights commitments shows how widespread transphobia is in both society and the legal system.

The legislation on people with diverse SOGI and hate speech and crime against them is well set up in Moldova, a country which tries to be aligned with European laws, but the social stigma and discrimination against LGBTQI+ people, especially those with HIV status, remains high in the range of 60-80% of negative perception (Frolov & Tilek, 2024).

On the societal level, LGBTQI+ individuals in EECA face significant challenges that go beyond legal restrictions. Social stigma, deeply ingrained conservative attitudes, and widespread discrimination permeate everyday life, often manifesting in verbal, physical, and psychological abuse. For example, Armenia adopted a National Strategy for the Protection of Human Rights, but that barely involved SOGIESC as a rights. Two trans women were murdered and one's house was burnt, yet the violence was exacerbated by comments and incitements of further violence against the LGBTQI+ community (*Annual Review 2024 | ILGA-Europe*, 2024). These societal challenges are compounded by the

lack of adequate legal recourse and protection mechanisms, which not only fail to prevent discrimination but also do not provide sufficient support for victims of violence and abuse. Health services, too, are often inaccessible to LGBTQI+ individuals due to discrimination from medical professionals and institutional biases that fail to recognize the specific health needs of this population (Kovtun & Tilek kyzy, 2023).

Politicians have used homophobic—in particular transphobic—language in Belarus, Georgia, Kyrgyzstan, Latvia, and Moldova, identical to Western European countries. Online and media hate speech drastically increased recently, including in Belarus, Armenia, and Estonia (*Annual Review 2024 | ILGA-Europe*, 2024). Kyrgyzstani politicians continue to instrumentalize the public discourse against the LGBTQI+ and people living with HIV. Blaming trans people and foreign-funded NGOs, they, mostly coming from the government ruling party, incite hatred and even argue not to receive HIV funding from international funding, denying the existence of homosexual people (*Annual Review 2024 | ILGA-Europe*, 2024; Eshalieva, 2023).

Due to mistrust of police and legal state representatives, LGBTQI+ youth in EECA mostly do not report hate crimes and speech cases. In Uzbekistan, systemic violence from police and internal affairs officers, who created fake accounts in dating apps, then caught, interrogated, and tortured gay men and trans* women, while forcing them to collaborate and reveal information about LGBTQI+ persons in the area (Eurasian Coalition on Health, Rights, Gender and Sexual Diversity, 2024b). The victims were also illegally detained and persecuted, getting on bail or home arrest after legal support of the working group. In 2023, 191 cases of violence against people with diverse SOGI were recorded, out of which those aged 16-18, 19-22, and 23-25 are the main victims. This is the youth with no stable job or social networks, the most vulnerable to systemic harassment, and violence from far-right groups, law enforcement officers, peers, and relatives. Even if there is regulation on hate crimes and hate speech against LGBTQI+ persons in Moldova, unlike in Kazakhstan, the LGBTQI+ community is afraid to report it because of SOGI disclosure. Police officers are often hesitant to accept the cases; or, if accepted, not follow them up. Therefore, it also limits the reporting of cases of

harassment and violations against LGBTQI+ people (Frolov & Tilek, 2024; Suvorova, 2024).

EDUCATION:

Though not always directly connected, there are indirect subjects of violence against youth from the state in access to education. 30% of youth in the EECA region, according to research by Khabibulina & Yourski (2021) indicated previous discrimination, and violence, and caused mental health issues in high school period, when people start opening up and researching about their sexual orientation and gender orientation. Azerbaijan, just like many other countries in the region, doesn't have an anti-discrimination law at educational institutions. A 17-year-old student faced systematic harassment and insults from a peer student and a teacher. The police did not take action due to the lack of legislation (*Annual Review 2024 | ILGA-Europe*, 2024).

While poverty is one of the main problems in getting an education, the state blocks sex education websites. More than

30% of Kyrgyzstan's population live under the poverty line, those living in rural areas, especially women and LGBTI+ youth are at the utmost vulnerability of discrimination in education, job opportunities, gender roles, etc. (Lazdane, 2013). There are countries in Eastern and Central Europe that made draft amendments to LGBTQI+ education, including Belarus, Lithuania, and Slovakia. The government and other actors claim about instrumentalization of LGBTQI+ against children and their safety. The Ministry of Education of Belarus is planning to introduce the Fundamentals of Family Life class to protect children from non-traditional sexual values and values of childless families and pedophiles. While Kyrgyzstan, Russia, and Georgia, mention LGBT as "sodomy" or "lesbianism," Kazakhstani law directly does not violate LGBTQI+ rights. Nonetheless, instrumentalization of "child protection" is common in the region. For example, a Kazakhstani informational site for LGBTQI+ youth, Selftanu.kz, was blocked by the government after a month of launch. The Committee for the Protection of the Rights of the Children of Kazakhstan and other anti-gender actors, including from Russia, worked on banning this site (Kusayinkyzy & Jumagazieva, 2024). Countries mostly strive to "protect" children from the "Western" values to increase child

fertility, act as a natural opposition to European laws, and present it through their own local traditions (Annual Review 2024 | ILGA-Europe, 2024)

Estonia, Latvia, and Lithuania face struggles on a different level. While there is no guideline on preventing bullying or harassment at school for LGBTQI+ youth in Estonia, educational institutions are obligated to reissue the certificate, according to a person's self-determined gender (Karsay, 2018). While sex education is embedded in school programs, the Latvian president of the National Center for Education was suspended for allowing the release of educational materials on sex education and transgender persons (Kaža, 2023). Similarly, the Lithuanian Ministry of Education issued a detailed sex education program with comprehensive details on SOGI, but the school curricula still have harmful information, and teachers are distancing themselves from talking about diverse SOGI and their SRHR needs.

In essence, education is one of the interesting aspects of LGBTQI+ rights violations. However, there is not much attention given to making research or advocating. While the anti-rights actors and far-right politicians are advancing well off,

instrumentalizing children and school students, LGBTQI+ youth, their education, and further possibility of getting a job should reconfigure to the center of the scholarly discussion.

HEALTH:

HIV

In Eastern Europe and Central Asia, organizations dealing with HIV and sexual and reproductive health (SRHR) encounter significant political, economic, and social obstacles, complicating open discussions and action on these issues (UNFPA & IPPF, 2017). The region has observed a concerning increase in HIV infections, especially among marginalized groups such as the LGBTQI+ community, who experience significant challenges in healthcare access. This is worsened by social stigmas and discriminatory legal frameworks. Doubling HIV prevalence from 0.25 to 0.41 from 1994-2014, the EECA region remained the only region with an increase of spreading HIV, where drug users, MSM,

and youth under 24 are in the most vulnerable position (Lazdane, 2013). The UNFPA report stresses the immediate need for inclusive, comprehensive SRHR services that honor individual dignity and focus on these vulnerable populations.

A disproportionate number of marginalized groups are impacted, such as transgender people, gay men and other men who have sex with men (MSM), sex workers, and people who inject drugs (PWID). PWID, MSM, sex workers, and transgender individuals had much higher HIV prevalence rates than the overall adult population (7.2%, 4.3%, and 1.7%, respectively) (UNAIDS, 2024b). Limited access to crucial prevention and treatment services exacerbates these discrepancies; for example, only 58% of sex workers, 43% of gay men, 52% of drug injectors, and 65% of transgender individuals obtain HIV preventive treatments (UNAIDS, 2024b). Moreover, access to services for these important populations is made even harder by stigma and discrimination in healthcare settings. Marginalized communities are reluctant to seek medical care because of the prejudices and cultural incompetence of healthcare personnel. Additionally, the region's HIV response is greatly impacted by financial limitations.

With a 60% gap to reach the UNAIDS 2025 targets to eradicate AIDS as a public health issue by 2030, the EECA region has one of the largest HIV funding shortages in the world (UNDP, 2024). The implementation of comprehensive HIV care, including harm reduction initiatives, which are still few or nonexistent in many nations, suffers from this underfunding.

Effective HIV prevention and treatment initiatives are further hampered by the criminalization of activities linked to these groups, such as drug use and same-sex relationships, which feeds their fear and avoidance of medical facilities (ILGA-Europe, 2024). It is a significant issue across the region, particularly in countries like Uzbekistan, Russia, and Azerbaijan, where legal consequences deter people from seeking testing and treatment. Seven countries, including Armenia and Georgia, impose penalties even for unintentional HIV transmission (Bolotbaeva et al., 2023). In Russia, strict foreign funding laws have made it challenging for NGOs supporting MSM and transgender individuals with HIV to operate, leading many organizations to either register as "foreign agents" or work covertly (Guz et al., 2021). In Azerbaijan, where HIV prevalence is lower compared to neighboring countries, a

substantial portion of HIV-positive cases come from MSM, many of whom confront social and economic stigmas. The country's Law on Ensuring Gender Equality (2006) does not address LGBTQI+ issues, and forced HIV testing and police violence against LGBTQI+ individuals continue to be serious concerns. Similarly, in Uzbekistan, HIV transmission is heavily criminalized, with those testing positive compelled to disclose their partner under legal penalties (Suleimanova, 2020). Tajikistan is in closer proximity to arresting and imprisoning men for HIV transmissions, both knowingly or unknowingly (*Annual Review 2024 | ILGA-Europe*, 2024; Chiam et al., 2020). In general, while some countries in the region have made progress in addressing HIV and SRHR, many continue to encounter deeply ingrained challenges in providing equitable healthcare access and safeguarding the rights of marginalized communities.

The ongoing increase in HIV infections in Central Asia and Eastern Europe highlights the critical need for inclusive, all-encompassing healthcare policies that give priority to underserved populations. The situation is made worse by structural obstacles like stigma, discrimination, and criminality

that keep important communities from obtaining necessary preventative and treatment services. Many people lack access to proper care as a result of financial limitations and restrictive regulatory frameworks that further impede effective solutions. The region will continue to face growing infections and widening health disparities, putting the most vulnerable at even higher risk, unless there are swift policy changes, more financing, and a rights-based approach to HIV prevention.

Above the general stigma in society, LGBTQI+ youth face barriers in getting healthcare services. 62% of respondents in a research about LGBTQI+ youth needs indicated the low-quality services and 57% indicated discriminatory experience in healthcare (Khabibulina & Yourski, 2021). In terms of treatment and prevention of HIV, access to pre-exposure prophylaxis (PrEP) is accessible in only seven countries, including Armenia, Kazakhstan, and Georgia. However, in countries like Uzbekistan, where homosexuality is criminalized, MSM encounters significant

challenges in accessing these services (Suvorova, 2024). In some areas, mandatory HIV testing precedes receiving PrEP, creating additional barriers, especially for those already facing stigma. Currently, Armenia is the sole country offering the dapivirine vaginal ring, while Kazakhstan provides injectable cabotegravir (CAB-LA) (Bolotbaeva et al., 2023).

In Estonia, even though maternal mortality decreased from 48 to 5 out of 100,000 live births before 2013, public healthcare funding is available to LGBTI groups but could be discriminatorily withdrawn like a recent case from the city council claiming the film festival to be “gay propaganda” (Lazdane, 2013). In general, the involvement of the LGBT in public policy-making depends on the willingness of the public servant. Hormonal therapy for trans people is covered in half and the surgery is not covered as it is considered “plastic surgery” (Karsay, 2018). Georgia, Russia, and Lithuania, in turn, hardly cover any gender-affirming healthcare services (Karsay, 2018, p. 102).

Regarding gender marker changes, countries like Azerbaijan, Armenia, and Georgia do not necessitate psychiatric diagnosis, but eight others, including Kyrgyzstan, Uzbekistan, and Kazakhstan, require surgical intervention. Despite some legal advancements, many transgender individuals encounter administrative and surgical obstacles, making gender marker changes almost unattainable. For example, in Kazakhstan, legal recognition of gender necessitates surgery, and in Russia, bureaucratic challenges along with a lack of specialists further complicate the process (Kirey-Sitnikova, 2023).

Overall, In Eastern Europe and Central Asia, the availability and caliber of healthcare services for LGBTQI+ people continue to be wildly uneven and frequently discriminatory. Access to necessary medical services is nevertheless hampered by institutional impediments, even in the face of notable advancements, such as the implementation of PrEP in a few nations and the lack of financing for transgender healthcare. Additional obstacles for persons seeking treatment and preventative programs are created by the prohibition of homosexuality in nations such as Uzbekistan and the demand for

HIV testing in certain areas. In a similar vein, although gender marker alterations are permitted by law in some areas, many people cannot access the procedure since it requires surgery in other places. These inequities are made worse by the absence of comprehensive public healthcare programs and the reliance on the judgment of individual legislators.

There are certain limitations to ableism in the world, which were dictated by normativity, similar to heterosexuality, and excluded sexual and reproductive health and the needs of those with disabilities. Confined in domestic conditions through medicalization and stigmatization of disability, this legacy goes on to reproduce the existing socialistic labor system, where maximized productivity was valued the most (Mladenov, 2021). Accordingly, with bodies seen as heterosexual and as an instrument of reproduction, disabled LGBTQI+ persons were double oppressed and forced to be invisible in communities. As (homo)sexuality was criminalized and disability was a taboo,

inexistent by the state apparatus which admitted only traditional masculinity and child-bearing feminine productive body, the “imperfect” and non-full “defective” bodies were not seen as normal or relevant to the needs of the state. A similar approach was developed and reproduced in the post-Soviet era, but the NGOs and other discourses affected to topics of SRHR and disability to be discussed. Nonetheless, disability and sexuality’s intersection is still not a widely addressed topic. Sumskiene and Orlova (2015) note that social care institutions left by the Soviet Union or related regimes reproduce the stigma and violations against the human rights of people with intellectual and physical disabilities, limiting them from basic sexual and reproductive rights. Therefore, there is no data collected or reported to reveal forced sterilization, abortion, or sexual abuse and harassment, due to the extensive and repressive state apparatus.

Having researched sexuality in social care institutions in Latvia, Lithuania, and Georgia, Sumskiene and Orlova (2015) noted about constant oppression of women's sexuality by the institution's staff, prevention of birth through abortion, and physical abuse and treatment of ‘unwanted people” in isolating

spaces. Similarly, systemic discrimination is highlighted by the fact that women and girls with disabilities are denied access to full SRHR services and are subjected to involuntary sterilizations in numerous European countries (Council of Europe Commissioner for Human Rights, 2022). People with disabilities and LGBTQI+ identities are frequently more vulnerable due to the intersectionality of these identities, which exacerbates stigma and creates obstacles for them to obtain legal protection, healthcare, and education (European Disability Forum, 2023). Turdiev (2022) emphasized that disability in Soviet and post-Soviet spaces shifts the power paradigm based on pathologizing people and their agency. Now, disabled LGBTQI+ people, who are already stigmatized and rejected from existence because of their sexuality and the “othered” gender identity, are oppressed and invisibilized twice more in such care systems. While most of the post-Soviet spaces identify three levels of disability in relation to the ability to work and maintain the educational degree of a “defectologist,” Ukraine, Estonia, Latvia and Lithuania moved from stigmatizing disability as charity along with the process of democratization and human rights advocacy (Turdiev, 2022). Forced sterilization is another aspect of violating SRHR of people with mental

disabilities. Oftentimes, people are not even informed about the procedure as they are treated as not full or abled bodies (Kirey-Sitnikova & Kirey, 2019)

CONCLUSION:

This study highlights the urgent SRHR needs of LGBTQI+ youth in Eastern Europe, the South Caucasus, and Central Asia, a region where political, legal, and societal barriers significantly impact access to inclusive health services. Through a combination of quantitative and qualitative methods, this research brings to light the realities faced by LGBTQI+ youth, particularly those navigating intersecting vulnerabilities related to gender identity, geography, and economic status. The findings reveal that structural discrimination, restrictive legislation, and healthcare system shortcomings remain pervasive across the region, though with significant variation by country.

First, the data show that stigma and discrimination are key systemic obstacles to SRHR access. Transgender and non-binary

youth, especially those living in rural areas, reported the greatest barriers, including denial of healthcare services, lack of access to gender-affirming care, and mistreatment in medical settings. These experiences are compounded by socio-legal environments where laws criminalizing same-sex relationships or restricting freedom of association and expression continue to reinforce social exclusion. While some countries, such as Ukraine, Georgia, Armenia, Kyrgyzstan, and Estonia, demonstrated comparatively higher levels of inclusivity according to the composite Inclusivity Index, others such as Russia, Tajikistan, Uzbekistan, and Kazakhstan continue to maintain or enforce restrictive measures that severely hinder LGBTQI+ rights and access to health services.

Second, the study underlines a significant lack of comprehensive, disaggregated data on LGBTQI+ SRHR issues in the EECA region. The absence of official statistics, combined with widespread fear of reporting due to potential retaliation and limited research funding for LGBTQI+ organizations, continues to create substantial knowledge gaps. These limitations weaken advocacy efforts, undermine programming effectiveness, and restrict international pressure for policy reforms. Notably, key areas such

as access to contraception, sexual and gender-based violence, safe abortion services, and STI prevention beyond HIV remain poorly documented, posing further risks to the health and wellbeing of LGBTQI+ youth.

Third, findings emphasize how the hostile sociopolitical climate in many EECA countries exacerbates the vulnerabilities of LGBTQI+ youth. The instrumentalization of “child protection” narratives by authoritarian regimes, far-right groups, and religious institutions fosters public hostility and justifies discriminatory legislation. State-led propaganda and restrictions on foreign funding for LGBTQI+ organizations have also contributed to a shrinking space for civil society. These actions not only limit access to essential services but also deepen socio economic exclusion, increase the risk of violence, and curtail opportunities for self-advocacy by LGBTQI+ communities themselves. Particularly at risk are young LGBTQI+ people living at the intersection of multiple marginalized identities, including rural youth, low-income individuals, and those with disabilities.

Despite these challenges, the research also reveals important opportunities. In several EECA countries, LGBTQI+ youth activism

remains vibrant and resilient, continuing to push for greater inclusion in health, education, and policy spaces. Youth-led advocacy, when supported with reliable data and international solidarity, has the potential to drive significant change. However, to be effective, future efforts must be rooted in a strong evidence base, prioritize the leadership of LGBTQI+ youth themselves, and address the regional nuances of discrimination and access barriers.

Several limitations of this study should be acknowledged. Although efforts were made to recruit a diverse sample, participant distribution was uneven across countries, with some contexts underrepresented. Additionally, detailed socio demographic data for focus group participants were not systematically collected, limiting the ability to fully disaggregate qualitative findings. Finally, the security context in certain countries may have influenced who was able and willing to participate, potentially excluding the most marginalized voices.

In light of these findings, several next steps are critical. First, greater investment is needed in large-scale, disaggregated research on LGBTQI+ SRHR needs in EECA to better inform

programming and advocacy. Second, international and regional actors must prioritize protecting and expanding civic space for LGBTQI+ organizations, including legal protections for freedom of association and access to funding. Fourth, health systems must be reformed to ensure non-discriminatory, inclusive, and confidential SRHR services for LGBTQI+ youth, with targeted interventions for the most vulnerable subgroups.

Finally, this study calls for coordinated regional action to advance LGBTQI+ rights and health in EECA. Regional collaboration among civil society actors, governments, donors, and multilateral agencies is essential to dismantle structural barriers, promote evidence-based policies, and build societies where all young people—regardless of their sexual orientation, gender identity, or expression can fully realize their health rights and live free from stigma, violence, and discrimination.

Ensuring equal rights and protections for LGBTQI+ youth in Eastern Europe, the South Caucasus, and Central Asia requires urgent and coordinated action across legal, social, healthcare, and educational sectors. Based on the findings of this study, several key steps must be taken by governments, civil society organizations, and international partners.

First and foremost, governments must strengthen legal protections and reform discriminatory laws. This includes repealing legislation criminalizing same-sex relationships, as seen in Uzbekistan, and aligning national legal frameworks with international human rights standards. Revisions should also ensure comprehensive anti-discrimination protections in employment, education, healthcare, and access to services. Procedures for legal gender recognition must be simplified and based on self-determination without requiring invasive medical interventions, particularly in Kazakhstan, Kyrgyzstan, and Uzbekistan. Additionally, strengthening hate crime legislation

and enforcing penalties for bias-motivated violence remain urgent across the region, including in Moldova, Lithuania, Latvia, and Ukraine. International actors have an important role to play by supporting legal reform efforts and monitoring state compliance with human rights obligations.

In parallel, it is essential to expand access to inclusive healthcare services. Ministries of Health should ensure that SRHR services, including HIV prevention measures such as PrEP and PEP, STI testing, mental health support, and gender-affirming care, are accessible, confidential, and stigma-free. Expanding anonymous HIV testing and revising mandatory disclosure laws will be particularly important in countries like Russia, Uzbekistan, and Kazakhstan to protect the rights and privacy of LGBTQI+ individuals. Public healthcare systems should also cover gender-affirming treatments, such as hormone therapy and psychological support, which are vital for the well-being of transgender youth. Moreover, healthcare provider training must be expanded to build competency and respect in serving LGBTQI+ patients.

At the same time, reforming education systems to foster inclusion is crucial. Governments should integrate comprehensive sexuality education that reflects the realities of LGBTQI+ youth into national curricula, particularly in Russia, Lithuania, Georgia, and Moldova. Educators should receive training to deliver accurate and inclusive content on gender and sexual diversity, helping to combat misinformation and stigma. In countries like Russia, Kyrgyzstan, and Lithuania, public awareness campaigns should be launched to counter the influence of anti-gender movements and promote acceptance and equality. International agencies and donors have a role in funding education initiatives that challenge discriminatory narratives and advance human rights.

In addition to legal and educational reforms, protecting and empowering civil society organizations must be a priority. Governments must remove legal and administrative barriers that restrict LGBTQI+ and human rights organizations, including eliminating foreign agent laws and other funding restrictions. Civic spaces must be safeguarded to enable advocacy, service provision, and community mobilization. Law enforcement

agencies must receive targeted training to respect LGBTQI+ rights, and mechanisms for the safe reporting of harassment and violence should be established. International donors should prioritize providing long-term, flexible funding to support LGBTQI+ civil society organizations and frontline services.

Finally, it is critical to promote safe and inclusive public spaces. Authorities must guarantee the safety of LGBTQI+ public events such as Pride marches by providing adequate security measures and protecting participants from violence. In countries such as Moldova, Latvia, Estonia, and Ukraine, governments should reassess law enforcement practices to better respond to anti-LGBTQI+ violence and ensure access to justice for victims. Regional collaboration among civil society organizations should also be encouraged to strengthen advocacy efforts, share strategies, and amplify LGBTQI+ voices in policy making processes.

By adopting targeted legal, healthcare, educational, and civic reforms, governments across the EECA region can make substantial progress toward creating more inclusive and equitable societies. Stronger partnerships between

governments, civil society, and international actors are essential to dismantle systemic barriers and ensure that LGBTQI+ youth can fully realize their rights to health, safety, and dignity.

FIGURES AND TABLES

Figure 1. Correlation Matrix of Predictor Factors

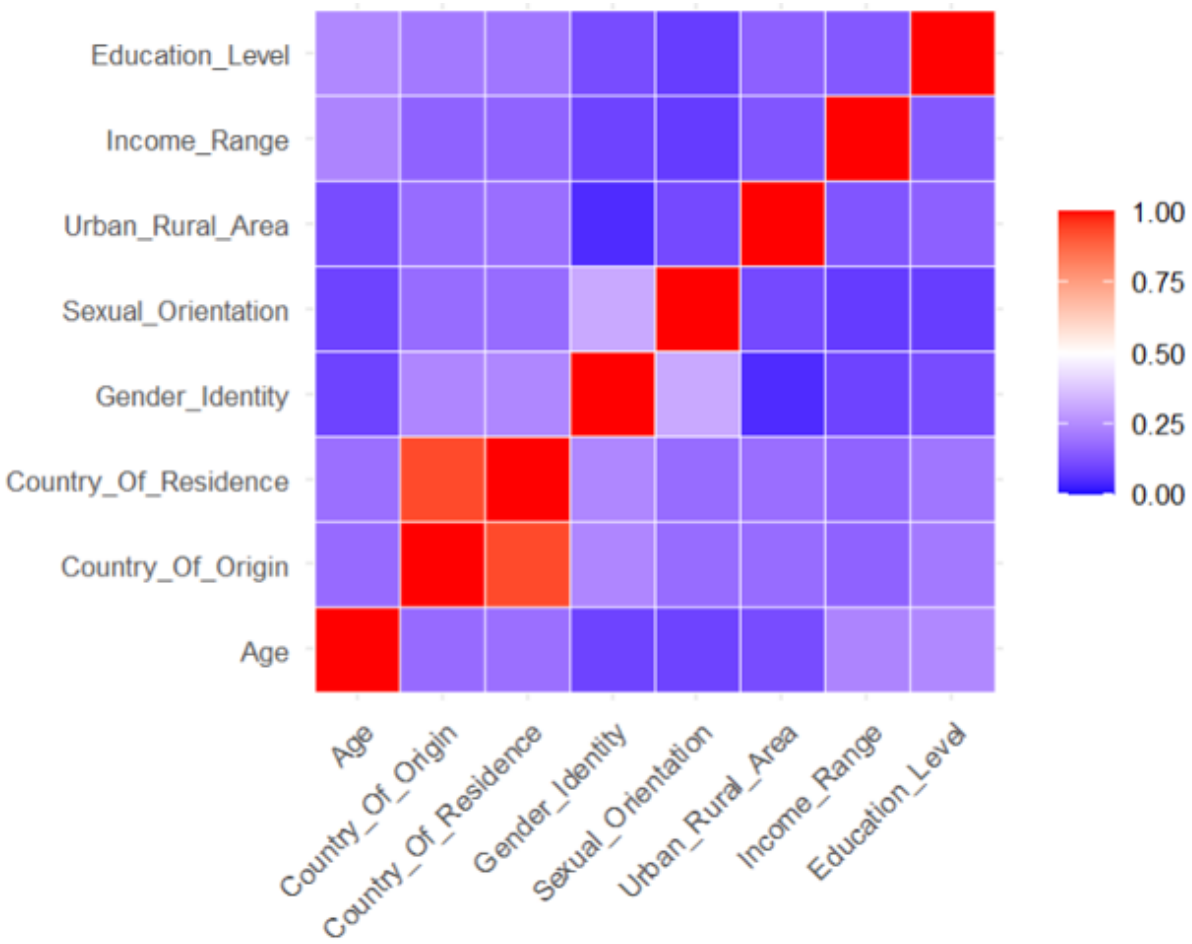


Figure 2. Inclusivity Index in Eastern Europe & Central Asia

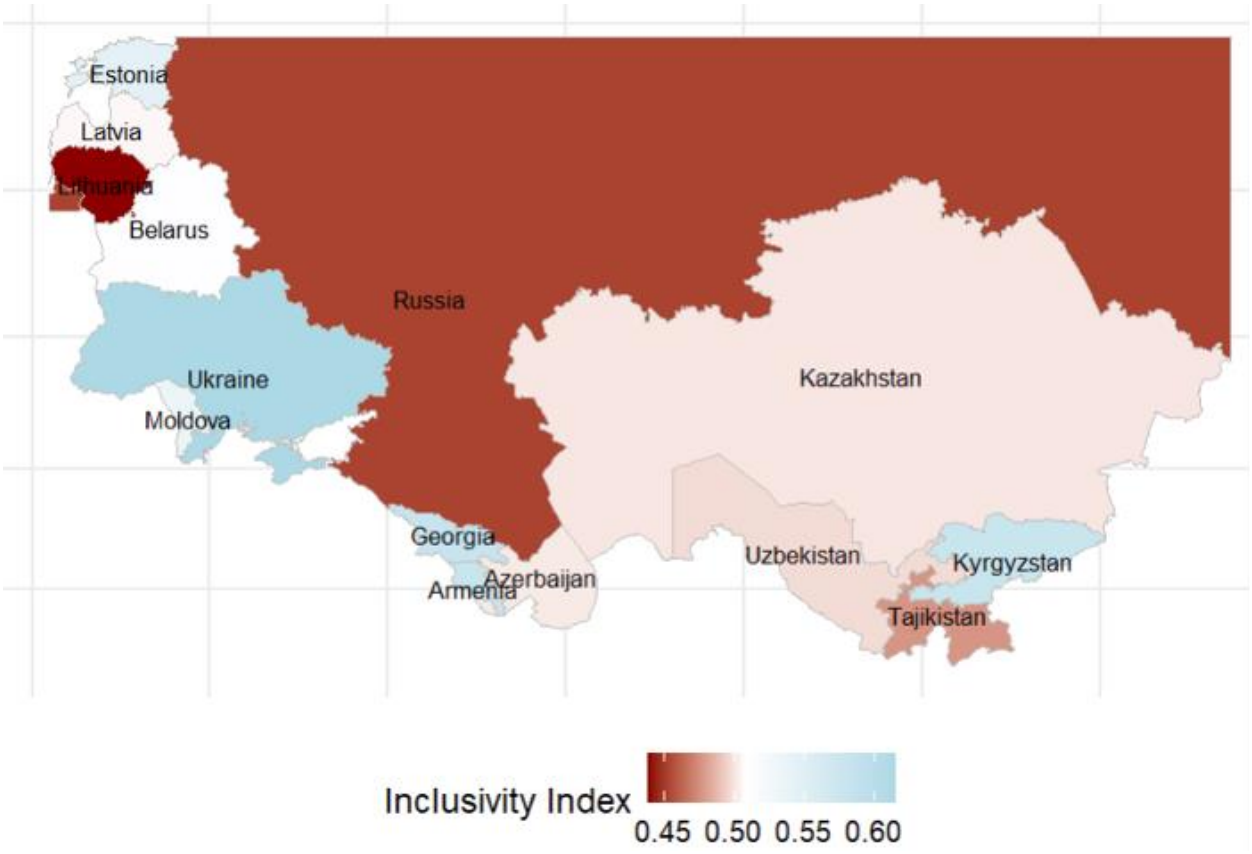


Figure 3. Distribution of Respondents by Country of Origin and Country of Residence

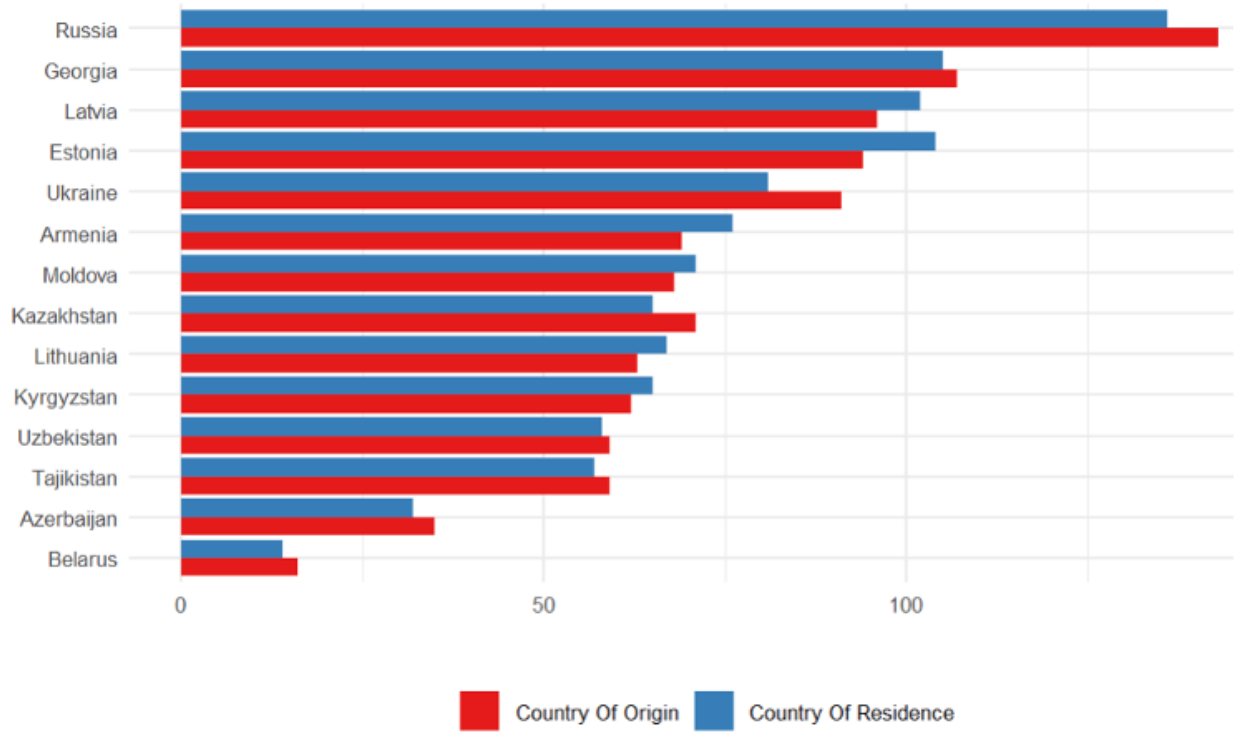


Figure 4. Gaps in Sexuality Education: Key Missing Topics Identified by Respondents

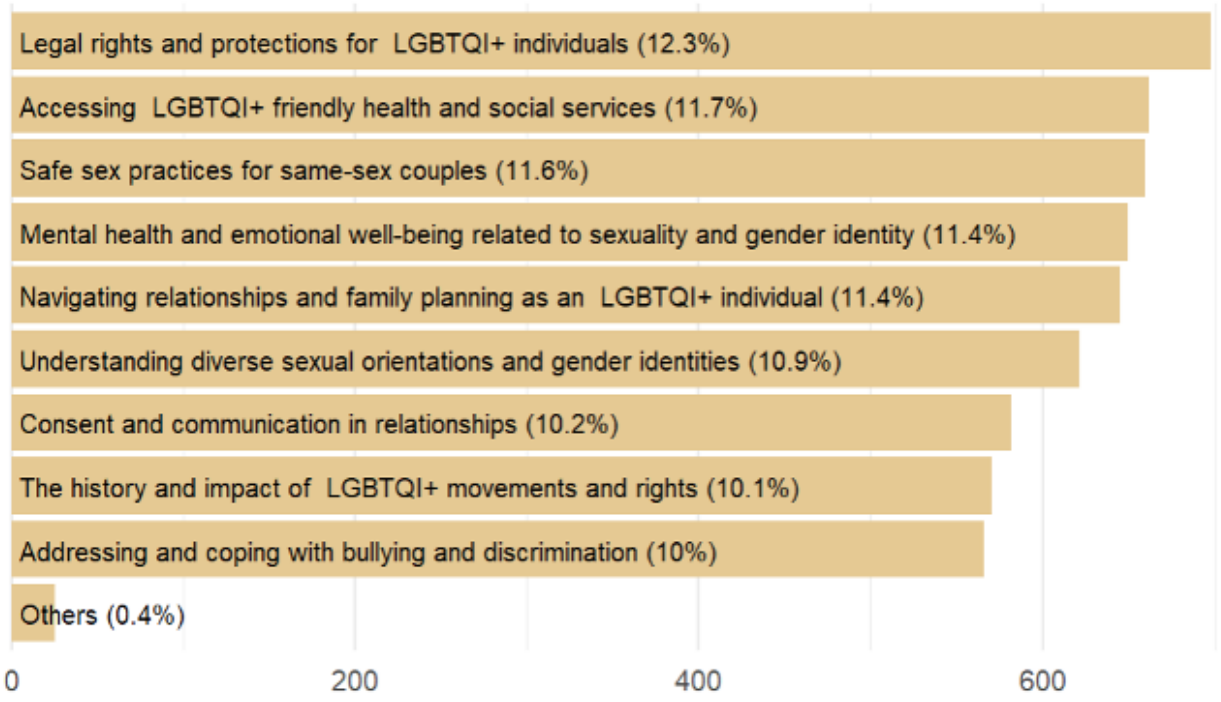


Figure 5. The main barriers LGBTQI+ youth face in their countries

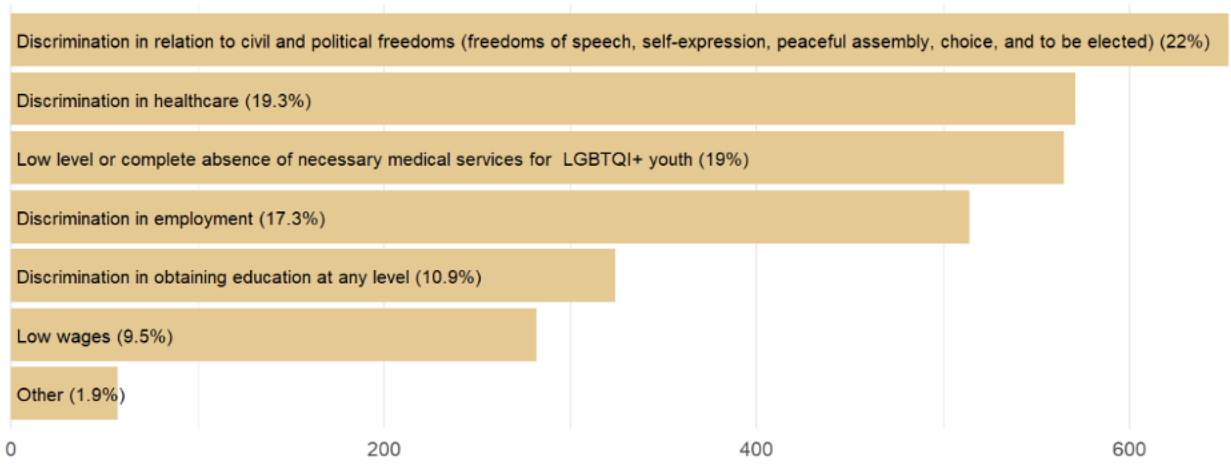


Figure 6. The reasons for existing barriers LGBTQI+ youth face in their countries

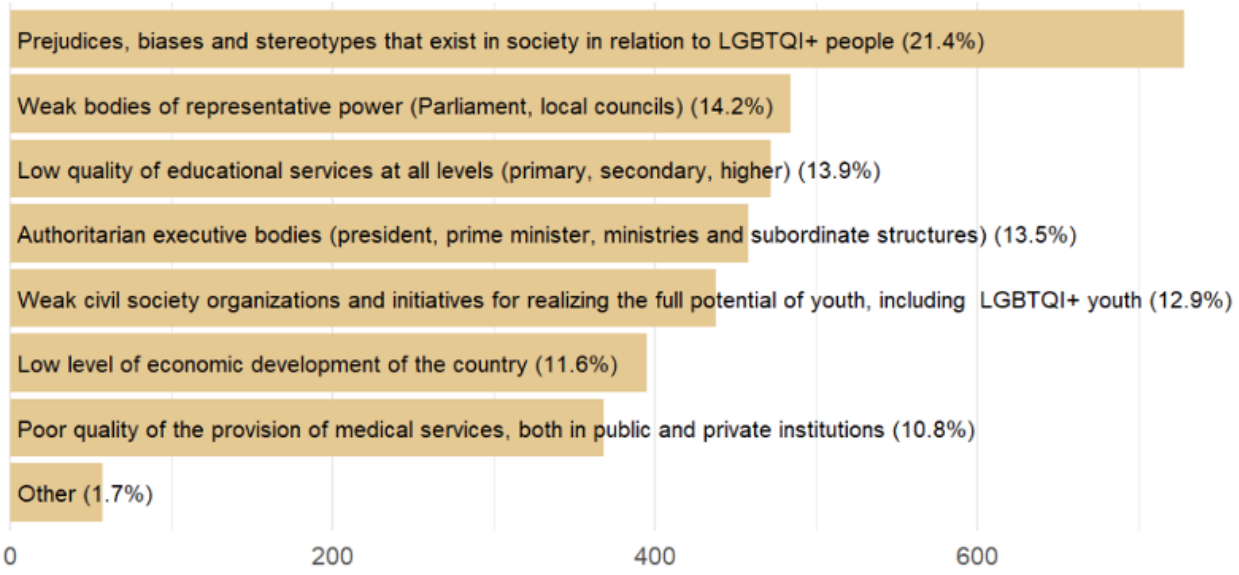


Figure 7. Priority Areas for National Advocacy to Support LGBTQI+ Youth

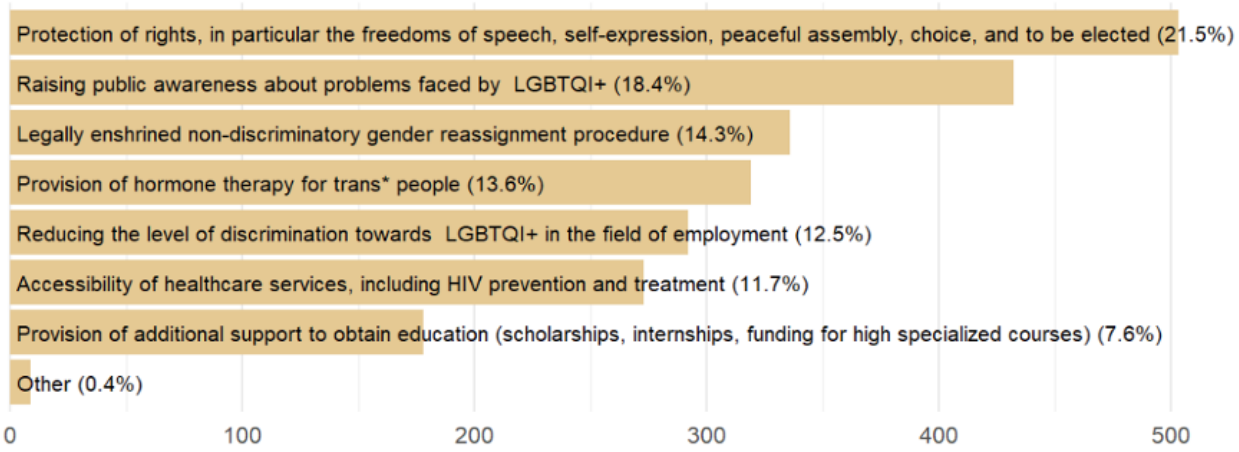


Figure 8. Actions to Reduce Stigma and Discrimination Against LGBTQI+ Individuals in Healthcare Settings

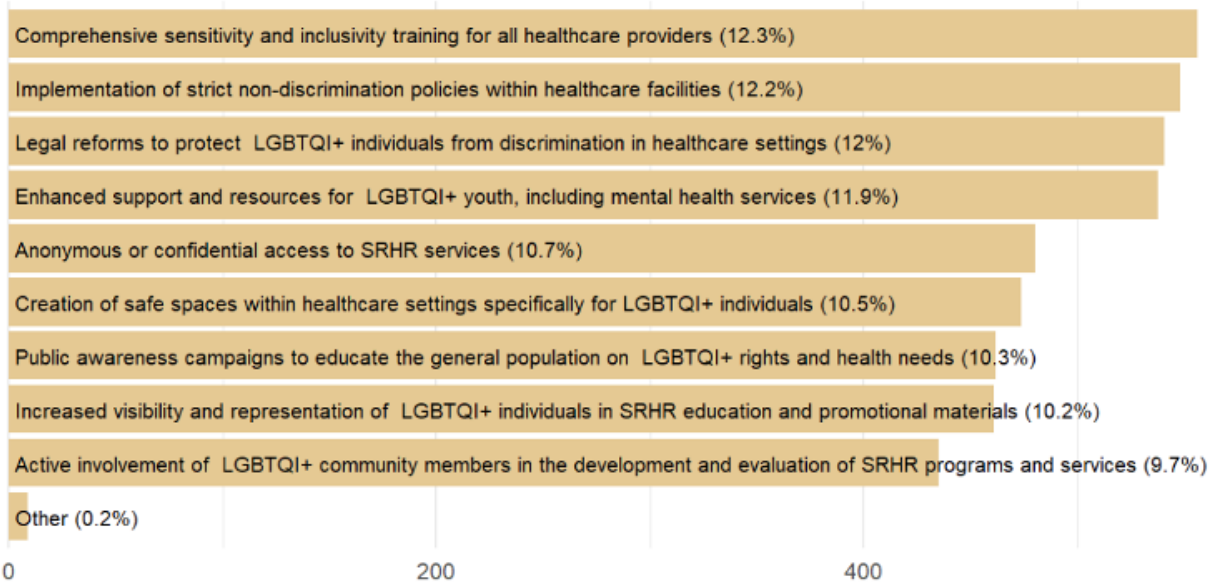


Table 1. ANOVA Results

dep_variable	ind_variables	Chi-Square Statistic	Df	P-value	Significance
Sexuality_Education_Received	Age	2.2483163	4	0.6901940	
Sexuality_Education_Received	Country_Of_Residence	126.5916993	13	0.0000000	***
Sexuality_Education_Received	Gender_Identity	12.7378621	6	0.0473928	*
Sexuality_Education_Received	Sexual_Orientation	11.7285901	6	0.0683048	
Sexuality_Education_Received	Urban_Rural_Area	5.9053312	1	0.0150951	*
Sexuality_Education_Received	Income_Range	3.1401190	5	0.6783938	
Sexuality_Education_Received	Education_Level	11.9840700	5	0.0350067	*
Sexuality_Education_Quality	Age	11.3720499	4	0.0226860	*
Sexuality_Education_Quality	Country_Of_Residence	82.7680860	13	0.0000000	***
Sexuality_Education_Quality	Gender_Identity	7.6227457	6	0.2670647	
Sexuality_Education_Quality	Sexual_Orientation	4.1083896	6	0.6620110	
Sexuality_Education_Quality	Urban_Rural_Area	5.3014327	1	0.0213079	*
Sexuality_Education_Quality	Income_Range	3.5181141	5	0.6206485	
Sexuality_Education_Quality	Education_Level	5.0501519	5	0.4097903	
Access_To_Sexual_Health_Info	Age	3.4164698	4	0.4906924	
Access_To_Sexual_Health_Info	Country_Of_Residence	39.0086359	13	0.0001993	***
Access_To_Sexual_Health_Info	Gender_Identity	10.9910717	6	0.0886528	
Access_To_Sexual_Health_Info	Sexual_Orientation	17.4251726	6	0.0078414	**
Access_To_Sexual_Health_Info	Urban_Rural_Area	0.6587151	1	0.4170139	
Access_To_Sexual_Health_Info	Income_Range	5.8091017	5	0.3252396	
Access_To_Sexual_Health_Info	Education_Level	5.7884470	5	0.3273512	
Awareness_Of_HIV_Services	Age	8.0423240	4	0.0900401	
Awareness_Of_HIV_Services	Country_Of_Residence	138.0680591	13	0.0000000	***
Awareness_Of_HIV_Services	Gender_Identity	4.8273304	6	0.5661426	
Awareness_Of_HIV_Services	Sexual_Orientation	23.9296220	6	0.0005381	***
Awareness_Of_HIV_Services	Urban_Rural_Area	8.6782883	1	0.0032202	**
Awareness_Of_HIV_Services	Income_Range	3.4639609	5	0.6288477	
Awareness_Of_HIV_Services	Education_Level	8.6483168	5	0.1239410	
Comfort_Accessing_HIV_Services	Age	13.5162662	4	0.0090103	**
Comfort_Accessing_HIV_Services	Country_Of_Residence	57.9764487	13	0.0000001	***
Comfort_Accessing_HIV_Services	Gender_Identity	10.8648335	6	0.0926448	
Comfort_Accessing_HIV_Services	Sexual_Orientation	3.1968073	6	0.7837709	
Comfort_Accessing_HIV_Services	Urban_Rural_Area	0.0263596	1	0.8710253	
Comfort_Accessing_HIV_Services	Income_Range	16.5484611	5	0.0054408	**
Comfort_Accessing_HIV_Services	Education_Level	9.4580631	5	0.0921303	

Awareness_Of_PrEP	Age	26.3478528	4	0.0000269	***
Awareness_Of_PrEP	Country_Of_Residence	50.9217840	13	0.0000021	***
Awareness_Of_PrEP	Gender_Identity	8.1538118	6	0.2270499	
Awareness_Of_PrEP	Sexual_Orientation	25.6387852	6	0.0002599	***
Awareness_Of_PrEP	Urban_Rural_Area	7.8557647	1	0.0050659	**
Awareness_Of_PrEP	Income_Range	5.9772657	5	0.3084374	
Awareness_Of_PrEP	Education_Level	4.9335031	5	0.4240494	
PrEP_Availability_And_Usage	Age	13.1771173	4	0.0104420	*
PrEP_Availability_And_Usage	Country_Of_Residence	120.4045820	13	0.0000000	***
PrEP_Availability_And_Usage	Gender_Identity	11.0089543	6	0.0881001	
PrEP_Availability_And_Usage	Sexual_Orientation	8.3803364	6	0.2115417	
PrEP_Availability_And_Usage	Urban_Rural_Area	4.3608249	1	0.0367745	*
PrEP_Availability_And_Usage	Income_Range	1.9002644	5	0.8627661	
PrEP_Availability_And_Usage	Education_Level	12.4753329	5	0.0288243	*
Anonymous_HIV_Testing	Age	18.8090320	4	0.0008568	***
Anonymous_HIV_Testing	Country_Of_Residence	82.5221906	13	0.0000000	***
Anonymous_HIV_Testing	Gender_Identity	3.8977169	6	0.6905159	
Anonymous_HIV_Testing	Sexual_Orientation	36.8840055	6	0.0000019	***
Anonymous_HIV_Testing	Urban_Rural_Area	21.1937077	1	0.0000042	***
Anonymous_HIV_Testing	Income_Range	10.5536730	5	0.0609837	
Anonymous_HIV_Testing	Education_Level	9.7706926	5	0.0819995	
Confidentiality_Practices_HIV_Care	Age	11.3008768	4	0.0233828	*
Confidentiality_Practices_HIV_Care	Country_Of_Residence	55.3576677	13	0.0000003	***
Confidentiality_Practices_HIV_Care	Gender_Identity	1.5332488	6	0.9572554	
Confidentiality_Practices_HIV_Care	Sexual_Orientation	5.6626621	6	0.4620188	
Confidentiality_Practices_HIV_Care	Urban_Rural_Area	0.1405482	1	0.7077366	
Confidentiality_Practices_HIV_Care	Income_Range	5.1372670	5	0.3993588	
Confidentiality_Practices_HIV_Care	Education_Level	2.7395713	5	0.7400598	
Accessibility_Gender_Affirming_Care	Age	11.3008768	4	0.0233828	*
Accessibility_Gender_Affirming_Care	Country_Of_Residence	55.3576677	13	0.0000003	***
Accessibility_Gender_Affirming_Care	Gender_Identity	1.5332488	6	0.9572554	
Accessibility_Gender_Affirming_Care	Sexual_Orientation	5.6626621	6	0.4620188	
Accessibility_Gender_Affirming_Care	Urban_Rural_Area	0.1405482	1	0.7077366	
Accessibility_Gender_Affirming_Care	Income_Range	5.1372670	5	0.3993588	
Accessibility_Gender_Affirming_Care	Education_Level	2.7395713	5	0.7400598	

Inclusive_SRH_Services	Age	13.7831967	4	0.0080201	**
Inclusive_SRH_Services	Country_Of_Residence	56.8143090	13	0.0000002	***
Inclusive_SRH_Services	Gender_Identity	22.1845625	6	0.0011211	**
Inclusive_SRH_Services	Sexual_Orientation	8.1204739	6	0.2294093	
Inclusive_SRH_Services	Urban_Rural_Area	3.9781402	1	0.0460944	*
Inclusive_SRH_Services	Income_Range	10.1462677	5	0.0711953	
Inclusive_SRH_Services	Education_Level	6.0033417	5	0.3058939	
HPV_Screening_Availability	Age	2.9006106	4	0.5745934	
HPV_Screening_Availability	Country_Of_Residence	44.0331219	13	0.0000303	***
HPV_Screening_Availability	Gender_Identity	14.4002964	6	0.0254706	*
HPV_Screening_Availability	Sexual_Orientation	6.0981323	6	0.4122876	
HPV_Screening_Availability	Urban_Rural_Area	16.7980051	1	0.0000416	***
HPV_Screening_Availability	Income_Range	3.7646826	5	0.5837683	
HPV_Screening_Availability	Education_Level	11.0201718	5	0.0509815	
STI_Testing_Availability	Age	3.7735322	4	0.4375216	
STI_Testing_Availability	Country_Of_Residence	29.5344343	13	0.0054934	**
STI_Testing_Availability	Gender_Identity	5.9543571	6	0.4283224	
STI_Testing_Availability	Sexual_Orientation	4.8943041	6	0.5574393	
STI_Testing_Availability	Urban_Rural_Area	19.2405822	1	0.0000115	***
STI_Testing_Availability	Income_Range	7.9537990	5	0.1588003	
STI_Testing_Availability	Education_Level	10.7904946	5	0.0556958	
STI_Tested_Past_Year	Age	21.3702452	4	0.0002674	***
STI_Tested_Past_Year	Country_Of_Residence	56.6527540	13	0.0000002	***
STI_Tested_Past_Year	Gender_Identity	5.5272737	6	0.4781665	
STI_Tested_Past_Year	Sexual_Orientation	11.7144676	6	0.0686504	
STI_Tested_Past_Year	Urban_Rural_Area	10.3790481	1	0.0012745	**
STI_Tested_Past_Year	Income_Range	11.7086057	5	0.0390062	*
STI_Tested_Past_Year	Education_Level	5.4541748	5	0.3629970	
STI_Treatment_Experience	Age	5.4463904	4	0.2444822	
STI_Treatment_Experience	Country_Of_Residence	45.9236439	13	0.0000147	***
STI_Treatment_Experience	Gender_Identity	2.9160875	6	0.8193027	
STI_Treatment_Experience	Sexual_Orientation	7.6057978	6	0.2684288	
STI_Treatment_Experience	Urban_Rural_Area	0.2967682	1	0.5859156	
STI_Treatment_Experience	Income_Range	4.5917244	5	0.4677056	
STI_Treatment_Experience	Education_Level	6.5986900	5	0.2522371	

Contraceptive_Access	Age	1.0267273	4	0.9057165	
Contraceptive_Access	Country_Of_Residence	50.7950290	13	0.0000022	***
Contraceptive_Access	Gender_Identity	2.2703999	6	0.8932268	
Contraceptive_Access	Sexual_Orientation	3.5280797	6	0.7402301	
Contraceptive_Access	Urban_Rural_Area	0.5099633	1	0.4751548	
Contraceptive_Access	Income_Range	6.2352191	5	0.2839993	
Contraceptive_Access	Education_Level	2.3031945	5	0.8057976	
Comfort_Discussing_SRHR_Needs	Age	2.7840770	4	0.5945844	
Comfort_Discussing_SRHR_Needs	Country_Of_Residence	67.5797335	13	0.0000000	***
Comfort_Discussing_SRHR_Needs	Gender_Identity	6.5970679	6	0.3597210	
Comfort_Discussing_SRHR_Needs	Sexual_Orientation	2.2400145	6	0.8963544	
Comfort_Discussing_SRHR_Needs	Urban_Rural_Area	4.5043246	1	0.0338092	*
Comfort_Discussing_SRHR_Needs	Income_Range	7.2441673	5	0.2031054	
Comfort_Discussing_SRHR_Needs	Education_Level	3.9116267	5	0.5622085	
Awareness_Of_Discriminatory_Laws	Age	0.7827571	4	0.9407447	
Awareness_Of_Discriminatory_Laws	Country_Of_Residence	185.7362778	13	0.0000000	***
Awareness_Of_Discriminatory_Laws	Gender_Identity	5.5014407	6	0.4812826	
Awareness_Of_Discriminatory_Laws	Sexual_Orientation	11.3579978	6	0.0779225	
Awareness_Of_Discriminatory_Laws	Urban_Rural_Area	7.2963095	1	0.0069096	**
Awareness_Of_Discriminatory_Laws	Income_Range	5.3239335	5	0.3776385	
Awareness_Of_Discriminatory_Laws	Education_Level	3.4734727	5	0.6274053	
Discrimination_By_Healthcare	Age	3.3637341	4	0.4988979	
Discrimination_By_Healthcare	Country_Of_Residence	49.3186227	13	0.0000039	***
Discrimination_By_Healthcare	Gender_Identity	46.7484535	6	0.0000000	***
Discrimination_By_Healthcare	Sexual_Orientation	5.9210140	6	0.4320961	
Discrimination_By_Healthcare	Urban_Rural_Area	0.1472243	1	0.7012022	
Discrimination_By_Healthcare	Income_Range	8.9745999	5	0.1100816	
Discrimination_By_Healthcare	Education_Level	4.0403697	5	0.5436185	
Service_Refusal_By_Healthcare	Age	3.3539301	4	0.5004331	
Service_Refusal_By_Healthcare	Country_Of_Residence	54.8700907	13	0.0000004	***
Service_Refusal_By_Healthcare	Gender_Identity	32.3609303	6	0.0000139	***
Service_Refusal_By_Healthcare	Sexual_Orientation	10.3735003	6	0.1097789	
Service_Refusal_By_Healthcare	Urban_Rural_Area	0.2509324	1	0.6164193	
Service_Refusal_By_Healthcare	Income_Range	6.5408563	5	0.2570865	
Service_Refusal_By_Healthcare	Education_Level	11.6151785	5	0.0404586	*

Judgment_By_Healthcare_Providers	Age	3.3539301	4	0.5004331	
Judgment_By_Healthcare_Providers	Country_Of_Residence	54.8700907	13	0.0000004	***
Judgment_By_Healthcare_Providers	Gender_Identity	32.3609303	6	0.0000139	***
Judgment_By_Healthcare_Providers	Sexual_Orientation	10.3735003	6	0.1097789	
Judgment_By_Healthcare_Providers	Urban_Rural_Area	0.2509324	1	0.6164193	
Judgment_By_Healthcare_Providers	Income_Range	6.5408563	5	0.2570865	
Judgment_By_Healthcare_Providers	Education_Level	11.6151785	5	0.0404586	*

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