



**AN ETHNOGRAPHIC PILOT STUDY:
IMPACTS OF STIGMA ON HEALTH AND WELLBEING
OF TRANSGENDER FEMALES IN NEPAL**

BY

PRARTHANA KOIRALA

**AN INDEPENDENT STUDY SUBMITTED IN PARTIAL
FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE
OF MASTER OF PUBLIC HEALTH IN GLOBAL HEALTH
FACULTY OF PUBLIC HEALTH
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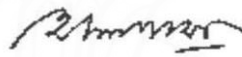
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ABSTRACT

This ethnographic study explores the effects of stigma on the health and welfare of transgender women in Nepal with an emphasis on how societal, institutional, and internalized forms of stigma influence transgender women's lived experiences. Even with Nepal's gradual legal acknowledgement of a third gender, transgender people nevertheless face discrimination and exclusion in important domains like healthcare, work, housing, and education.

The study draws upon qualitative data collected through field immersion and semi-structured interviews with five self-identified transgender women residing in Kathmandu. Thematic analysis reveals that stigma operates through three interconnected domains: social stigma—manifesting as family rejection and public discrimination; structural stigma—evident in healthcare, education, and employment discrimination; and self stigma—expressed as shame, self-isolation, and psychological distress. These combined marginalization experiences create major obstacles to receiving the right medical care, which frequently results in untreated mental health issues, increased susceptibility to HIV, and a lower standard of living.

In addition, participants reported using advocacy networks, moving to an urban area for anonymity, and hiding their gender identification as coping mechanisms.

This study provides policy-relevant insights for national and regional human rights frameworks and adds to the localized knowledge on transgender health. For transgender women in Nepal to achieve their right to health and dignity, stigma must be addressed in all of its social, structural, and psychological facets. The results highlight the urgent necessity of developing transgender-inclusive, gender-affirming healthcare services in Nepal as well as disaggregated policies that distinguish amongst LGBTIQ subgroups.

Keywords: Transgender women; Stigma; Nepal; Healthcare access; Qualitative research

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GLOSSARY

Initial remarks

Often an umbrella term is used for all people whose sex, sexual orientation or gender identity places them outside the mainstream, and people whose gender identity does not correspond with the sex they were assigned at birth (IOM & UNHCR, 2017).

LGBTI: An acronym for lesbian, gay, bisexual, transgender and intersex persons that is also used as shorthand for “persons of diverse sex, sexual orientation and gender identity.” Among other variations, sometimes intersex is not included and the acronym becomes LGBT; sometimes “queer” or “questioning” is included and the acronym becomes LGBTQ or LGBTIQ; and sometimes “ally,” “a-romantic” or “asexual” is included, and the acronym becomes “LGBTQA” or “LGBTIQA.” (IOM & UNHCR, 2017)

SOGI: An acronym for sexual orientation and gender identity (IOM & UNHCR, 2017)

This glossary is organized around the following categories:

1. Bodies and gender;
2. Sexual orientations; and
3. Societal attitudes/issues.

Bodies, gender and gender identities

Sex: Biological and physiological characteristics (genetic, endocrine, and anatomical) used to categorize people as members of either the male or female population (see also the definition of intersex). These sets of biological characteristics are not mutually exclusive, as they occur naturally in various degrees and combinations. However, in practice, they are used to differentiate humans as supposedly opposite extremes within a polarized binary system (male and female). Typically, a distinction

is made between primary sexual characteristics (an individual's reproductive organs) and secondary sex characteristics. The latter describe other non-genital physical traits, such as breast development, that are used to differentiate females from males (UNDP, 2015).

Sex assigned at birth: The sex to which a person is assigned at, or soon after, birth. This assignment may or may not accord with the individual's own sense of gender identity as they grow up. In medical and sociological literature, this often is referred to as a person's "natal sex" or "biological sex." For most people, gender identity and expression are consistent with their sex assigned at birth. For trans people, gender identity or expression differ from their sex assigned at birth (UNDP, 2015).

Intersex: an umbrella term that refers to individuals who have anatomical, chromosomal and hormonal characteristics that differ from medical and conventional understandings of male and female bodies. Intersex people may be "neither wholly female nor wholly male; a combination of female and male; or neither female nor male" Intersex people may identify as either men, women or non-binary (Australian Institute of Family Studies, 2019)

Gender: Gender refers to the socially constructed and hierarchical categories assigned to us on the basis of our apparent sex at birth. While other genders are recognized in some cultures, in Western society, people are expected to conform to one of two gender roles matching their apparent sex; for example, male = man/masculine and female = woman/feminine. (Australian Institute of Family Studies, 2019)

Gender norms define how we should dress, act/behave, and the appropriate roles and positions of privilege we have in society, for example the power relationships between men and women. Failing to adhere to the norms associated with one's gender can result in ridicule, intimidation and even violence Many people do not fit into these narrowly defined and rigid gender norms. Some women may feel masculine, some men may feel more feminine and some people may not feel either, or may reject gender altogether (Australian Institute of Family Studies, 2019)

Gender identity: A person's internal sense of being a man, a woman, or some alternative gender or combination of genders. A person's gender identity may or may not correspond with their sex assigned at birth (UNDP, 2015).

Gender expression: A person's ways of communicating culturally-defined traits of masculinity or femininity (or both or neither) externally through physical appearance (including clothing, accessories, hair styles, and the use of cosmetics), mannerisms, ways of speaking, and behavioral patterns in interactions with others (UNDP, 2015).

Gender-nonconforming or gender variant: Describes someone whose gender identity or gender expression is different from societal expectations or stereotypes. Not all trans people are gender-nonconforming. Some trans people, like other people, are comfortable conforming to societal expectations of what it means to be a woman or a man. Conversely, some people who are not trans may identify as gender-nonconforming, based on their gender expression rather than their gender identity (UNDP, 2015).

Gender dysphoria: "Refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics). Only some gender-nonconforming people experience gender dysphoria at some point in their lives" (UNDP, 2015).

Transgender/trans/ gender diverse: umbrella terms to refer to people whose assigned sex at birth does not match their internal gender identity, regardless of whether their gender is outside the gender binary or within it. Transgender/trans or gender diverse people may identify as non-binary, that is: they may not identify exclusively as either gender; they may identify as both genders, they may identify as neither gender; they may move around freely in between the gender binary; or may reject the idea of gender altogether (UNDP, 2015).

Transgender/trans or gender diverse people may choose to live their lives with or without modifying their body, dress or legal status, and with or without medical treatment and surgery. Transgender/trans or gender diverse people may use a variety of terms to describe themselves including but not limited to: man, woman,

transwoman, transman, trans guy, trans masculine, trans feminine, trans, gender-diverse, gender-queer, gender-non-conforming, non-binary, poly gendered, pan gendered and many more (Australian Institute of Family Studies, 2019).

Transgender/trans or gender diverse people have the same range of sexual orientations as the rest of the population. Transgender/trans or gender diverse people's sexuality is referred to in reference to their gender identity, rather than their sex. For example, a woman may identify as lesbian whether she was assigned female at birth or male (Australian Institute of Family Studies, 2019)

Transgender /trans or gender diverse people may also use a variety of different pronouns including he, she, they, ze, hir. Using the incorrect pronouns to refer to or describe trans people is disrespectful and can be harmful (see misgendering below) (IOM & UNHCR, 2017).

Trans woman: Term used to refer to a trans person who identifies as female (i.e., someone whose sex was assigned male at birth but who identifies as female). The acronym MtF (Male to Female) is also used to describe a trans woman (UNDP, 2015).

Trans man: Term used to refer to a trans person who identifies as male (i.e., someone whose sex was assigned female at birth but who identifies as male). The acronym FtM (Female to Male) is also used to describe a trans man. (UNDP, 2015).

Men who have sex with men (MSM): A term used to categorize males who engage in sexual activity with other males, regardless of how they identify themselves (IOM & UNHCR, 2017).

Women who have sex with women (WSW): A term used to categorize females who engage in sexual activity with other females, regardless of how they identify themselves (IOM & UNHCR, 2017).

Key to understanding male-to-male sexual behavior in Nepal is an awareness of the language and gendered sexual roles in which such relations are conceptualized. A Blue Diamond Society document supplies the following definitions (Tamang, 2003):

Meti: A self-identified label used by feminized males who have sex with men, and used their feminine behaviors in public spaces to attract men for sex. They usually are sexually penetrated. However, many metis will also be married to women and have children in a culture where “compulsory heterosexuality” is the norm (Tamang, 2003).

Dohori: A label given by metis to other males who are sexually penetrated and also penetrate males, and whose public behavior is normatively masculine. Most of these males do not have a label for themselves. Some will act like metis in public spaces to cruise Ta (“real men”) (Tamang, 2003).

Ta/"real"men: A label given by metis/hijras to “real” men who sexually penetrate, whether this be a woman or another male. Ta do not have a label for themselves other than man. Ta may have sex with metis/hijras because they like having sex with males, or they like having anal sex, or are sexually aroused at that moment. Called “body heat” in the region. These are men from the general male population (Tamang, 2003).

Hijra: A self-identified term used by males who define themselves as “not-men/not women” but as a “third gender.” Hijras cross-dress publicly and privately and are a part of a social, religious and cultural community. Ritual castration is part of the hijra identity. Sex with men is common. They also have their own language, known as “ulti” (especially in the southern lowlands of Nepal). In terms of sexually transmitted diseases and HIV, metis are at most risk because of the fact that they are the penetrated partner in anal sex and commonly have multiple partners. Ta are said to have less risk because they are penetrators – penetrating both meti and female partners (Tamang, 2003).

Cisgender/cis: Within an assumed binary system, gender and sex form a singular unit, where individuals who were assigned female at birth are viewed as women, and those assigned male at birth are viewed as men. The word cisgender is used to mean people whose gender identity aligns with the social expectations of the sex they were assigned at birth (Carman et al.,2021)

Transition: The process of changing one's external gender presentation in order to be more in line with one's gender identity. This is a complex process that typically occurs over a long period of time. Transition includes some or all of the following personal, medical and legal steps: telling one's family, friends and co-workers, using a different name and new pronouns, dressing differently, changing one's name and/or sex on legal documents, hormone therapy and possibly (though not always) one or more types of surgery. The steps involved in transition vary from person to person (IOM & UNHCR, 2017).

Gender confirmation/affirming surgery (previously sex reassignment surgery (SRS): Gender confirmation, or gender affirming, surgery refers to surgical interventions that may be one part of transition. Not all transgender people choose, have access to, or can afford surgery. "Gender confirmation" or "gender affirming" is preferred over "sex reassignment surgery" or "sex change operation." The terms "pre-operative" (or pre-op) and "post-operative" (or post-op) should also be avoided (IOM & UNHCR, 2017).

Gender dysphoria: A diagnosis contained in the fifth edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-V). It refers to a feeling of disconnect from or discomfort with one's sex as assigned at birth. It replaced the outdated diagnosis "gender identity disorder." The need for a psychiatric diagnosis for transgender persons to undergo elements of transition such as surgery remains controversial (IOM & UNHCR, 2017).

Sexual orientations

Sexual orientation refers to an individual's sexual and romantic attraction to another person. This can include, but is not limited to, heterosexual, lesbian, gay, bisexual or asexual. It is important to note, however, that these are just a handful of sexual

identifications - the reality is that there are an infinite number of ways in which someone might define their sexuality. Further, people can identify with a sexuality or sexual orientation regardless of their sexual or romantic experiences. Some people may identify as sexually fluid; that is, their sexuality is not fixed to any one identity (Australian Institute of Family Studies, 2019).

Lesbian: an individual who identifies as a woman and is sexually and/or romantically attracted to other people who identify as women (IOM & UNHCR, 2017).

Gay: an individual who identifies as a man and is sexually and/or romantically attracted to other people who identify as men. The term gay can also be used in relation to women who are sexually and romantically attracted to other women (IOM & UNHCR, 2017).

Bisexual: an individual who is sexually and/or romantically attracted to both men and women (IOM & UNHCR, 2017).

Pansexual: an individual whose sexual and/or romantic attraction to others is not restricted by gender. A pansexual may be sexually and/or romantically attracted to any person, regardless of their gender identity (IOM & UNHCR, 2017).

Asexual: a sexual orientation that reflects little to no sexual attraction, either within our outside relationships. People who identify as asexual can still experience romantic attraction across the sexuality continuum (IOM & UNHCR, 2017).

Heterosexual: an individual who is sexually and/or romantically attracted to the opposite gender (IOM & UNHCR, 2017).

Ally: a heterosexual, cisgender person who supports LGBTI persons.

Queer: a term used to describe a range of sexual orientations and gender identities. Although once used as a derogatory term, the term queer now encapsulates political ideas of resistance to heteronormativity and homonormativity and is often used as an umbrella term to describe the full range of LGBTIQ+ identities (IOM & UNHCR, 2017).

Societal attitudes/issues

Homophobia and biphobia: refer to negative beliefs, prejudices and stereotypes about people who are not heterosexual (IOM & UNHCR, 2017).

Transphobia: refers to negative beliefs, prejudices and stereotypes that exist about transgender and gender diverse people (IOM & UNHCR, 2017).

Heterosexism: is the set of beliefs that privilege heterosexuality, heterosexual relationships and cisgendered identities over non-heterosexual relationships and non-normative gender identities (Leonard, Mitchell, Patel, & Fox, 2008). Heterosexism provides the "social backdrop" for homophobic and transphobic prejudices, violence and discrimination. (IOM & UNHCR, 2017).

Heteronormativity: is the view that heterosexual relationships are the only natural, normal and legitimate expressions of sexuality and relationships. These assumptions are reinforced through cultural beliefs and practices and through social and political institutions such as the law, family structures and religion (Australian Institute of Family Studies, 2019).

Homonormativity: a term that describes the privileging of certain people or relationships within the queer community (usually cisgendered, white, gay men). This term also refers to the assumption that LGBTIQ+ people will conform to mainstream, heterosexual culture, for example by adopting the idea that marriage and monogamy are natural and normal (Australian Institute of Family Studies, 2019).

Cis-normativity: assumes that everyone is cisgendered and that all people will continue to identify with the gender they were assigned at birth. Cisnormativity erases the existence of trans and gender diverse people (Australian Institute of Family Studies, 2019).

Mis-gendering: is an occurrence where a person is described or addressed using language that does not match their gender identity. This can include the incorrect use of pronouns (she/he/they), familial titles (father, sister, uncle) and, at times, other words that traditionally have gendered applications (pretty, handsome, etc.). It is best

to ask a person, at a relevant moment, what words they like to use (Australian Institute of Family Studies, 2019).



CHAPTER 1

INTRODUCTION

1.1 Background

The curiosities regarding the identity of an individual have taken the interest of many scholars since decades. More so in socio-political spheres, the concept of “Identity” seems to stir debates in many major subfields like gender, sexuality, nationality, ethnicity, culture and the interrelation between political ideologies like liberalism. Identity in this sense has also been viewed as social categories and an individual’s source of respect and dignity. Hence, this concept put forward the belief that “Identity” reflects the idea that social categories are linked with an individual’s self-respect (Bhatta,2017).

A great portion of an individual’s identity is derived from their Sexual Orientation and Gender Identity (SOGI). “Sexual Orientation” here denotes an individual’s romantic interest in another individual (Australian Institute of Family Studies, 2019). A person’s sexual interest may be heterosexual, homosexual, bisexual or asexual. However, it is important to understand that there are infinite ways that people can manifest their sexual interest to the extent that some people may be sexually fluid, which means that their sexuality is not fixed to a single manifestation(Australian Institute of Family Studies, 2019). Thus “sex” here is merely the anatomical, hormonal and chromosomal characteristic of an individual. A male or female label is given to an individual based on their external biological features. Whereas Sexual Orientation, referring to an individual's sexual and romantic attraction, encompasses variables like: Lesbian, Gay, Intersex, Queer, Pansexual, Heterosexual, Bisexual and Asexual (Australian Institute of Family Studies, 2019).

“Gender Identity” refers to the inner sense of one’s being; be it a man, woman, masculine, feminine, both or moving freely outside the binary. “Gender” on the other hand refers to the socially prescribed hierarchical categories assigned at birth based on an individual’s sex (Australian Institute of Family Studies, 2019). People are expected to fit into either of the two gender stereotypes matching their biological sex: for example, male equals being a man socially determined as masculine and female equals being a woman socially determines as feminine. These binary roles then prescribe individual how to dress, act, behave and acquire respective positions and or privileges in the society. Thus the power relations between men and women are put in place by these prescribed roles (Australian Institute of Family Studies,2019).

While some individuals’ gender corresponds to the sex they were assigned at birth (Cisgender), many people however do not fit into this narrowly defined gender binary. Some women may feel masculine, some men may feel more feminine and some people may not feel either, or may reject gender altogether as in cases of Transgender, Brotherly-boy, Sisterly-girl and so on (Australian Institute of Family Studies,2019).

Thus LGBTIQ is an umbrella that is used to encompass all these heterogenous groups of individuals who do not adhere to the homogenous idea of gender binary and sexual heteronormativity (Bhatta, 2017). However, their non-adherence to the societal norms of gender and sexuality has caused them to fall victim of ridicule, violence and intimidation (Australian Institute of Family Studies, 2019). LGBTI people globally face violation of their human rights as a result of their varied sexual orientation and gender identity. These human rights violations take many forms, from denials of the rights to life and personal security, freedom from torture, freedom from discrimination in accessing economic, social and cultural rights such as health, housing, education and the right to work, from non-recognition of personal and family relationships to pervasive interferences with personal dignity, forced suppression of diverse sexual identities, attempts to impose heterosexual norms, and pressure to remain silent and invisible (Karki, 2012).

This background has put LGBTI persons around the world in a compromised situation making them to be most vulnerable to various forms of violence including killing

(Karki, 2012). Particularly in patriarchal South Asian societies this alternate to the heterosexual lifestyle is governed by religious norms and the mind-set that identifies deviation from the norm as alternate lifestyle and sexual offence to be the same (Bhattacharjee, 2014). Heteronormativity is a deep seated conventional notion that by default makes gender 'binary' a historical, universal and essential social norm. The affirmation of the normality of heterosexuality then makes diverse sexuality an anomalous behavior (Karki, 2012). As a consequence, all individuals are expected to confirm to the stereotypical gender roles prescribed by the society. Consequently, the individuals who fail to fit into these socially accepted gender roles namely: Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) persons, are then subjected to exclusion, discrimination and violence (Karki, 2012). Many are bullied, physically assaulted, often ostracized by their family for being different, and several were murdered or have committed suicide. Such discrimination, lack of social support, limited social relation and care have exacerbated their condition of being outcasts (Karki, 2012).

Although it is estimated that LGBTIQ people comprise of 10 to 20 percent of the global population, their unique needs have not yet been addressed in the development and the implementation of many national and global policies (Haghir-Vijeh, 2013). For example, they have been inadequately represented in the International Human Rights Agenda (Jayarathne, 2017). Traditionalists and moralists around the world viewed homosexuality as a significant threat to society and societies. What was even troubling was that psychologists often regarded homosexual desire or sexuality as "mental illness" (Chhetri, 2017). Only in 1970 did the American Psychological Association and the American Psychiatric Association accept that they made a mistake in describing homosexuality as a "disease or ailment". Thus, it is rather surprising to find that homosexuality was still on the list of conditions identified as a mental disorder by the WHO (World Health Organization) until May 1990, when it was eventually removed from their list as well (Chhetri, 2017). This also gives us an idea of how most of the world used to look at third-gender or gender orientations as "problems" for not conforming to men and women's binary categories. An inclusive attitude towards

people of different sexual orientations and roles, other than those in male and female groups, did not exist (Chhetri, 2017).

Despite its societal background, Nepal is often considered more progressive than other South Asian nations with regards to LGBTIQ advocacy (UNDP & USAID, 2014). The Supreme Court ruling in December 2007 that promoted the human rights of LGBT has proven to be one of the major political achievement in LGBT advocacy in the past two decades (Karki, 2012). However, the vague references in amendments, remaining gaps to be addressed and the lack of implementation of these amendments have thus not sufficiently protected LGBTIQ people of Nepal from human rights violations. While Nepal has signed and ratified numerous international treaties that intend to protect human rights, these are however not implemented at the community level (Karki, 2012).

Advances in policy have not necessarily translated into the daily existence of LGBT population who can experience discrimination and violence in all aspects of their life – in jobs, family, housing and education (Blue Diamond Society, 2018). Referring to the Constitution, Article 18 "The right to equality", Nepal has acknowledged the presence of sexual minorities as a nation and is deemed progressive in terms of having regulations to safeguard the LGBTIQ community from discrimination compared to many other nations (Blue Diamond Society, 2018). Article 42 "The right to social justice" of the Constitution guarantees the right to opportunities and facilities for their protection, progress, empowerment and development in the areas of education, health, housing, employment, food and social security (Blue Diamond Society, 2018). Although the Constitution guarantees these freedoms, they are not expressed in legislation and policies (Blue Diamond Society, 2018). Policy makers may not be interested or the government may not have the capacity to implement policies and laws that protect or entitle LGBTIQ people (UNDP & USAID, 2014).

In a nation blighted by extreme poverty, LGBTIQ people's human rights may be less prioritized than problems perceived to be more pressing such as meeting fundamental requirements including appropriate food and shelter (Karki, 2012). Thus, incorporating a gender viewpoint into growth and humanitarian strategy and programming did not

automatically lead to the incorporation or representation of people (Daigle & Myrntinen, 2018).

According to the census of 2011, 80% of the Nepalese population follow Hinduism and more than 10% follow Buddhism(UNDP & USAID, 2014). The Hindu scriptures and epics itself have representations of diverse sexual orientations and gender identities and the Pali Canon which holds scriptures from Buddha's original teaching too have references to same sex behaviors (UNDP & USAID, 2014). Thus, both religions do not project violent religious extremist views and are in principle not homophobic. This might explain a higher tolerance towards diverse sexual orientation and gender identity in Nepal with respect some other South Asian counterparts (UNDP & USAID, 2014).

The religions may not contribute strongly to the discrimination of the LGBTIQ people, and no imminent violent behavior or obvious acts of condemnation are noticeable. However, Nepal is a mainly patriarchal society that does not yet easily accept individuals of varied sexual orientation(UNDP & USAID, 2014). The family structure usually succumbs to the socio-cultural pressure and ends up setting rigid standards of expectations regarding gender roles for these individuals. Thus, most of the LGBTI people do not come out in order to avoid the stigma and loss of face their choice may bring to the family (UNDP & USAID, 2014).

LGBTI students also face discrimination in school, not only from other students but from their teachers as well. This has direct implications on their physical safety and mental wellbeing. In some occasions students are also denied access to exams due to the inconvenience caused by their identification cards and their uniforms(UNDP & USAID, 2014). Transgender people even more so face explicit discrimination when their citizenship documents do not reflect their gender identity. This then would lead them to face difficulty to obtain documents in their preferred gender in order to seek employment(UNDP & USAID, 2014). Since Nepal does not have anti-discrimination laws to cover employment, many LGBTIQ people face discrimination and harassment in the workplace (UNDP & USAID, 2014).

These individuals who do not confirm to the heteronormative gender roles encounter prejudice, discrimination and even violence (Bhatta, 2017). Experienced discrimination based on sexual and gender orientation that deviates from one's biological state and the societal norm has led to a high burden of suicidality in the sexual and gender minority groups in Nepal (Kohlbrenner et al., 2016). Individuals belonging to the transgender minority have higher risks of suicidality than the general population. For the general population of Nepal, the average estimated prevalence of suicidal ideation ranges from 3.1% to 12.4%. However, the estimated prevalence of suicidal ideation in the transgender population of Nepal is 20.1%(Kohlbrenner et al., 2016). Hence this makes a subgroup within the LGBTIQ community of Nepal at risk of self-harm due to experienced discrimination, making the transgender group being most vulnerable (Kohlbrenner et al., 2016).

1.2 LGBTI demographics of Nepal

In the periphery of a strong patriarchal societal setting the LGBTI advocacy took place. This societal background formally and informally molds the politics pertaining to the LGBTI community. In addition, the heteronormative norms compel young men and women to marry and bear kids at an early stage. Thus it is enormously difficult for individuals of diverse sexuality to openly express themselves. Furthermore, the LGBTI individuals have been generalized into a single community with very little distinction of individual subgroup features and representation (UNDP & USAID, 2014).

Estimations on the LGBTI population are subject to controversy and debate in most societies. Obtaining reliable data is difficult for various reasons. Differences in findings may be explained by the sensitivity of the issue, variances in socio-cultural perspectives on sexuality, and or methodological factors(UNDP & USAID, 2014). The public is largely unaware of the diversity in the sexual orientation and gender identity within the LGBTI community (UNDP & USAID, 2014). As a result, there exists a considerable gap in disaggregated data in Nepal on gender and sexually non-conforming population including the transgender population (Majeedullah et al., 2016).

A Nepal LGBTI Survey in 2013 indicated 4.2% of the population in the country to be LGBTI (Chhetri, 2017). The composition of this population included Transgender 2.17% being the largest subgroup followed by gay 1.35%, lesbian 0.31%, bisexual 0.1%, and intersex 0.05% (Chhetri, 2017). Even among the largest subgroup of the transgender, the female transgender known as *metis* which are usually the most visible. (Majeedullah et al., 2016). However, of all the subtypes within this LGBTI umbrella, the transgender population seems to be the most susceptible in various aspects (UNDP & Williams Institute, 2014). The overall discrimination and harassment encountered by the trans population was at least twice as often than the others of the same group (UNDP & Williams Institute, 2014). Similarly, only 73 percent of the trans population could read and write as compared to 93 to 96 percent of the other subgroups (UNDP & Williams Institute, 2014). Again, 14 percent of the transgender reported to have no income as compared 7 percent of the gay/lesbian group (UNDP & Williams Institute, 2014).

1.3 Problem Statement:

The Constitution of Nepal 2015 lacks an anti-discrimination law for the LGBTIQ community of Nepal. While the Interim Constitution guaranteed gender based equality before the law, it does not safeguard against discrimination in other fields of life such as education, employment, housing, social discourse and access to health services (Blue Diamond Society, 2018). The prevalent heterosexual cultural norms in Nepal create a basis for stigma, prejudice, discrimination and violence, which underlie society's general lack of attention to the challenges in health and wellbeing of LGBT people (UNDP & USAID, 2014). This inadequacy in the representation of the LGBTIQ community in the Nepalese constitution in combination with deep rooted social stigmatization has subjected them to barriers in maintaining health and wellbeing (Bhatta, 2017).

Structural stigma hindering access to health care on the basis of one's sexual orientation or gender identity constitutes discrimination and is a clear violation of both the ICCPR (International Covenant on Civil and Political Rights) and the ICESCR (International Covenant on Economic, Social and Cultural Rights) to which Nepal is a signatory. This

denial interferes with their right to life and to be free from discrimination in compliance with ICCPR Articles 6(1) and 2(1), respectively. It also interferes with their right to health under article 12 of the ICESCR. Moreover, discriminatory treatment of persons on the basis of their sexual orientation, gender identity and/or perceived HIV status is incompatible with the existing interim constitution of Nepal, which also provides for individuals' fundamental right to health care. The state has a responsibility to protect LGBTIQ people and allow them access to health care without fear or barriers. This duty is not being met at present (UNDP & USAID, 2014) and therefore impact the physical, mental and social wellbeing of LGBTIQ people.

Under the umbrella term LGBTI, groups are too often handled regularly and misleadingly as a single population (Majeedullah et al., 2016). Trans women-specific health needs need to be met by creating an evidence base that will enable the provision of transgender-specific health care to address gender dysphoria (UNDP & USAID, 2014). This lack of disaggregated data has been constantly highlighted as a policy, research and programming issue in addressing the specific needs of the trans women (Majeedullah et al., 2016).

Insights on how self-stigma and structural stigma in healthcare could affect the health and wellbeing of trans women in Nepal are lacking. Such insights could inform advocacy efforts to address the health needs of trans women in Nepal. (Majeedullah et al., 2016).

1.4 Research Questions:

1. How does stigma hinder access to health services of trans women in Kathmandu, Nepal.
2. What are the health and wellbeing consequences of stigma experienced by trans women in Kathmandu, Nepal?

3. What is needed to prevent that stigma hinders access to health services for trans women in Kathmandu, Nepal?

1.5 Research Objectives:

1. Describe Nepali trans women s' experiences on how stigma hinders utilization of health services.
2. Describe Nepali trans women s' experiences in overcoming stigma preventing them to utilize health services
3. Describe Nepali trans women s' experienced health and wellbeing consequences of stigma
4. Describe Nepali trans women s' perceptions on how stigma could be mitigated

1.6 Research Purpose:

The purpose of this study is to offer trans women a voice in the debate on how stigma affects the health and wellbeing of trans women in Kathmandu Nepal with the aim to contribute in addressing violation of the right to health faced by the transsexual people of Nepal and the need for reorienting health systems.

CHAPTER 2

REVIEW OF LITERATURE

The review of literature in this Chapter serves as an exploration of what is known regarding stigma and discrimination in the Nepalese society and its impacts on the various aspects of life of trans women like family, education, employment and

accommodation. Further, this Chapter also explores key constructs such as: stigma and coping and how it applies to trans women . Finally, this review introduces ‘ethnography’ as one of the five main methods in the qualitative inquiry and research design. While qualitative methods generally use similar data collection techniques (observation, interviews, and reviewing text), the purpose of the study differentiates them.

2.1 Overview

Untill 2011, the trans women in Nepal were still arrested by the police while the government stayed aloof and did not warrant any support. By 2015 however, arrests had almost ceased as trans women were officially recognized as a “third gender” by the Nepalese government (Capriles, 2016).

However this recognition did not translate into the acceptance of the transgenders in the society. The third gender population of Nepal are constantly subjected to discrimination and stigmatization. Their gender and sexual orientation leads them to encounter prejudice, discrimination, and violence. They feel that they are perceived differently by the people and hence are excluded from socializing in mainstream activities (Bhatta, 2017). This lead the transgenders to not only bear injustice but also refrain them from contributing to the society. Transgenders are believed to be incapable to contribute to the society (Bhatta, 2017). They basically have two choices in society: either they give in to the social norm or they challenge the prevailing social order and thus are treated either sympathetically or disrespectfully by their contemporaries. Challenging the social norm results in consistent humiliation and are thus obligated to remain inferior and suppressed. Eventually they have difficulties in building their capabilities and hence often lag behind their contemporaries (Bhatta, 2017). Thus , societies are failing to benefit from their potential human capability. Undermining this issue is refractory to the entire nation since the development and the progress of any country remains halted if it fails to include the role of the people in nation building (Bhatta, 2017).

2.1.1 Hidden identity

Often, the first resort to protect one-self from social exclusion and the associated pain inflicted by the contemporary Nepalese society is to hide their identity although it means living a suffocative life. As described by the theory of social identity (Tajfel & Turner, 1979), the socio-cultural structures defined their identity rather than their self-identification. Thus, it becomes very difficult for trans women to reveal their identity to their straight gendered family, friends and acquaintances in the Nepali society (Bhatta, 2017).

2.1.2 Home and family

Most trans women do not open up about their identity at home due to the stigma, confusion and loss of face that it may cause to the family (UNDP& USAID, 2014). The family structured by heteronormativity and socially constructed gender roles based on sexual binary has a great influence in the lives of transgender people of Nepal. Thus their acceptance is rare, due to the rigid societal norms and overwhelming cultural pressure. Thus they often find safety in concealing their identity. However, in circumstantial situations like the pressure to enter a heterosexual marriage when they come of age, many are compelled to reveal their identity (UNDP& USAID, 2014). In doing so, many are faced with strong rejection by the family as they come out about their identity. They are abandoned by family members and many are expelled from their parents' home. Losing familial support early on in their lives often leads to minimal educational and job opportunities, not to mention the psycho-social trauma associated with loss of family support. The revelation of their identity immediately strips them from the possibility from inheriting any property from the family (Bhatta, 2017). This kind of gender muddle and divergent sexual orientation puts them in conflict with their family members and society. Hence they are compelled to leave their parents' home and migrate to the capital, where for most of them, coming to terms with their identity and coming out happens in settings that offer greater anonymity (Bhatta, 2017).

Although the social prejudice towards trans women excessively takes place in rural areas, housing and employment becomes likely a struggle for them in urban cities as well (Bhatta, 2017).

Socio-cultural stigma in Kathmandu Valley often poses a barrier to equal opportunities and social inclusion compared to other people. They abstain from going to social gatherings or taking part in political activities (Bhatta, 2017).

2.1.3 Education

Transgender students find it difficult to find a friendly environment in their school. The rejection does not stop at home, they are disliked in their schools as well. They are tormented by their peers and more so by the teachers who are supposed to provide them with unbiased care and support just like they do for other students (Bhatta, 2017). They are commonly suspended by superintendents in examinations for having fake ID cards as they appear to present themselves different than the attributed gender mentioned in their ID cards. Occasionally they are expelled from their schools as well. In such cases they become dependent on informal ways to attain life skills (Bhatta, 2017). Hence transgender children do not receive the security and protection their family members and teachers are supposed to provide. Their fundamental rights and the right to education as outlined in the Constitution are thus systematically violated (Bhatta, 2017).

2.1.4. Employment

While gender identity and sexual orientation do not affect workplace efficiency in any way, employers are not willing to provide trans women with equal opportunities, nor are trans women readily accepted in the company by co-workers (Bhatta, 2017). If they somehow manage to land themselves a job then they are not spared from harassment and social stigma. Their abilities are disregarded and are not considered of great value. They have limited possibility of landing a dignified job. And wages are often barely enough to sustain basic needs. Thus they are often unable to earn sufficient savings to purchase a property unlike their counterparts who conform the social norms (Bhatta, 2017). Sustaining a job becomes difficult once their identity is revealed. This usually happens when official documents do not match their identities. They are then humiliated, harassed and even expelled from their jobs. As coping with the constant stream of harassment and discrimination becomes hard they become vulnerable to

anxieties and depression and eventually are at risk of committing suicide (Bhatta, 2017).

Some are even compelled to riskier activities like sex work as they find themselves incapable to attain any other job, and it might be the only profession where they are able to open up about their sexual orientation and gender identity (Greene, 2015). Hence as they try to keep a balance between their psychological fulfillment and economic wellbeing, they are exposed to a plethora of risks and problems (Greene, 2015).

2.1.5 Accommodation

Finding an accommodation in urban settings is often a problem. People deny giving their homes on rent for the trans women because they don't know what "transgender" stands for: whether they are male, female or both (Bhatta, 2017). In the Nepalese society, intolerance towards trans women is common because they do not conform to the concepts of the binary male and female gender identity. Some believe that misfortunes would occur in their homes due to occupancy by transsexuals (Bhatta, 2017). Parents also believe that the trans women will have a negative influence on their children. They claim that they have raised their children right and don't want them to get spoilt by sinful examples. They believe that being transsexual is sinful instead of seeing transsexuality as the nature of their being. (Bhatta, 2017).

2.1.6 Access to general health services

The health discrepancies faced by LGBT individuals are different from the rest of the population. Because LGBT are clumped under the single umbrella term, this community's health needs are often grouped together. Each subset of LGBT represents a distinct population with its own set of health needs and concerns that are shaped by caste, ethnicity, socioeconomic class, geographic location, age, gender identity, lifestyle, HIV status, and other factors as well. And for each population, these variations have significant health consequences. It is essential to highlight these differences because in some existing scientific discourse and in the media of Nepal, these groups

have been constantly been treated as a single population under terms such as "third gender" or LGBT (UNDP & USAID, 2014).

Trans women have particular issues regarding access to health care. The HIV epidemic affects MSM disproportionately, with more than a fifth of the HIV prevalence in this sub-population. About 22% of all HIV cases in Nepal are gay men, trans women and MSM (UNDP & USAID, 2014). This puts them at a risk of infection with HIV more than 12 times higher than the general population (UNDP & USAID, 2014). Therefore, there is a need for evidence based information on the health needs of the broader LGBT community, including mental health issues, lesbian reproductive health concerns, and transgender hormone use (UNDP & USAID, 2014).

There is an increased risk of HIV infection for trans women. There is consistent evidence which shows that trans women are disproportionately affected by HIV. They are at a higher risk than the general adult population to be HIV-positive (UNDP, 2015).

For those trans people who have receptive anal sex without the use of condoms, the resulting HIV risks are greatest. For some trans women, engaging in receptive anal sex with a cisgender male partner is associated with a personal or community perception of a female gender identity (UNDP & USAID, 2014). For example, one study found that, during receptive anal sex without a condom, trans women expressed their desire to receive semen from their partner, "getting wet". This was seen as a way in which they expressed their femininity during sex (UNDP & USAID, 2014). Protection can also be a way for trans women to differentiate between a casual partner and a potential relationship (UNDP, 2015).

Trans women in the Pacific and Asian regions are perceived to be HIV positive or be sex workers by default. This has led them to experience increased discrimination in healthcare centers (UNDP, 2015).

Trans women require access to the health care system in all levels including: primary, secondary, and tertiary just like other people do. Health professionals can be strong

advocates for the right to health for trans people. Unfortunately, many health care workers are not used to deal with needs of the trans people since either lack the background training , knowledge or familiarity with the life experiences of the trans people (UNDP, 2015). Merely the expression of their gender identity has caused trans women to be a subject of judgement and have been dismissed of healthcare services. To further aggravate this situation, transgender individuals have been knowingly or unknowingly been addressed as “it” while trans women have been called out as men and vice versa. (UNDP, 2015).

As already noted, there are no legal protections for trans women in Nepal against discrimination. Health records usually disclose the gender assigned to a trans person at birth and potentially expose the person to health care providers' assumptions or prejudice. It involves refusing treatment or denying access to similar sex-segregated hospital wards or clinics (UNDP, 2015).

Furthermore, most trans women may find it especially difficult to approach a physician, a clinic, or a hospital to ask for health support. Medical appointments that may require some form of physical examination exacerbate the disadvantages associated with being unwell. For many trans women , having a body that does not match their gender identity can trigger discomfort or dysphoria by having to show parts of their body to a health professional (UNDP, 2015). The question is heightened if a health care professional's verbal or non-verbal expressions contradict the sense of self of the trans women . As a result, most trans women do not seek professional care for their specific health needs (UNDP, 2015).

2.1.7 Perceived discrimination

In a study conducted among 112 LGBTI employees of the Blue Diamond Society in an overall perceived discrimination survey, it was found that more than one-fourth (32.1%) of the individuals were treated with less courtesy than others. Of these, most respondents (30.4%) reported to always been treated with less respect than others. Threatened or harassed almost always (26.8 percent). One quintile (20.5%) of

respondents reported that they were physically assaulted. Regarding the assumption that people make that they abuse street drugs or alcohol, a majority (40.2%) selected “never”. About 40 percent felt that people around them acted uncomfortable (Ghimire et al., 2019).

Participants in the study faced a strong psychological barrier in the quest for health care. About 53% of the study participants showed strong psychological barriers (Giri et al., 2019). The findings of the study revealed that 10 out of 87 study participants admitted that they did not go to regular health check-ups due to fear of being treated rudely by health care staff. Approximately 60 percent of the participants reported that the main reason for postponing their health care services was based on “fear of being treated rudely by health care workers”. Further, 42.5 percent expressed that they had fear of being discriminated on the basis of their sexual orientation and gender identity (Giri et al., 2019). Giri et al. (2019) concluded that previous negative experiences of LGBT persons with the health care system or perceived discriminatory policy or regulations in the system can cause them to delay seeking medical care (Giri et al., 2019).

2.1.8 Degree of social acceptance of third gender in Nepal

While the people of “third gender” have always been a part of the human society and culture, the flares of debate regarding their equality and acceptance have started just recently. Their presence in the past had been dismissed mainly owing to the heteronormative base of the society. Until recently, this heteronormative concept went unchallenged and it labelled any other individual who did not fit in the binary concept as the results of either “biological birth defect” or “behavioral deviance as they grow up” (Chhetri, 2017). Thus those who manifested out of the binary system were characterized as "problems or abnormal" who were a product of either a "cultural disorder" or as a result of the individual's cultural defiance (Chhetri, 2017). In the past, due to the prevalence of such beliefs in many societies around the world, it was hard to imagine a positive outlook on the recognition and acceptance of third along with other genders as normal individuals. But there seem to have been exceptions (Chhetri, 2017).

We note, for instance, that some cultures and religions in South Asia have also looked at and viewed the third gender with recognition and respect (Chhetri, 2017). The Hijara (third gender) is seen in societies across India as people with the power to bless others with good luck, wealth, achievement, good fortune, etc. During ceremonies such as birth and naming, initiation rites, marriages, etc., they are welcomed to offer the blessings. Therefore, the Hijaras are regarded more as a social phenomenon and they are also considered a 'special group of people' with the power to give blessings (Chhetri, 2017).

Hijras are India's predominant third-gender or transgender group. Historically known as eunuchs, hijras have a long-standing role in society and culture. They are “phenotypic men who wear female clothing and ideally, renounce sexual desire and practice by undergoing a sacrificial emasculation – that is, an excision of the penis and testicles – dedicated to the goddess Bedhraj Mata” (Dickson & Sanders, 2014). In this sense, hijras differ from the Western concept of transgenderism because they do not adopt the gender attributes of their non-birth sex; instead hijras often occupy a special gender space with distinctive attitudes that are not traditionally associated with men or women (Dickson & Sanders, 2014). While the words are often used loosely or interchangeably, hijras are best understood to be a third gender rather than a transgender. Hijras within India are not welcomed or respected by the general population, but are accepted for their traditional social roles of performing dances at weddings, births, and other ceremonial functions (Dickson & Sanders, 2014). Hijras represented India's historical sexual difference and have been the subject of academic and journalistic accounts seeking to chronicle their unique role in Indian and South Asian society (Dickson & Sanders, 2014).

The academic and journalistic scenario however is not quite the same in Nepal. Tower (2016) writes that in developing countries, transgender literature is scanty and the few available “sources describe the current situation of the transgender community, and some describe the past, but virtually none draw a link between the two and ask why things are the way they are” (Tower, 2016). Tower also points out that there was no

dedicated scholarly work on third gender for Nepal and thus “news articles had to fill in the missing information” (Tower, 2016; Chhetri, 2017).

Third gender citizens in Nepal are evident in documents relating to human rights, given equal rights in legal realms, but at the same time are marginalized and overlooked in the enforcement of those rights. Similarly, there is a lack of research on the perceptions of people about the third gender population in Nepal (Chhetri, 2017). There is hardly any research that provides information about third genders of Nepal compared to third genders in other countries (Chhetri, 2017). Recently students of Gender Studies in Nepal have started writing their Master’s thesis on issues related to third gender (Chhetri, 2017). Works such as these may enhance understanding of a group of people who are least known to the public and are not visible. The knowledge gained and the information obtained during such study could also be useful for policymakers and lawmakers to address the problems faced by the third gender minority in Nepal (Chhetri, 2017).

Issues regarding the rights of the transgender population in Nepal has not received adequate attention from the researchers and the academics. (Chhetri, 2017). Thus it is required that proper attention be paid not only by the researchers but by the policy makers as well in order to better understand the problems faced by this subgroup of individuals (Chhetri, 2017).

2.2 Key Concepts

To better understand the experiences, views and actions of the trans women in Nepal and their particular circumstances in the society it is vital to be familiar with some key concepts such as *stigma and coping*.

2.2.1 Stigma

The Greek society, which appeared to be powerful on visual aids, coined the word "stizein," referring to a body mark placed on slaves to define their place in the social structure and imply that they were of less importance (Arboleda-Florez, 2002).

These marks were cut or burnt onto the body of the individual as a sign that the person was a criminal, slave or a traitor who was ritually polluted and was to be avoided (Goffman & Erving, 1963).

Today, the word is used in its original meaning, however the use of it has shifted to the fundamental recognition of differentiation and subsequent devaluation of a person rather than the bodily mark of it (Arboleda-Florez, 2002).

Stigma has been described as an attribute that is “deeply discrediting” and reduces a person from intact, unspoiled or unimpaired to a tainted discounted one. Stigma occurs as a “discrepancy between *virtual social identity* (how a person is characterized by the society) and *actual social identity* (the attributes possessed by a person) (Yang et al., 2007). Hence stigma is a deviant condition identified by the society that labels the individual as flawed. Although the process of stigmatization has been described as relational implying that the environment dictates whom and what is deviant, there is also an element of “impression engulfment” which is a psychological process located within the stigmatized individual (Yang et al., 2007).

Stigmatized individuals are often believed to have an objective attribute that features a devalued social identity within the social context. Thus, stigma is not only limited to a deviant condition within the stigmatized person but is also influenced by social, economic, political power that identifies differentness, constructs stereotypes and separates labelled people into different categories (Yang et al., 2007).

Thus, stigma is believed to exist when the following interrelated components converge. Individuals differentiate and label human differences in the first element. In the second element, dominant cultural beliefs link marked individuals to unwanted features i.e. to negative stereotypes. In the third element, labeled individuals are put in separate categories in order to achieve some degree of separation between 'us' and “them”. In the fourth element, labeled person experience loss of status and discrimination that lead to unfair results (Link & Phelan, 2001).

The society generally creates a means to categorize people and establishes the attributes felt to be natural for the members of this category. The routines of social encounters and interactions allow these members to anticipate from and relate to others without special thought or attention. When a new person comes in contact within this established setting the other member of this setting are able to anticipate his/her category and attributes. We lean on these anticipations and give them a form of normative expectations which are deemed righteous. In real time, however, we are neither conscious of these expectations nor understand what these requirements are until an active issue arises as to whether or not they will be met (Goffman & Erving,1963). The demands we expect from this new individual are the demands made “in effect” and the potential character we assign to him/her is the characterization “in effect” –a *virtual social identity*. However, the attributes this new individual has actually proved to possess is considered his *actual social identity* (Goffman & Erving,1963).

When a stranger is present before us with an attribute that is different than those possessed by the individuals from the same subgroup and the attribute is of a less desirable kind, extreme, bad, dangerous or weak, then this makes him/her different from the others in the same subgroup. In such case the person is reduced in our mind from a intact, unspoiled or unimpaired to a discounted one or is even called abnormal, weird, sick, failing, shortcoming or handicapped (Goffman & Erving,1963). Thus there is an inconsistency between the virtual and the actual social identity. However, there are different types of discrepancies between the virtual and the social identity for example: sometimes we may reclassify an individual from one anticipated category to another equally well anticipated category or in some cases we alter our assumption about an individual to an upward better version. Thus not all attributes are undesirable, only those that do not fit in with our stereotypes are (Goffman & Erving, 1963).

Also stigma has two major components: a public component or the reaction that the general population has to the stigmatized individual and self-stigma or the prejudice that the stigmatized people tend to turn against themselves (Arboleda-Florez, 2002). Stigma also has a double perspective in that sense, whether the stigmatized individual

thinks that his differentness is already known about and evident or whether he/she thinks that it is neither known and not perceived by others (Goffman & Erving, 1963). This brings us to the three gross types of stigma. Firstly, there are the abnormalities of the body i.e. various physical deformities. Next there are weaknesses of the character perceived as unnatural passions, weak will, rigid beliefs, or illegal acts which are translated to addiction, homosexuality, radical political opinions and acts, imprisonment etc. Finally, there are stigmas that can be transmitted down the family lineage and may contaminate all family members equally like stigma of race, nationality and religion (Goffman & Erving, 1963).

Whatever the type of stigma related to the transgender population, the more visible the stigmatizing mark is the more the society believes it to be under the control of the bearer and the higher the possibility that it will have an impact on others, hence the stronger the prejudice and the discriminating behavior becomes (Arboleda-Florez, 2002).

Interestingly, these stigmatized individuals are also considered less competent than the stereotypes representing normality (Link & Phelan, 2001). The interactions between the stigmatized and the non-stigmatized groups are not smooth either. The presence of a stigma mark disrupts interaction, causes awkwardness and discomfort. This situation is more uncomfortable for the non-stigmatized individuals since they are not familiar with “mixed contacts” and don’t know how to behave or what to expect from the unfamiliar person. This unpredictability provokes anxiety (Link & Phelan, 2001).

The stigmatized people too do not know how to react to the non-stigmatized person’s discomfort. Thus to avoid this uncomfortable situation the stigmatized individuals are casted out the circle of the normal. By doing so we also exclude them from participating in consensual processes (Link & Phelan, 2001). Again, the anxiety that is provoked due the unpredictability and unsettled reaction may manifest as fear and disgust especially when some attributes are culturally defined to be outside the boundaries of normal (Link & Phelan, 2001).

Thus stigma here implies a comparative difference between the standard normal kind of people “we” are and the stigmatized deviant people “they” are. Additionally, stigmatized people are considered to be “not quite human”. While a low status person is seen as an individual below the high status person, a stigmatized person is seen as not only below but also apart from a non-stigmatized individual. Hence the outcomes of stigma are social rejection and status loss (Link & Phelan, 2001)

2.2.2 Coping

Stigma is deeply rooted in societal standards and norms and is embedded in the everyday practical engagement of the sufferers like: status, money, life chances, health, good fortune, a job or relationships. Such daily life engagements matter deeply to all individuals. Thus stigmatized individuals are constantly exposed to social suffering in addition to violence and trauma (Yang et al., 2007).

For the perpetrators, stigma is a natural response. It is a process of psychological defense that comes to play as the individual feels his existential and moral familiarities are being threatened. Hence it is an act of self-preservation. But for the stigmatized individuals, stigma compounds suffering. Stigma breaks the link that connects the person to social networks of support, resources and life chances. Thus, since the stigmatized individuals face such adverse circumstances on a daily basis they actively cope using various cognitive strategies (Yang et al., 2007).

Thus here by coping we refer to the development of a set of adaptive processes that helps an individual fend off potential threat or harm. At the heart of this concept lays the fundamental assumption that our body is actively responsive to forces that encroach upon our mental and physical functioning where in many situations these forces are usually social in origin. Over the years coping has been used interchangeably with kindred concepts such as mastery, defense and adaptation. For the purpose of this study, coping refers to: “any response to external life strains that serves to prevent, avoid, or control emotional distress” (Pearlin & Schooler, 1978). These strains are usually not a

single discrete traumatic event but a series of ongoing, new and cumulative experiences (Folkman & Nathan, 2011).

Positive coping involves an adaptive process through which an individual “fights back” with a stressor and transforms a stressful situation into psychological growth (Folkman & Nathan, 2011). These adaptive processes are not only governed by personal factors but are also influenced by the type of stress they are facing, the social resources available and their judgement of the stressful experience. While constructing a coping mechanism, an individual is not only seeking for an effective solution but is also managing emotions, maintaining relationships and defending their priority goals (Folkman & Nathan, 2011).

Thus, coping is not a simple process, rather a dynamic one comprising of episodes of dealing with different facades of stressors. As new stressors emerge during the process of coping, the appraisals are recalibrated. Again if a certain coping strategy fails, it is replaced by a new one, or may fall into helplessness. Thus it is an ongoing phenomenon to balance and rebalance the struggle and recover from setbacks (Folkman & Nathan, 2011).

An individual may pass through various stages of coping as per the Kubler-Ross model (Lim, 2013). These five stages include denial, anger, bargaining, depression and acceptance. However, these five stages are neither chronological nor complete, which implies that not all persons who experience stress will go through all the five stages. These first stage of coping is *Denial*. It is a temporary state in which the sufferer refuses to accept the reality of an adverse situation that he/she has been faced. The second stage is *Anger*. It is an essential stage in which the sufferer realizes that denial cannot continue. The more the individuals’ attachment to a particular object the more he/she projects anger via rebellious actions such as rage and envy. The third stage is *Bargaining*. This is a stage in which the individuals are willing to bargain anything to avoid the pain. They often turn to a higher power or religion to solve their problem. More often than not, these negotiations rarely provide a sustainable solution. The forth state of coping is *Depression*. In this stage the individual realizes the certainty of the

adverse situation and may succumb to the feeling of mourning, hopelessness, feeling numb and losing control. The last stage of coping is *Acceptance*. This is a stage of realization in which the individuals accept their loss and become more calm and stable. They understand that the adverse situation was not their doing and that something positive may come out of the pain and the loss (Lim, 2013). Instead of denying one's feelings, one listens to his/her needs, moves on, chances and grows. Some start reaching out to peers and assist in the coping process of others.

The ways on which an individual may cope is unlimited. This is because an adaptive coping response must be suited to deal with the adverse situation with the available resources and time. Thus, no encounter with a stressful situation can be dealt with by a single coping strategy. Although there is no consensus for the best coping strategy, researchers have dealt with this issue by creating groups, most common ones being: “problem-solving, avoidance, seeking social support, distraction, direct action, aggression, self-blame, escape, social withdrawal, religion, positive cognitive restructuring, emotional expression, information-seeking, acceptance, wishful thinking, rumination and worry, denial, and focus on the positive” (Folkman & Nathan, 2011). Thus twelve such group also known as *Families* have been listed where each family includes a varieties of ways to cope that serve the same function in dealing with the stress (Folkman & Nathan, 2011). For example, if “Problem solving” is considered part of a family, it could include other ways of coping that serve the same functions, such as “strategizing, planning, repair, direct attempts, instrumental action and decision making”. Other components of this family include: information seeking, helplessness, escape, self-reliance, support seeking, delegation, isolation, accommodation, negotiation, submission and opposition (Folkman & Nathan, 2011).

Coping is a complex systemic process and therefore coping cannot be understood by looking at coping only. Coping involves the stressor, the individual's assessment of the situation, the time and resources available, the liabilities in the situation and the history of the results of the past coping attempts. Hence since coping comprises this entire system it is difficult to understand its complete meaning. When coping was theorized as a manifestation of a person's ego process, maladaptive coping indicated a neurotic

personality. However, coping has come to be seen as situation specific and no coping strategies can be considered “maladaptive” because they were suited to their particular contexts and demands (Folkman & Nathan, 2011).

The perspective of functional adaptation discourages the simplistic categorization of “good” and “bad” coping (Wadsworth, 2015). Maladaptive coping are neither wrong ways of coping nor does it indicate that the person is flawed; they are the result when the stressor is so great that the coping system is overwhelmed especially when the vulnerabilities are high and the resources are low (Folkman & Nathan, 2011). These may include manifestations that are detrimental in the long run like helplessness, rumination and exploding as they weaken the coping system and result in low self-efficacy and exhausted friends (Folkman & Nathan, 2011).

These maladaptive manifestations are of particular interest in this paper since mental and physical problems that arise as a consequence of such overburdened stress response among minority groups in the society (Wadsworth, 2015). This is mainly due to the inadequacy of resources, especially financial resources. Such stress which usually has an early onset in life and is chronic in nature directly affects the biological system causing cognitive, emotional, behavioral disorder and diseases (Wadsworth, 2015).

Coping is not a straightforward structure, therefore it does not constitute a single perception of a set of unidimensional behaviors. It is a multilevel interactional system that unravels with time. Hence it is difficult to access all aspects of coping in a simplistic manner (Folkman & Nathan, 2011).

Initially coping was perceived an indicator of ego maturity hence clinicians used extensive questionnaires to access coping. As it became uncoupled with the ego theory and was seen as a personality trait, coping was accessed by questionnaires that selected one or two dimensions of coping (Wadsworth, 2015). Today questionnaires that access the transactional, contextual and process-oriented views of coping are widely used, one of such tools being COPE Inventory questionnaire (Wadsworth, 2015). Although measurement of coping would be inappropriate in an ethnographic study, instrument domains may inform discussion of qualitative study findings later on.

2.3 Ethnography

Every study conducted seeks at finding responses to recognize issues through the application of systematic processes. Although qualitative research produces non numerical information, it is used in social environments to comprehend the experiences, attitudes, opinions, behaviors and interactions of people (Pathak et al., 2013).

If people are only studied in a statistically aggregated fashion, the research may fail to suit the entire truth as access to the person's unquantifiable facts may be lost. Facts from conversations with the participants or their personal traces cannot be arithmetically displayed (Berg, 2001). Thus while quantitative research aims to understand the breadth of a problem, qualitative research explores the depth of the problem (Palinkas et al., 2015).

Since qualitative techniques such as ethnography would enable the researcher to comprehend people's perception of themselves and structure their daily life, it is appropriate to gather information from the respondents that suit the study's objectives (Berg, 2001).

Ethnography requires the researcher participating overtly or covertly in individuals' life which maybe for an extended period of time. During this period the ethnographer listens to what is said, watches what happens, asks questions through formal interviews and informal discussions and eventually collects documents and artefacts to find answers to the research questions (Atkinson, 2007).

In more detail, Atkinson (2007) has described the features of ethnographic work which will also be used to guide this study:

- The activities and accounts of people are researched in everyday contexts rather than under conditions developed by the investigator, such as in experimental setups or in extremely structured interview circumstances. In other words, research is going on in the daily lives of participants.

- Data are collected from a variety of sources, including documentary proof of multiple types, but generally the primary ones are participant observations and/or comparatively casual discussions.
- For the most part, data collection is relatively unstructured in two senses. First, it does not involve following through an initially specified fixed and detailed research design. Second, the categories that are used for interpreting what people say or do are not built into the data collection process through the use of observation schedules or questionnaires. Instead, they are generated out of the process of data analysis.
- Usually, the focus is on a few cases, usually relatively small, perhaps a single setting or group of individuals. This is intended to promote in-depth study.
- Data analysis includes interpreting the meanings, functions, and implications of human behavior and/or organizational procedures, and how they are involved in local environments, and perhaps broader ones as well. What are produced, for the most part, are verbal descriptions, explanations, and theories; quantification and statistical analysis play a subordinate role at most.

2.4 Summary

In summary, it has been established that the individuals who do not give in to the social binary norm are stigmatized by the society and are made victims of abuse and harrassment, however information regarding how these individuals “internalize” this stigma is missing (Brohan et al., 2013). This then directly corresponds to how these stigmatized individuals cope and how its affects their lives. This Chapter reviewed the literature on issues as stigma and discrimination of transgender people in Nepal, however the measures transgender people in Nepal take in order to cope with the challenges stigma and discrimination pose and sustain themselves is missing (UNDP & Williams Institute, 2014).

To complement the existing body of knowledge on transgender people in Nepal, it is important to describe the life journeys of transgender people in Nepal and explore their experiences with stigma and discrimination, how it impacts their lives and wellbeing,

and how they cope with these challenges from a native point of view, which is missing in the existing literature on Nepal.

Finally, an ethnographic design to inquiry was considered appropriate. This because within the qualitative paradigm, ethnography allows a researcher to immerse oneself in the participants' environment to understand their goals, culture, challenges, motivations, and describe the themes that emerge. Rather than solely relying on interviews or surveys, one experiences the environment first hand, and at times as a "participant observer."



CHAPTER 3

RESEARCH METHODOLOGY

3.1 Research Design

The proposed study was designed as a pilot multiple holistic ethnographic case study, with individual trans women living in Nepal, as the unit of analysis for exploring and describing their experiences. The study explored the perceptions on self and structural stigma and how these experiences hinder access and/or utilization of health services with in turn impact their health and wellbeing.

3.2. Study Population and Sampling

Study population: The population for this pilot study were trans women residing in Nepal. Transgender people are the largest subgroup in the LGBTI demography, the trans women known as *metis* are usually the most visible (Majeedullah et al., 2016).

Sampling:

5 volunteers willing to participate in this study were identified by purposive selection, based on following inclusion criteria: (i) being a Nepali national, (ii) self-identifying as trans women (iii) above 18 years of age, and (iv) self-report not currently under treatment for a mental health disorder.

As argued by Englander (2012), in case of a hidden and hard to access population, a small number of study units may prove to be an adequate number and provide extremely valuable information. In such cases 5 participants are acceptable with single participants as unit of analysis (Onwuegbuzie & Collins, 2007). Participants were identified through snowball sampling, starting with few acquaintances who were served by the Blue Diamond Society, for overt interviews, covert observations and to participate in informal transgender group discussions.

Ethnographic findings are not intended to serve generalizations as this is not the goal of an ethnographic research project. Instead, an ethnographic study is undertaken to reveal a deep, culturally and contextually grounded understanding. Further,

ethnographers also sample settings and particular contexts as much as they sample people. This means that the ethnographer are interested in “where” and “when” something happens as they are in “who”. Although ethnographers generally work with small samples, they carefully consider choosing participants and contexts. It is important to realize that findings of ethnographic research are often utilized as an input to future research (Rea-Holloway, 2012).

3.3 Data Collection

Methods	Instruments	Records
• Overt in-depth interviews	• Interview protocol	• Audio-recording and transcripts or jotted notes and field reports
• Covert observations	• Unstructured observations	• Field reports
• Informal group discussions	• Unstructured observations	• Field reports

Instruments

The in-depth interview protocol consisted of an unstructured open-ended questionnaire which is presented in Appendix H.

Unstructured observations were applied to covert participatory observations, informal group activities and spontaneous discussions. Field reports were used to record these observations chronologically indicating coded participants.

3.4. Procedures

Ethical clearance was obtained from (a) the Thammasat Ethical Review Committee-3 and (b) the Nepal Health Research Council (NHRC) for the proposed study. Permission was obtained from participants for the researcher to participate in informal group activities and related spontaneous discussions.

Prior to participation in the study, all participants received information about the study, benefits and potential risks for participants, and their right to withdraw from the study

at any time. Informed consent was obtained from all participants. The participant's rights, interests and the sensitivities were safeguarded and confidentiality was protected at all times.

The in-depth interview was conducted in suitable private or public places offering required privacy and convenient for participants. Permission was sought to audio-record interviews. As and when the participants' expressed uneasiness with audio-recording, jotted notes were used to facilitate data collection. Informal group activities and discussions were unplanned for and spontaneously arranged especially on occasion of socializing activities and events. These informal events involved attending public events, parties, going to movies, eating out etc. The purpose of these informal events was to familiarize with participants, get a sense of the wider transgender community and make participants comfortable in spontaneous settings owing to the nature of this study.

The final pilot study was produced in English and made available to the participants. For those participants that did not master English language an executive summary of the study in Nepali was provided.

The in-depth interview protocol was translated from English to Nepali by the researcher and an independent translator translated back from Nepali to English. For the transcripts of audio records, the researcher translated from Nepali to English and an independent translator randomly translate 10% back from English into Nepali.

3.5 Analysis

A logbook was maintained to record demographic characteristics of all participants to facilitate analysis to data. Qualitative data served a latent thematic content analysis. The approach to analysis was inductive and led to identification of themes which facilitated in the development of a codebook alongside the analysis process.

The use of matrix displays facilitated comparative analysis of sources and methods. Triangulation of sources and methods (i.e. in-depth interviews, covert observations, and discussions) was applied in identifying cross-validation and or discrepancies.

3.6 Resources

- Activity plan by time
- Required human resources (translator)
- Equipment: Recorder, stationary items
- Estimated Budget

Table 1: Activity Plan 2019-2023

ACTIVITY	2019-2020	2020-2021	2021-2022	2022-2023
Apply for TU ethical approval	X			
Apply for NHRC ethical approval	X			
Field preparations		X		
Data collection and analysis		X	X	
Report writing			X	X
Submit draft IS report				X
Examination IS report				X
Revise IS report as required				X
Submit final thesis and Turn-it-in report				X

CHAPTER 4

FINDINGS AND RESULTS

4.1 Findings

In-depth interviews and unstructured observations were conducted involving five participants who identified themselves as trans women in Kathmandu between “2019-2022”. Notwithstanding the centuries old cultural traditions including a role for Hijras in society, Nepal’s Supreme Court ruling in 2007 to end discrimination of LGBT people, and Nepal’s Government adding the third gender to its census since 2011 and passports since 2015, stigma remains deeply rooted in the societal norms which was reflected in the everyday engagements of all participants.

Vignette-1

The following excerpt highlights how social stigma translates into discrimination in family relations.

Once she moved to Kathmandu, Megha transitioned and enjoyed hanging around with her sisters from the Blue Diamond Society at the Gaijatra (LGBTQI pride festival). Of course she shared plenty of pictures of herself from the Gaijatra event on her Facebook account. What Megha did not realize was that one of her cousins at the same time searched for her Facebook profile and discovered her postings. The cousin found it necessary to inform Megha’s sister, and so the news of Megha’s transition spread to her parents... With only one sister and mom and dad Megha’s family was small, nevertheless family bonds are important in giving a sense of belonging. However, once Pandora’s box was opened Megha’s parents told her that (s)he was no longer welcome at home and as far as they were concerned (s)he was considered dead.

All participants realized at an early childhood that they did not fit the narrowly defined gender binary of the society, and they were compelled to hide their sexuality and gender identity even as they progressed into their adulthood.

All the participants who were living with their parents lost parental support and had troubled family relations as soon as they expressed their sexuality and gender identity to their family. Those who were supported by some of the family member also had to ensure that they were not seen as a female with their family in public. Most would change their clothes and hide their long hair while visiting family members. The sexist comments and remarks in the neighborhood and in the community further led parents to abandon their children (the participants) in order to save face. Those

participants having faced such situations from their caregivers at an early age became socially withdrawn to the extent that they experienced bouts of mental health issues and also attempted self-harm.

Vignette-2

The following excerpt highlights how self- stigma translates into feeling unworthy and how participants cope with it.

Initially Renu's family was not supportive of her coming out regarding her sexuality. The neighbours would crowd up her around her home every time she came for a visit as though the neighbourhood had become a local circus. The frustration that this brought to the parents was immense. They believed that she was born normal and somehow deviated into something absurd. For the next 3-4 years Renu changed into her set of boy's clothing and visited her parents outside of their neighbourhood. Things gradually changed when Renu convinced her parents to come visit the Blue Diamond Society. Her parents got to witness many of her friends who were just like her. Her parents then seemed to grasp the concept that Renu's transition was not a fanciful wish but a voluntary transition.

Being raised by their parents and growing-up among neighbors, who all adhered to the conservative societal norms, participants internalized the social stigma towards deviating from the gender binary. The stereotypical gender views along with criticisms and remarks led the participants to segregate themselves, leading them to believe that they did not belong and were an outcast, hence having a sense of feeling unworthy.

Three out of five participants who got enrolled into school further faced issues of name calling and bullying in school. The participants were made to sit with the boys in their class and were also asked by the teachers to change their clothing, hairstyle style, mannerisms and behavior in general. Remarks were made by the classmates as the participants did not mix up with the boys but instead preferred making friends with the girls. Because of separate toilets for boys and girls, they felt uncomfortable using the school toilets. Hence, all three participants who attended school reported that they did not use the toilets at all to avoid being bullied and or reported by their peers.

Vignette-3

The following excerpt highlights how structural stigma translates into discrimination and bullying at school

Neha says that she wasn't sure if her teacher in school really knew what Napungsak (Third Gender) meant but whenever the word was thrown around in the class everyone would stare at her. Her friends noticed that she never used the toilet. Neha never felt comfortable going into the boy's toilet as it was mostly designed to be open. After the classes were over she would sneak into a private toilet meant for the staff. Gradually the school started getting more vulnerable as the boys of her class started to call her their girlfriend and mock her by giving her flowers on valentine's day. They did not hesitate from teasing her and touching her unnecessarily. She almost felt like she was some sort of a cartoon character. And although she did inform her teacher about the behaviour, she did not really take it seriously as they did not know what exactly to do about it. Neha wanted to finish her undergraduate degree but the hassle she had been facing has dissuaded her from doing so.

During the annual examination, like any other student, the participants were asked to show their ID cards to the examination guard, but since their gender on the ID did not match their appearance the participants were not allowed to appear for their examination even if they wanted to. Missing out on examinations and under performance at school led immense stress and anxiety among these participants. The sense of shame projected onto them by the teachers and harassments by their classmates led two out of three participants to drop out after high school. As a way of coping all the participants chose to reach out to the transgender community of the Blue Diamond Society which acted as a safe haven in the process of their "coming out". The peer support they received during this phase and hence forth has been the main support system for the participants. Due to their low literacy only one out of five participants secured a formal job while the remaining participants were working as a house maid, a sex worker and a freelance model. However, income generating activities are fluid. In times of financial hardships they may engage in sex work. Because of them being trans women, those participants who took up informal occupations were frequently verbally and physically harassed by the police. In case an unfavorable incident broke out between a participant and their clients, the authorities would rarely have a say in the favor or in support of the transgender participants.

Vignette-4

The following excerpt highlights how gender stereotype views translate into instability of romantic relationships

It had been a couple of months that Riha had been in a relationship with a man. He knew that she was a sex worker because she met him via the same channel. What apparently seemed like a healthy romantic attraction suddenly turned cold after her boyfriend started inquiring about her with her friends. As he eventually came to know that she is a transgender he cut off all contacts and abandoned the relationship. The following year one day, he saw her on the same street and asked her to resume talking to him again. He also implied that he would continue being in a relationship with her only if she left sex work completely

As the participants met their romantic interest often through their promiscuous lifestyle this negatively impacted their relationship. Three out of five participants were asked to leave their paid sex activities by their partners. While the participants were often trapped in the loops between securing income, promiscuity and romance, their romantic relationships have not been long lasting or secure. While lack of legal recognition of and social support for these relationships may have aided the falling apart of these relationships, other contributing factors such as unrealizable childbearing and societal stigma have an impact too.

Vignette-5

The following excerpt highlights the experiences of a transgender female in seeking care at a hospital in Kathmandu

When you as a transgender person need healthcare it's not just about a single health issue. Thousands of worries pop-up in one's head about the questions that might be asked. One of Ashmitta's trans-sisters took her to the hospital when she was suffering from severe food poisoning. Ashmitta felt really miserable having fever, diarrhea and vomiting for some time. When they reached the hospital Ashmitta explained her health condition to the nurse. When they finally met the doctor he caught Ashmitta's hand to check her pulse and then asked her when her last menstrual period was, and whether her periods were regular or not. Ashmitta's trans-sister explained that she could not have periods as she is not a woman biologically, but a transgender female. As soon as the doctor heard this he dropped Ashmitta's hand, left the room and did not return. The nurses too did not attend to Ashmitta, they just pointed at her while gossiping and teased her publicly. Ashmitta's trans-sister became very upset and wanted to formally complain to the hospital authorities. At that time Ashmitta was not aware of her rights, and asked her sister not to make a fuss out of it. In the transgender community most of the girls have to face embarrassments and suffer from unfair treatment when having to attend the hospital for a health issue

The participants faced significant obstacles while seeking for health care as well. All participants concluded that health professionals, including doctors, have limited understanding and awareness of the needs of transgender patients. Some doctors refused to acknowledge the existence of a transgender patient, while others were completely oblivious to it. Often when doctors figured out that a patient was transgender, they refused to examine their patient or attend to them and left them in the care of nurses or health assistants.

Hospital staff would often name call, talk behind or tease the participants on various occasions. The hospital staff more often than not asked the participants to change their queue in the waiting areas. Such incidents made it very difficult for the participants to not only discuss their very special needs regarding bodily hormonal balance and transformative surgeries, but also prevented them from seeking out basic health care. Four out of five participants expressed to prefer staying at home and treat their illness by self-medication with medicines available in the local pharmacy, rather than to use hospital healthcare services.

All five participants by virtue of them being transgender females faced social and structural stigma that translated into discriminative encounters which affected their perception of self and every aspect of their individual lives including family relations, schooling, job opportunities, income, personal relationships, healthcare and the sense of belonging. As a result, they become socially marginalized which adversely impacts their health and wellbeing.

A common message across participants were directed towards peers and towards society. For peers the message was that self-help groups and peer support are there to support them in coming out. However, at the same time they expressed caution that stigma, marginalization and injustices often create conditions of hardship. For society the message was that transgender people are real people, with abilities and aspirations as any other person and able to contribute to society. To make this happen however, gender diversity must be recognized, human rights respected, and education, workplaces and healthcare made transgender sensitive.

4.2 Stigma-based Discrimination and Its Effects on Nepali Transgender Females

The ethnographic study conducted on five self-identifying, volunteering and willing transgender females of Kathmandu showed that they had been subjected to stigma and discrimination in many if not all parts of their life. The stigma was identified at social and structural levels while self-stigma played a role as well. The stigma then acted as a catalyst for discrimination in various areas such as: family, community, school, job, healthcare and on an individual (self) level as well. The outcomes of such discriminatory behaviors resulted in the individual to be less equipped in life and socially subtracted in such a manner that they became systematically socially marginalized. This systematic social marginalization threw them in a loop of stigma and discrimination again due to the nature of their social separation. The result of such disconnectedness and non-inclusion had a direct adverse effect on their overall health and wellbeing. The overall stigma that the participants had systematically faced can be categorized into social stigma, structural stigma and self-stigma.

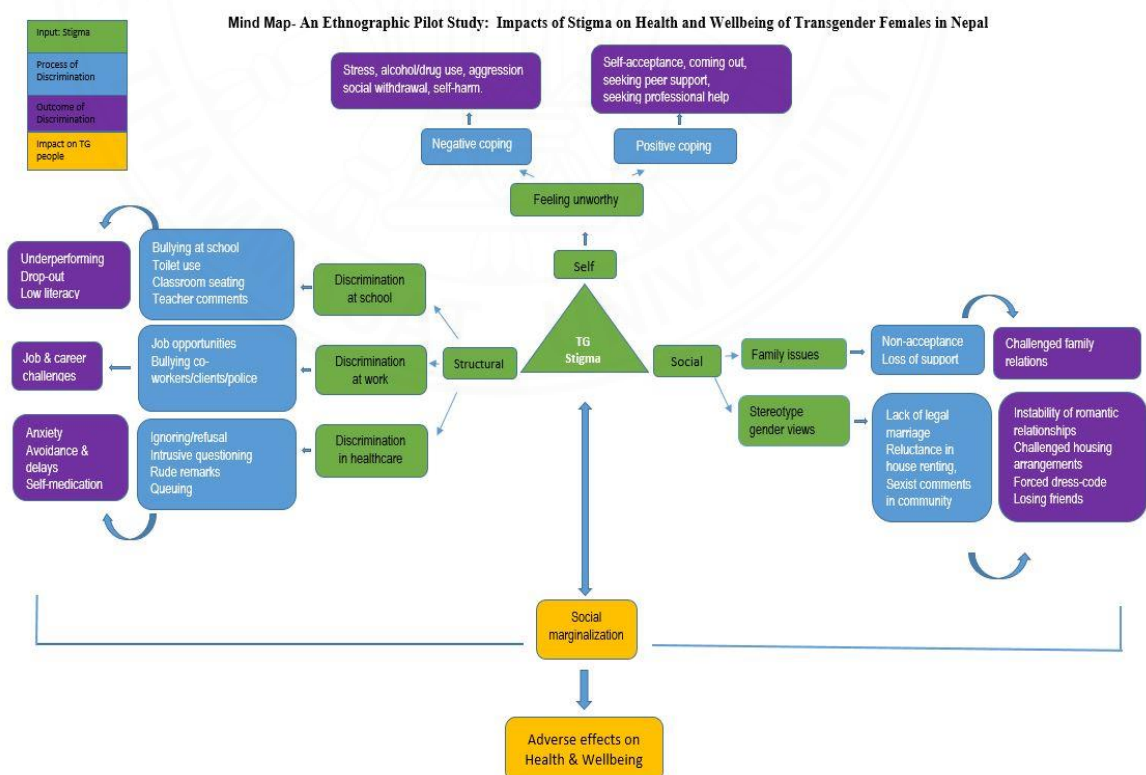


Figure 1: Stigma-based Discrimination and its Effects on Nepali Transgender Females

4.2.1 Social Stigma

Participants have faced stigma and discrimination in their family and have been targets of stereotype gender views from the public. Within the family they have lost support from their parents and family members due to which they had to leave the comfort and security of their home. Family ties were broken due to various family members not accepting their gender identity. The members that were more accepting of the participants' gender identity faced challenges maintaining their family relationship and often resorted to meeting in secret or away from the eyes of the rest of the family and the community.

Such stigma was greatly contributed by the stereotype gender views ingrained into the society. The fact that the participants did not fit into the gender binary of the society made them victims of sexist comments in the community. In many instances they were forced to a certain dress code or felt obligated to change their clothes before meeting their family or going back into their community. They lost the friends they had due to their friends' reluctance to be seen with them. They found it more comfortable and familiar to be around women than men in regards to friendship. Their lack of adherence to the binary norm made it very difficult for them to attain housing arrangements as well. Some participants were denied renting apartment for them being an alleged bad influence on the children of the owner of the apartment. The sexist views of the society along with the lack of proper amendments in the law has also been a major factor for the instability of the romantic relationships for the participants. The lack of legal provision of the marriage of the third gender of the Nepalese society has made relationships limited to romantic interest instead of a legally binding association.

4.2.2 Structural Stigma

The participant of this study have faced stigma and discrimination in their daily life activities. All the participants who attended school faced bullying from their friends. As the participants had the tendency to make friends with the girls more than the boys in class and had the mannerism of the girls, this not only enticed negative attentions from the boys but also attracted a lot of negative and sexist comments from the

teachers. In most of the instances the teachers asked the participants to be seated with the boys instead with the girls and also asked them to dress and behave like boys. The participants admitted that they almost never used the toilets in school entirely. The open compartments of the boys' toilet caused them avoid it completely. This further added to the various rude remarks and name calling by the peers in class. Due to such unpleasant experiences at school some participants did not pursue higher education in spite of their desire to do so while some completely dropped out of school. Most participants have not cleared their School Level Certificate (SLC) which is the elementary degree requirement for any professional career in the country.

Due to the lack of the basic educational degree four out of five participants have resorted to informal jobs which included home maid service, sex work and freelance modelling in the entertainment industry. Owing to the marked sexism in this line of professions the participants not only faced bullying, name calling and abusive behavior during the payment transaction but also struggled with the authority(police) in such instances. The participants have faced significant challenges in their jobs and career.

The participants faced similar challenges in the health care centers and hospitals. For most of the part the participants were ignored by the nurses and the general staff even in simple inquiry process and queuing. The doctors would either ignore the participant, refer them to the care of a health assistant or blatantly refuse to attend to them. In one of the instance the hospital administration refused to take the participant as a patient in their hospital because of their gender identity. The anxiety that the participants had when refused treatment of a likely morbid condition was very high. Such experiences have caused the participants to avoid the health care institutes as much as possible and resort to self-medication and usage of local remedies for the treatment of their ailment. In many cases the healthcare workers' general lack of understanding of the transgender bodily anatomy and hormonal physiology has induced many intrusive questions about their physical body which has made the participants anxious in public setting and hence have delayed or even avoided hospital visits completely.

4.2.3 Self-Stigma

The participants after having faced stigma and discrimination in their daily life from their family and society as a whole, agree and internalize the stereotype enforced upon them to a great extent. This can be seen in the various ways they have tried to cope during unwelcoming situations. Some have struggled internally and chose to withdraw from their family, friends and society. They have had aggressive outbursts in unfavorable scenarios and even attempted to harm themselves by inflicting (wrist) cut injuries at their moments of loneliness. Others have chosen to take a more optimistic outlook and have accepted their gender identity and opened up about their sexual orientation. The physical, physiological and emotional journey of their transitioning was greatly supported by their fellow transgender peers who have been their major source of strength and resilience.

CHAPTER 5

DISCUSSION AND CONCLUSION

5.1 Introduction

There is no anti-discrimination statute for Nepal's LGBTIQ minority under the 2015 Constitution. Even while the Interim Constitution guarantees gender equality before the law, it does not provide protection from discrimination in other spheres of life, such as education, work, housing, social discourse, and access to healthcare (Blue Diamond Society, 2018).

A clear violation of the ICCPR (International Covenant on Civil and Political Rights) and the ICESCR (International Covenant on Economic, Social, and Cultural Rights) is observed to which Nepal is a signatory. The ICCPR Articles 6(1) and 2(1) respectively states that “Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life” and “Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.” Furthermore, the ICESCR Article 12 states that “The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” (UNDP & USAID, 2014).

As already noted, there are no legal protection for trans women in Nepal against discrimination. The inadequacy in the representation of the LGBTIQ community in the Nepalese constitution in combination with deep rooted social stigmatization has subjected the transgender community of Nepal to stigma, prejudice, and discrimination including violence (Bhatta, 2017). The effect of the prevalent heterosexual cultural norms in Nepal created detrimental consequences in the overall health and wellbeing of the transgender population of Nepal (UNDP & USAID, 2014).

The purpose of this study was to offer trans women a voice in the debate on how stigma affects the health and wellbeing of trans women in Kathmandu Nepal with the aim to contribute in addressing violation of the right to health faced by the transsexual people of Nepal and the need for reorienting health systems.

This ethnographic pilot study was conducted to explore lived experiences on stigma, health and well-being of trans women in Kathmandu. Despite the fact that qualitative research yields information that is non-numerical, it is still employed in social settings to understand the experiences, attitudes, views, behaviors, and relationships of individuals (Pathak et al., 2013). It is appropriate to obtain information from the respondents that is relevant to the study's aims since qualitative research methods, such as ethnography, allow the researcher to understand how individuals perceive themselves and organize their everyday lives (Berg, 2001). According to Englander (2012), a small number of research units may prove to be an appropriate quantity and provide incredibly useful information in the case of a hidden and difficult to access population.

Since this is not the aim of an ethnographic research endeavor, ethnographic data are not meant to be used to support generalizations. Instead, a culturally and contextually grounded perspective is revealed through an anthropological investigation. It is crucial to understand that the results of ethnographic research are frequently used as a starting point for subsequent investigations (Rea-Holloway, 2012). The ethnographic pilot study conducted involved five self-identifying, volunteering trans women residing in Kathmandu. Findings illustrate that they all have been subjected to stigma and discrimination in many aspects of their life. In-depth interviews were complemented by unstructured covert observations during informal group activities and spontaneous discussions. An appropriate private or public location that provided the necessary privacy and was convenient for the participants was chosen for the in-depth interview. Interviews were audio recorded with permission. Jotted notes were employed to help with data gathering as and when the participants indicated that they were uncomfortable with audio recording. Particularly on the occasion of socializing activities and events, unscheduled and spontaneous group discussions and activities were organized. These unofficial activities included going to parties, public events, movies, eating out, and so forth. These unofficial gatherings served the purposes of

getting to know the participants, getting a sense of the larger transgender community, and helping individuals feel at ease in unplanned situations given the nature of this study. Field reports were used to place interviews into context. The duration of the study's fieldwork component expanded for over a year amidst the COVID 19 pandemic.

5.2 Interpretation of findings

I had the opportunity to get acquainted, interact and listen to many stories that members of the transgender community of the Blue Diamond Society¹ shared about the difficulties they faced with stigma and discrimination. The Blue Diamond community to them is like one big family, where there is a mentor appointed to every new trans female that has come out. The mentor is like a big sister to her who teaches her the way of life after coming out, as to how to build a constructive relation with themselves and the world. She is taught how to accept herself, how to take care of her physical and bodily needs and is introduced to hormones and medications. She is taught how to deal with unsupportive family members, how to choose romantic partners, find a suitable job and remain financially stable during the process. These conversations led me to realize that society labels these people as outcasts, therefore pushing an entire segment of the population into social marginalization and utter despair as they have to rebuild themselves in many different ways.

As the day of meeting the study participants arrived I was not anxious as I was sure that I was going to meet warm people and that was exactly how it was. The general introduction happened in a restaurant which served mainly LGBTIQ community members. They were kind enough to allow me to record any conversation or take a note of anything that I may find useful for my study. When I introduced myself as a medical doctor, the participants visibly tried to present themselves with their best behavior. As I told them about my university they started filtering the conversation and made it seem a big deal that a doctor studying abroad wanted to take interviews with them. This posed a potential threat for response bias. Thus, to ease the

¹ Blue Diamond Society is a Nepal-based NGO that works with local communities and on a national level with the mission to improve the sexual health, human rights and wellbeing of sexual and gender minorities in Nepal including LGBTIQ.

environment we started off by going out on social gatherings and spending some time in general conversations. We went to quite a few social gatherings that included dinners, lunches, and parties. It was here I realized that they interacted very freely with the men they were acquainted with, they were even flirtatious at times. Around women they were mostly indifferent, however they did observe their appearance which would then be talked about a lot among themselves. The general conversations would be about men, relationships, fashion and pulling legs or even slandering of fellow peers from the transgender community. A lot of gossip would be shared about peers, mostly about their sexual relations, betrayals and money issues like debts and frauds. While it seems that they presented a united front as sisters forming a community, there was envy and jealousy within the community. The peers mostly exchanged views about how a certain member of the transgender community was unworthy of the attention they were getting, be it sexually, financially or in a social sense. There were conversations of how certain members did not deserve the attention they received during a certain social event. All the participants revealed that within their own group there were betrayals in friendship and sisterhood in many instances. At the time interview sessions started off participants were comfortable to talk freely about their personal experiences with me. I too was confident in having long conversations privately in their apartment and tried my best not to make them uncomfortable in any way. Although the interviews and observations were limited to 5 participants, the experiences and the information shared was rich and allowed me to explore a way of life previously unknown to me. I would take tokens for the participants, which were mostly the cupcakes and sweets that I baked at home, and the participants were happy receiving cakes and sweets while telling their stories. I did learn that the transgender community is a unique community in the Nepalese context. Although not all transgender are Hijra the term is often used in North India and Nepal to refer to transgender people and their role in South Asian Hindu societies goes back millennia. The traditions of the guru-chela system often remain in place to date, where existing members take on the role of big sisters to novice disciples (Bhatta, 2017). Trans women in Nepal, unlike many other South Asian counterparts, rarely face obvious violent extremism from the society, but are still largely discriminated and marginalized by the society (UNDP & USAID, 2014). While the

trans community is looked upon to be religiously significant and important in matters of blessing a wedding or a new born ceremony in the Terai region of Nepal, the stigma that the transgender community has to face at social and structural levels along with internalized self-stigma has nevertheless led them to face discrimination in almost all aspects of their life (UNDP & USAID, 2014).

Often the transgender females participating in this study felt a general sense of rejection that affects them the most. Members of the general public, often unaware of a trans women's identity may display a sudden change in response or a change in body language, once they come to realize they are dealing with a trans women. This very change in people's reactions makes transgender females uncomfortable.

The conversation with the person then takes up a certain sexual undertone. They then feel the need to objectify themselves in a more feminine manner for validation. The participants in this study took feminizing hormones and body transitioning surgeries, such as breast implants, to model themselves to fit the persona of the ideal body of feminine image. A certain sense of competitiveness was observed among the peers in the transgender community as to who transitioned most impressively as often measured by the posher romantic dates they had or the more men or women they attracted.

In contrast, some of their peer transgender females refrained to fit completely into the feminine image as they wanted to be seen as the unique transgender person that they were. While most of the transgender female participants did crave for male validation, they did not seem to be affected or threatened in any way by the presence of cis gender females, but rather seemed unbothered.

As observed while they may have some playful bickering amongst themselves they would always present a united front as a community of transgender sisters to the rest of the society, helping and comforting each other in their times of need.

As the interviews progressed, insights related to the experiences and perceptions shared by participants regarding their lives and the transgender community came to fruition. The interviews revealed how transgender stigma, prejudice and discrimination, and its effects on the various aspects of their lives like family, housing, employment, education, personal relationship impact their overall health and wellbeing. Stereotype gender views deeply ingrained into societal values and norms

stigmatizes deviation from these values and norms. Social stigma then in turn fuels structural and self-stigma. The stigma (negative attitude towards deviation from the norm) then acts as a catalyst for discrimination (behaviors that result from those negative attitudes) in various aspects of their lives. The outcomes of these discriminatory behaviors result in the individual being less equipped in life and socially subtracted in such a manner that they become systematically socially marginalized. This social marginalization subjects them to a loop of stigma and discrimination due to the nature of their social disconnectedness and non-inclusion, which adversely impact their overall health and wellbeing.

5.3 Comparison to previous studies done in South Asia

Findings from this study did not differ from the existing body of knowledge. However, this study highlights the vast unawareness and indifference that was seen among doctors, nurses and other health care workers regarding the specific needs, including basic bodily anatomy and hormonal physiology, of transgender patients. Healthcare needs have not been explored by the previous studies.

Apart from the aforementioned scenario, various studies have shown that some cultures and religions in South Asia have viewed the third gender with recognition and respect (Chhetri, 2017). The Hijara (third gender) is seen by communities across India as people with the power to bless others and hence are welcomed in various religious ceremonies. Therefore, the Hijaras are regarded more as a social phenomenon and they are also considered a 'special group of people' with the power to give blessings (Chhetri, 2017). Although the religions in South Asia may not contribute strongly to the discrimination of the LGBTIQ people, and no imminent violent behavior or obvious acts of condemnation are noticeable, the patriarchal family structure usually succumbs to the socio-cultural pressure and ends up setting rigid standards of expectations regarding gender roles for these individuals (UNDP & USAID, 2014). Thus, most of the LGBTIQ people do not come out in order to avoid the loss of face their choice may bring to the family (UNDP & USAID, 2014).

Nepali transgender literature is scanty and the few available sources “describe the current situation of the transgender community, and some describe the past, but virtually none draw a link between the two and ask why things are the way they are”

(Tower, 2016). There is hardly any research that provides information about third genders of Nepal compared to third genders in other countries. Similarly, there is a lack of research on the perceptions of people about the third gender population in Nepal (Chhetri, 2017). The lack of scholarly work dedicated to the third gender in Nepal calls for future studies fill the knowledge gap” (Tower, 2016; Chhetri, 2017).

Recently students of Gender Studies in Nepal have started writing their Master’s thesis on issues related to third gender (Chhetri, 2017). Works such as these may enhance understanding of a group of people who are least known to the public. As argued by Chhetri (2017), the knowledge gained from studies could inform advocacy targeting policymakers and lawmakers to address the problems faced by the third gender minority in Nepal.

5.4 Implications and recommendations:

The overall experience of this study has been very valuable and insightful for me as a novice researcher. While my hope before conducting the interviews was to figure out the loopholes in the law of Nepal that presumably placed the transgender community in a challenging position, I realized on the contrary how the society was utterly unaware and uneducated about an entire segment of the population. With regards to the insights I gained, I experienced a great shift in my own perspective. Looking back, I feel this study has been more valuable to me than it might be for the transgender females involved.

It seems that people are fearful of what they do not understand, hence they avoid, dismiss, belittle or distance themselves. The same appears to apply towards the transgender community in Nepal. The lack of acknowledgement of a transgender community and the lack of a general understanding greatly contributes to the stigma, which leads to discrimination in families, communities, schools, workplaces and healthcare services, which in turn fuels social marginalization and adversely impacts their health and wellbeing.

When medical doctors and other health professionals are unaware of the specific needs of the transgender population, it speaks a great deal about the status of awareness concerning gender fluidity among the people of Nepal. Advocacy for the basic rights of transgender people and the expectation change views does not seem to

hold much value when health education teachers in schools are unaware of what a “Hijra” actually means. In such context it not realistic to expect change in favor of the acceptance of transgender persons and respect their basic rights to education, a job, health and relationships. A targeted bottom up approach in raising awareness about the existence of a “third gender” is likely to be more effective in reducing fear for the unknown, and fostering acceptance and integration of the transgender people in the Nepalese society which then would pave the way in achieving the rights they are entitled to.

5.5 Limitations and future research:

As the country was in a complete lockdown at times as a measure to control the COVID 19 pandemic, it was not possible to collect data during these periods. Any form of physical closeness was prohibited at the time, making it difficult to have conversations in person. It would have been irresponsible to conduct the study and risk the health of the participants and expose myself to the same threat. The data collection had to be halted for several months. The initial set of participants dropped out of the study to return to their village before interviews were conducted in person. Further, as a medical doctor the situation called me to volunteer in the health sector for the control and prevention of the COVID 19 pandemic. This clearly impacted the implementation of the study.

I was called by the Ministry of Health (Government of Nepal) to opt for a position of a Research Assistant in the Ethical Review Board of the Nepal Health Research Council. Reviewing dozens of research papers enhanced my insights as to how to implement my own study. I also became aware of the various biases that may occur in designing and conducting research. Nevertheless, being a novice researcher with no prior experience in ethnographic studies, required guidance from my advisor, to minimize the potential impact on implementing the study.

As the lockdown eased I contacted a new group of participants. However, I came to realize that initiating the data collection proved to be the most challenging part. No matter how much literature I read, I had a lot of skepticism and even fear, which made me hesitant to collect myself and finally meet my candidate participants. Every significant person to me, be it a friend or a family member, who took interest to ask

about my research were often stunned as to why I took up this particular topic. For many I had to clarify that I was not a transgender myself to have taken up the topic, while others warned me how dangerous it could be. Almost all my friends and family asked me to take a male friend along with me while doing the interviews. I knew I could not keep a friend with me for too long to drop me off or collect me from the meetings due to the risk of infection during the pandemic. However, I did manage to convince my sister to drop me off at the meeting locations. I do admit that I felt a nervous by the thought that I was meeting a group of men who merely look like women and belonged to a community that had the reputation of being potentially violent. These ideas made me so nervous that I decided to go the Blue Diamond Society a few times just to look around and soak up the environment. Visiting and exploring the premises of the Blue Diamond Society a few times was helpful to get acquainted with the LGBTIQ community and to explore perspectives on gender new to me. After talking to random members of the Blue Diamond Society I not only found how immensely jovial and decent people they were, I realized that they were just as much terrified meeting people who did not belong to their own community. It became clear to me that the more time I could spend the more the participants would feel at ease and let me into their world.

Finally owing to the nature of this study and the limited number of participants, the findings of this study may not be generalized to the entire population of trans women in Kathmandu. Since the study population in this study comprised of a hard to access group of people, there is a possibility that not all transwomen face the same difficulties and challenges brought about by discrimination. Furthermore, there have been informal indications that some trans women in Kathmandu have been accepted by their families and have received care and support from their families. Future study to explore factors that promote family acceptance and family support for trans women in Nepal is needed to inform counseling practice.

5.6 Conclusion:

The Nepali trans women participants in this study were pressed to comply with the patriarchal standards of heteronormativity as divergence from the gender binary is still considered deviant by the family and community. The social stigma towards

transgender people in the Kathmandu Valley often poses a barrier to equal opportunities and social inclusion. The transgender people face stigma, prejudice and discrimination which has consequences on various aspects of their lives. The social stigma drives both structural and self-stigma. The social and structural stigma then acts as a catalyst for discrimination in various aspects of a transgender person's life such as family, community, school, job, relationship and healthcare and on a personal level (self) as well. The outcomes of such discriminatory behaviors or actions result in the individual being less equipped in life and socially subtracted in such a manner that they become systematically socially marginalized which adversely impacts their overall health and wellbeing.

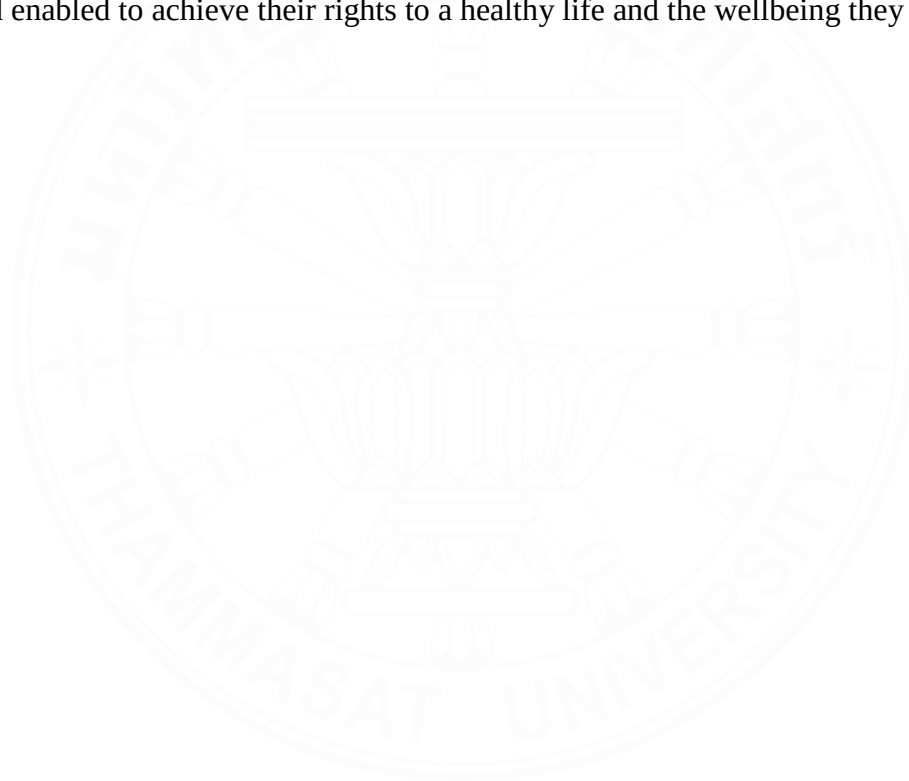
The participants were frequently denied care for a probable morbid disease, which made them extremely anxious. Due to their negative experiences, the participants tried to minimize their visits to medical facilities and instead self-medicate or utilize home remedies to address their ailments. Many times, intrusive questions about the participants' physical bodies from healthcare professionals have made the participants uncomfortable in healthcare settings, causing them to postpone or even forego hospital visits.

While various previous studies have highlighted the presence of discrimination faced by the transgender population in the areas of health, education, housing, job opportunities and familial support, there has been barely any reports on awareness and understanding in the Nepalese society of the concept of the third gender population including the trans women. This study revealed that there is an immense lack of awareness and understanding about trans women by members of the Nepalese society, including educated individuals like teachers and health care professionals.

Hence the study participants were driven to accept and take on the stereotype imposed on them to a large extent, after experiencing stigma and discrimination in their daily lives from their families, their loved ones and society at large. This is seen in the various coping strategies they have employed in uncomfortable circumstances. Some participants have internally struggled with themselves and decided to cut themselves apart from their family, friends, and society. They frequently display violent behavior in unpleasant situations and have even tried to injure themselves when feeling

isolated. This study revealed that trans women participants were most affected by a general feeling of rejection.

Although it is important, having policy and laws in place that recognize transgender persons and respect their human rights, it does not diminish the lack of public awareness and the persistence of social stigma. To make a difference in the daily lives of transgender persons often bottom up approaches in raising awareness about the existence of the “third gender” are required to address the lack of awareness, and promote acceptance and integration of the transgender people in the Nepalese society. When public acceptance grows then gradually transgender people can be supported and enabled to achieve their rights to a healthy life and the wellbeing they are entitled to.



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APPENDICES

APPENDIX A: Legal living situation of LGBT individuals in Nepal

Same-sex sexual activity legal	√ (since 2007)
Equal age of consent	√
Anti-discrimination laws in all areas	×
Same-sex marriages	×
Recognition of same sex couples	×
Step-child adoption by same sex couples	×
Joint adoption by same sex couples	×
Gays and lesbians allowed to serve openly in military	√
Right to change legal gender	√(since 2011)
Third gender option	√
Access to IVF for lesbians	×
Commercial surrogacy for gay male couples	×

Source: (UNDP& USAID, 2014).

APPENDIX B: Approach to analysis

Findings	Participant-1	Participant-2	Participant-3	Participant-4	Participant-5	Participant-6
Interview						
Observations						
Activities						
Discussions						
						

Source: (Batterham, 2012)

APPENDIX C: Project information sheet for participants

Patient/ Participant Information Sheet

Instruction : Need to use simple/lay language, avoid technical terms) .If used, give explanation in lay language(

Do not copy content of research proposal/thesis as information for participant. The information must be consequently arranged as follows.

Title of research protocol : An Ethnographic Pilot Study: Impacts of Stigma on Health and Wellbeing of Transgender Females in Nepal

Principle researcher's name Prarthana Koirala :

Position: Student: Master of Public Health-Global Health

Office address: Faculty of Public Health, Thammasat University, Rangsit, Thailand

Home address: Kathmandu-16, Nepal

Telephone)office 29869213 66+ (

Telephone)home 4428997-01 :(

Cell phone 0927876321 ,9823667218 977+

E-mail prarthana.k@fph.tu.ac.th :

1. You are being invited to take part in a research protocol .Before you decide to participate it is important for you to understand why the research is being done and what it will involve .Please take time to read the following information carefully and do not hesitate to ask if anything is unclear or if you would like more information.

2. This research protocol involves:

An academic perspective on stigma and health of trans women in Nepal with the aim to contribute to the debate on addressing violation of the right to health faced by the transsexual people of Nepal and the need for reorienting health systems.

3. Objective)s(of the project :are to

- Describe Nepali trans women's experiences on how self & structural stigma hinders utilization of health services.
- Describe Nepali trans women's experiences in overcoming self & structural stigma preventing them to utilize health services
- Describe Nepali trans women's experienced health & wellbeing consequences of self & structural stigma
- Describe Nepali trans women's perceptions on how self & structural stigma could be eliminated

4. Details of participant.

- Characteristics, including inclusion and exclusion criteria: The population for this study are female transgender residing in Nepal.
- Number of participants needed: 5-6 volunteers who are willing to participate in this study will be identified by purposive selection.

Participants will be selected based on following inclusion criteria: (i) being a Nepali national, (ii) self-identifying as trans women, and (iii) above 18 years of age. Whereas participants complying with these inclusion criteria but self-report being currently under treatment for a mental health disorder will be excluded.

- How to approach potential participants :

Participants will be identified through snowball sampling, starting with few acquaintances who are served by the Blue Diamond Society, for overt interviews, covert observations and to participate in informal transgender group discussions.

- Reason why this person is invited :

Transgender subgroup are invited for this study as they occupy the largest population in the LGBTI demography. Since the female transgender known as *metis* are usually the most visible, they are selected for the study.

- Group allocation and number of participants in each group :

In case of a hidden and hard to access population, a small number of study units may prove to be an adequate number and provide extremely valuable information. In such cases 5 participants are acceptable with single participants as unit of analysis

- 5. Procedure upon participants :who, will do what, how, when, where, how much time involved as indicated in the research proposal :

Prior to participation in the study, the researcher will inform all participants about the study, benefits and potential risks for participants, and their right to withdraw from the study at any time. Informed consent will be obtained from all participants. For those who cannot understand English language, the consent paper will be translated into Nepali. For those who cannot write Nepali, thumb impression will be taken instead of signature. The participant's rights, interests and the sensitivities will be safeguarded and confidentiality will be protected at all times. The in-depth interview will be conducted in suitable private or public places offering required privacy and convenient for participants. Permission will be sought to audio-record interviews. If participants' express uneasiness with audio-recording jotted notes will facilitate data collection. Data collection will be stopped after data saturation is reached. Informal group activities and discussions are unplanned for and spontaneously arranged especially on occasion of socializing activities and events. These informal events could be attending public events, parties, going to movies, eating out etc. The purpose of these informal events is to familiarize with participants, get a sense of the wider transgender community and make participants comfortable in spontaneous

settings owing to the nature of this study. The final research report will be in English and made available to the participants along with the sponsors. For those participants that do not master English language an executive summary of the study in Nepali will be provided.

6. Process of providing information which also be stated in the proposal.

6.1 Who will provide information to potential participants and how:

Prior to participation in the study, the researcher will inform all participants about the study, benefits and potential risks for participants, and their right to withdraw from the study at any time.

6.2 If potential participant is illiterate/ can not write/ can not speak native language, how the researcher will proceed with the process of informed consent :

Informed consent will be obtained from all participants. For those who cannot understand English language, the consent paper will be translated into Nepali. For those who cannot write Nepali, thumb impression will be taken instead of signature. The participant's rights, interests and the sensitivities will be safeguarded and confidentiality will be protected at all times.

6.3 In vulnerable group e.g .psychosis, prisoner, mental retarded, person under eighteen years old, pregnant woman, dementia, disabled, minority, drafted private, very sick person, refugee, etc., how informed consent is handled:

Individuals who do not meet the inclusion criteria will not be selected for the study.

7. If the process of screening potential participant found a person not meet inclusion criteria and in need of help/advice, researcher needs to state what will be done for that person) .If screening needs information in medical records, consent from hospital authority required(

8. If intervention and data collection intervene with treatments, permission from responsible physician is required.

(N/A)

9. Use of medical record.

(N/A)

9.1 Research involving medical records only, permission to access to medical records required.

9.2 If procedure done upon patient and need information in medical record, permission to access to medical record is required and patient's consent is needed.

10. Indicate risk/harm procedure which may cause ill effect to physical, mental, social, economic, belief of participants . State how the researcher has any preventive/protective measures toward those consequences .In case an ill effect occurs, state guideline how to handle the situation to help that participant.

(N/A)

11. For benefit of the project, state clearly; what/how to individual/public / academy .Do not exaggerate benefit.

If study's results proved beneficial, state what kind of benefit(s) (researcher will share with the control group/community:

This study aims to provide insights on how self-stigma and structural stigma in healthcare could affect the health and wellbeing of transsexual people in Nepal. Such insights could inform advocacy efforts to address the health needs of transgender people in Nepal.

12. Information will include “participation to the study is **voluntary** and participant has the **right to deny** and/or **withdraw** from the study at any time, no need to give any reason, and there will be no bad impact upon that participant) ”.state explicitly eg .still receive the same usual services(

13. Information will include “if you have any question or would like to obtain more information, the researcher can be reached at all time .If the researcher has new information regarding benefit on risk/harm, participants will be informed as soon as possible ”.This practice will provide an opportunity for participants to decide whether to stay/not stay with the project) .**Exception**, in case of one time interview and unable to re-contact participants(.

14. Information will include “Information related directly to you will be kept **confidential**. Results of the study will be reported as total picture .Any information which could be able to identify you will not appear in the report.

15. State explicitly whether there is any compensation for time loss/inconveniences transportation fee etc .The amount should be appropriate, not too high as if to “buy ”or not too low as to take advantage of participants.

16. State that if researcher does not perform upon participants as indicated in the information, the participants can report the incident to The Ethical Review Sub-Committee Board for Human Research Involving Sciences, Thammasat University, No .3)ECScTU(, Room No. 110, Piyachart Building, 1st Floor, Thammasat University Rangsit Campus, Prathumthani 12121, Thailand, Tel: 0-2986-9213 ext.7358 E-mail: ecsctu3@nurse.tu.ac.th

APPENDIX D: Consent form for research participants

Consent Form for research participants
Instruction :Please modify this form accordingly

Address.....

Date

Code number of participant

I who have signed here below agree to participate in this research protocol

Title”“

Principle researcher's name.....

Contact address

Telephone.....

I have **)read or been informed(** about rationale and objective)s (of the project, what I will be engaged with in details, risk/harm and benefit of this project .The researcher has explained to me and I **clearly understand with satisfaction**.

I willingly **agree** to participate in this project and consent the researcher to)indicate what will be performed upon participant**e.g:.** Response to questionnaires/.Enroll in the training program.For how long and how many time.

How many time and amount)tea spoonful (of blood will be taken .After the end of the project personal data e.g .**tape recorder will be deleted, blood will be destroyed . If it will be kept for future studies, should be stated in the Informed Consent Form.**

I have **the right** to withdraw from this research protocol at any time as I wish with no need to **give any reason** .This withdrawal **will not have any negative impact upon me)eg :still receive the usual services.(**

Researcher has guaranteed that procedure)s (acted upon me would be exactly the same as indicated in the information. Any of my personal information will be **kept confidential**. Results of the study will be reported as total picture .Any of personal information which could be able to identify me will not appear in the report.

If I am not treated as indicated in the information sheet, I can report to The Ethical Review Sub-Committee Board for Human Research Involving Sciences, Thammasat University, No .3)ECScTU(, Room No. 110, Piyachart Building, 1st Floor, Thammasat University Rangsit Campus, Prathumthani 12121, Thailand, Tel: 0-2986-9213 ext.7358 E-mail: ecsctu3@nurse.tu.ac.th

I also have received a copy of Information Sheet and Consent form.

Sign

(.....)

Principle Investigator

Sign

(.....)

Witness

Sign

(.....)

Participant

Sign

(.....)

Witness

Note : *If the research carries no more than minimal risk; risk is likely no more than routine care/life, e.g :. telephone survey/interview/research involving secondary data or anonymous specimens which names and addresses of the owner cannot be traced . The researcher can request to waive signed consent .In addition, signed consent might be waived when an unjustified threat to the subject's confidentiality is inevitable, e.g :. research in drug abuses, HIV subjects, persons infected with venereal diseases, sex workers, illegal workers etc . However, the information must be given to the participants.*



APPENDIX E: Questionnaire for In-depth interview:

Introduction:

- Research purpose.
- Informed consent, permission to audio record
- Confidentiality
- Concerns regarding the research.

The in-depth interview uses open ended questions and probes to maintain the interview.

1. Personal Information

- How would you summarize who you are?

Probes: Age, area of residence, prior education, duration living in Kathmandu, job, relationship/partner

2. Personal expression

- Can you help me out, how do you identify yourself?

Probes: Preferred pronoun

3. Experiences of stigma and health services

- How do you view yourself in Nepal's society being a transgender person?
- Being a transgender person, what makes you postponing to use health services?

Probes: can you give me some examples?

- Being a transgender person, what kind of health service providers have you been using?

Probes: primary, secondary, tertiary; government services; private services; NGO services; self-medication

- Being a transgender person, what are experiences did/do you face when you go to a health care facility to seek medical attention?

Probes: embarrassing situations, health professionals and staff attitudes, being forced to use male facilities

4. Personal coping

- What has been helpful in accepting yourself as a transgender person?

Probes: peers, close friends, family, partner

- How do you overcome your reluctance to use health services when needed?

Probes: concerns about your health, seeking assistance from a friend, confidence in demanding your right to healthcare, confidence in demanding respect

- When using healthcare services, how do you handle stigma or discrimination?

Probes: how does it make you feel; how do you respond if you feel treated unfairly or disrespectful? How do you react if you feel ignored?

- How have you handled such situations? The good and the bad experiences along with it?

Probe: How has it affected you?

5. Health consequences of stigma

- How has your reluctance to use health services affected your health and wellbeing?

Probes: did your health deteriorate; did you face complications; did it end up to be more costly; did it take more time to get better?

- How have experiences of stigma and discrimination at health facilities affected your health and wellbeing?

Probes: relationship with your doctor, denial of care, sub-standard care, discontinuation of treatment, poor health outcomes, reluctance to seeking treatment, anxiety, depression, suicidal ideation

6. Addressing self and structural stigma in healthcare

- What would be your message for young people coming-out as a transgender person in dealing with stigma?

Probes: accepting oneself; seek help when you need it; join a support group; social activities; speak out about what it is like to trans; speak out against stigma (media, health facilities, community and society); not harboring self-stigma

7. Message to the society

- Why did you choose to participate in this research?



APPENDIX F: Themes and Codes :

THEMES: PARTICIPANT 1

Themes and Codes

Theme: SOCIAL STIGMA

Sub Theme: Stereotype Gender Views

(Participant 1): “.. after I reached a certain age my body needed sex. I had sexual relation with a boy when I was in the 5th grade. But most people do not express their needs. They repress their sexual needs. They live life as if it's a movie and there is a reel going on, they just play along by suppressing their needs. But at one point the reel finishes are the reel breaks so they will have to start their life in their own understanding. Many who get married have no relationship even if they are husband and wife. Many of them are bisexual, they like both men and women some like only women while some like only men so even if they get married in such a situation the relationship is not like that of a husband and wife. They don't have any relationship, they stay like brother and sister.” **Instability of romantic relationships**

(Participant 1): “She told me not to be so available because boys use me for their work. If they make you happy in bed or financially then go with them otherwise don't be serious with random people. Many people try to take my name and climb up the stairs. She told me that I have already reached a height and they use me for that. The men who walk with me for 5 days, on the 6th day take a model with them in their car that is all because contacts. I feel the same too. That's why I have stopped going to the club very frequently.” **Instability of romantic relationships**

(Participant 1): “I want to be a successful worker outside but when I go home and look at my social media then the same person who applauds me outside tells me how much do I take for sleeping with him for one night. This is very disheartening to me because at that time people are not judging me for my skills but they are judging me for my body and how I look.” **Sexist comments in community**

Theme: STRUCTURAL STIGMA

Sub Theme: Discrimination at School

(Participant 1): “I was bullied in school. Also my voice was very soft like a girl's voice so I used to be bullied a lot. I was very feminine as well I almost look like a girl. I was very shy quiet and reserved.” **Bullying at school**

Sub Theme: Discrimination at Work

(Participant 1): “I am the first transgender in Nepal who got associated with the club and lounges on Nepal. These are places where the trans community was not allowed but I changed the perception of the people involved in the night club business of

Nepal and now transsexuals can access the night life of Nepal. I have put forth the notion that transsexuals should be able to attend and also have jobs in the night clubs.” **Job & career challenges**

Sub Theme: Discrimination in Healthcare

(Participant 1): “The nurses too did not attend to me, they just pointed at me and teased me.” **Rude remarks**

(Participant 1): “I think it's more about the body language that makes you feel uncomfortable, it pinches you in the heart when they talk about you using body language and signs.” **Rude remarks**

(Participant 1): “These days whenever I fall ill I try to make the medicines at my home with whatever I have available and with whatever I learned in my childhood. I tried to take care of myself at home instead of going to the hospital. I think I had a fever of 103 degrees but I did not go to the hospital, I made some ginger water at home and drank it. I think I felt better after 2 or 3 hours.” **Avoidance & delays**

(Participant 1): “The situation in the Nepali community for the transgender men and women is that there is one illness but there are thousands of issues going on in your head about the questions that will be asked, so people hide their disease and left to die.” **Anxiety**

(Participant 1): “During COVID, the hospitals had made rooms for COVID patients and kept them in isolation, but we heard that there was a lot of discrimination in the isolation ward that is why they did not go for the vaccines.” **Avoidance & delays**

(Participant 1): “She had been taken to the hospital by some sex workers and according to them had the hospital paid a little more attention to her my friend would have been alive and would not have died. When we reached there she had already died. Her dead body was lying there but it was in such a situation that nobody even came to touch the body. Seeing that I cried because of the thought that our lives are so pathetic and this is how it is going to be for people like us.” **Refusal, Anxiety**

(Participant 1): “I had a hard time but when I reached the hospital I told my history to the nurse then the doctor caught my hand and asked me for pulse then asked me when my last menstrual period was, and whether my period is regular or not. My sister said I could not have periods as I am not a woman, I am a transgender. As soon as the doctor heard he left my hand and left the room and did not come back.”

Refusal

(Participant 1): “When I tell the doctor that I am a trans then the doctor does not make any eye contact with me, he is playing with his pen and he is looking elsewhere but doesn't want to talk to me.” **Ignoring**

(Participant 1): “Even the specialist doctors do not talk with us openly about the hormones. They do not let us know what we need to know, we do not have a place to go and ask for medical advice regarding the hormones.” **Ignoring, Refusal**

(Participant 1): “In my community there are a lot of people suffering in the hospital. Sometimes they are sent to the male’s queue and sometimes in to female’s queue, sometime they are not attended to at all.” **Queuing**

(Participant 1): “That is how I cope, I try to avoid taking medications and I also avoid going to the hospital.” **Avoidance & delays**

(Participant 1): “The trans genders look like female and in their citizenship it was mentioned that they were male so they were asked to change their queues and people would laugh people, make jokes in the queues. It became very uncomfortable to go and many trans genders did not take the COVID injections. But as you know the government had supplied medications during COVID but none of the members from our community got it.” **Queuing, Refusal**

Theme: SELF STIGMA

Sub Theme: Feeling Unworthy

(Participant 1): “So whenever I feel low or feel let down, need energy to charge myself up, I call my best friend Akrisha. She is also like my godmother. She taught me how to meet with people and how to discuss situations with people. If it was not for her then I would not have been here talking with you today.” **Seeking peer support**

(Participant 1): “Now I'm trying to involve myself in a new project which is an LGBTI Q friendly hospital. We are trying to establish it and after that if any of the hospitals claim that they are open and free to all people including LGBTI community then I will probably go and have a word with them because of how and what situations we have faced.” **Coming out**

(Participant 1): “I try to overcome my pain by sharing my stories and trying to lobby for the rights of LGBTQ. I do a lot of advocating in media.” **Seeking peer support**

(Participant 1): “I don't like staying without working, I keep travelling and I keep myself busy that is how I distract myself. Whenever I feel low I like to work.” **Stress**

(Participant 1): “I do feel hurt that is obvious, I feel like crying but it is no place to cry. Sometimes when I feel that people have crossed their lines and I go and I start shouting these days.” **Aggression**

(Participant 1): “At such times I try to divert my mind. I try to think about different kind of thoughts, sometimes painful thoughts and sometime happy thoughts depending on the situation. Most of the times I think about painful thoughts, imagine how if I had done things better the situation would have been better even case of my relationships.” **Stress**

(Participant 1): “Social media shows a lot about the LGBTIQ community so people tend to open up very quickly but they do not know what lies ahead of them in the future after opening up. They do not know the consequence of it. It has become a fashion trend after going around as a girl for one month you might feel wow! but after the month ends and you go back, you have to be prepared for the consequence that it brings. You have to be mentally, emotionally and financially prepared for the consequences ahead. Unless you are fully aware of your future I would advise them to not open up.” **Social withdrawal**

(Participant 1): “I told my family about myself after SLC one week after the exam finished. I told about myself in a live interview I did not think about tomorrow, I did not think what will happen in the future. I just talked about myself. I was 16 years old at the time and when I went home my family accepted me.” **Coming out**

(Participant 1): “If you see in the trans community the girls look very feminine and pretty and wish that people would call them with female pronouns but I never thought that.” **Self-acceptance**

(Participant 1): “I want people to know that I am a transgender. And tomorrow if the government wants to give a citizenship based on the gender then I will want a citizenship that identifies me as a transgender female. My pronouns are she/her I just want people to be considerate of it.” **Self-acceptance**

(Participant 1): “Yes, some of them even committed suicide because the housekeeper would ask for rent but the people of my community did not have money during the lockdown. Most of my friends did not have food to eat. Only in the last moment did we know that they did not have ART treatments available due to the lack of money. My friends are HIV positive and during the lockdown since they did not have money they could not buy the medications for their treatment, there was a lack.”

Self-harm

THEMES: PARTICIPANT 2

Themes and Codes

Theme: SOCIAL STIGMA

Sub Theme: Family Issues

(Participant 2): “My family did not support me. I have a father and a brother who do not accept me. My mother is supportive but whenever I have to meet her I hide from my father and meet with her separately. Even when I go back home at times to meet my mother I wear clothes that cover me fully. Since my mother stays at home I do not want her to have any inconvenience because of my identity so I meet her outside most of the times.” **Non-acceptance**

(Participant 2): “I knew I was different but I did not know that I belonged to the transgender community. I wanted to open up since I was a child but I did not have support from my parents.” **Loss of support**

Sub Theme: Stereotype Gender Views

(Participant 2): “Ever since I was 5 or 6 years old I knew I was different. Since that age I enjoyed wearing girls’ clothes, eye liners and makeup. Since I belonged to the Tamang caste, I did not cut my hair until the Bartaman Ceremony (Twice Born Ceremony). The ceremony for me occurred when I was around 9 years old so until then I had long hair. I used to force my parents to buy me girls’ clothing items. I had long hair and I look like a girl too because everybody used to ask whose little I was when I was outside playing. I had a soft voice too like that of a girl so I grew up as a girl until the ceremony happened at 9 years old. After this age I started developing problems in my community in the village.” **Forced dress-code**

(Participant 2): “This was obviously because I was born or boy but I had the mannerisms of a girl. I used to try to hide my behaviour but it was something that came to me naturally. I had a lot of girls who are my friends.” **Losing friends**

(Participant 2): “In the class whenever I gave any answers to the questions asked the teacher is used to say that I spoke like a girl and that I am supposed to speak like a boy. They used to tell me to answer like a boy and learn how to speak like a boy because I was born a boy. People around me always asked why did I behave like a girl and why do I have so many girls as my friends.” **Losing friends**

(Participant 2): “Transgender men and transgender women have different bodies and so they require different services. But the doctors do not understand this and when they see a man they treat them like a man and when this year women they treat them exactly like a woman. After we have told them that we are transgender then the services should be accordingly but it is as just like mine they saw me like a female

and asked me where my uterus was. The same happens to transgender men.” **Sexist comments in community**

(Participant 2): “When I was teaching the students of the 9th and 10th standards, I found out that the children of many of the teachers belonged to our community. The teachers tell us that my son likes to put on makeup and wear girl’s clothing in such a young age. I tell them not to be harsh on their children not to scold or beat them. I tell them to learn to be happy in their children's happiness.” **Sexist comments in community**

(Participant 2): “However, there was one incident in which I tried to rent a room in an elderly lady’s home. Initially she did not know that I was a transgender but she found out she told me that I was some sort of perversion so she did not want to rent me her room.” **Challenged housing arrangements**

(Participant 2): “The society has this concept that all transgender are very scary in a way, they are promiscuous, violent and revealingly dressed. When I live in a society I do not want to live like that, I want to stay in a civilised way for my own self. The house owners that I live with right now are very supportive of me and care about me, I believe it is because of how I have maintained my behaviour.” **Sexist comments in community**

Theme: STRUCTURAL STIGMA

Sub Theme: Discrimination at School

(Participant 2): “Our teacher too did not know exactly what Napunsak meant so whenever there was a discussion of what sort of a person is called Napunsak, the whole class used to turn to me and look at me.” **Teacher comments**

(Participant 2): “In Kathmandu however they used to be a lot of bullying, some boys used to harass me as well. When I was in class they used to say that I am a girl and not a boy and they used to come and put their arms around me, sometimes touch me in my private places as well and tease me. When Valentine's Day arrived they used to tease me and give me roses and say that I was their girlfriend. I felt like I was some sort of a cartoon character. The boys in college were of that age that they did not listen to the teacher as well, and they used to do things with me that I did not like. When I told my teacher about it they did not take the matter seriously, because I think they did not know what to do. I faced a lot of bullying in school.” **Bullying at school**

(Participant 2): “Even while using the toilets I had a lot of problem because most of the toilets for men were designed to be open and I did not feel comfortable in them. There were 2 private toilets in which I could close the doors. After the break was over

and the classes started all the boys left the toilet and that was the time when I used to go and use the private toilet.” **Toilet use**

(Participant 2): “I wanted to continue my education in college but I'm not being able to go because I cannot sit for the exams. All of my documents have my male identity in it and when I sit for the exam the examiner questions if I am a fake student. The problem starts before entering the examination hall when the gatekeeper looks at my ID and says that I am a fake student and does not let me enter, this is because our exam centres are not located in the college but they are allocated in some other college the staff is not familiar with the students beforehand. My mind used to be very disturbed and I could not focus or concentrate on my studies at all, I did not feel like studying. I wanted to finish my college but I'm not being able to do that because I am very much disturbed when I go to college.” **Underperforming**

Sub Theme: Discrimination in Healthcare

(Participant 2): “Regarding health there was an incidence when I had to go to one of the hospitals in Kathmandu because of her very bad stomach ache. An ultrasound had to be done. The doctors started scanning my abdomen and then proceeded to go on the lower side, he was trying to look for my uterus and ovaries. The doctor asked me what happened to my uterus. I told him I am a transgender, I was born as a man so I don't have a uterus. I told him that I had transitioned to the identity of a woman. As soon as I told him this he stopped attending to me and left the room. I went to him and ask him what was wrong in my stomach but he did not speak a single word. Maybe he was looking for my ovaries but I cannot bring them, I cannot show him something that I do not have.” **Refusal, Intrusive questioning**

(Participant 2): “Then I went to another hospital which is also a popular hospital called Bir Hospital. I wanted to check my HIV status, I wanted to screen myself. A female health worker in the hospital asked me if I was third gender and since I said I was, she started saying that I must have surely come for HIV screening or screening for STD because I'm probably a sex worker that has multiple partners and works in the streets of Thamel. The questions she asked and the statements she made was very demotivating. But since I work in an organization I knew such statements were wrong so I asked her how could she make such assumptions about me when she did not know about my background and the organization I work for. I asked her why did she make all her assumptions just based on the fact that I was a transgender woman.”

Intrusive questioning

(Participant 2): “I go to the hospital whenever I feel that I am unwell. I cannot have negative thoughts always in my mind and trying to prevent me from going to the hospital. But if you look at the behaviour of the doctors and the nurses you don't really feel like going. That is why I go to the hospitals where I feel I am comfortable. I go to the same hospital, it's been long since I've gone there and people there already know me by now. So I do not have much difficulties in going to get myself checked up.” **Rude remarks**

(Participant 2): “I think I feel very moody and scared when I'm taking that medication Diane. I am a person who can go in front of public and easily speak, I do not have mass anxiety but when I take the hormones I feel very scared. That is not me so that is why I do not take that medication on a regular basis. Other than this I do not think I feel depressed because before I came into this community I had learnt a lot of meditation and yoga so I feel like can control my emotions. It makes me calm down and helps me relax.” **Self-medication**

(Participant 2): “I mostly try to talk to people and try to make them aware of the situation. If people understand it is well and fine and if they do not then I ignore them. Before I go to the hospital I mentally prepare myself that I may face such consequences and I will have to hear a lot of comments from people. Since I am also using hormones and hormones make people aggressive, I tell myself not to be aggressive in these situations. I know I am a different person and I know I will have to face these situations.” **Anxiety**

(Participant 2): “I had a friend who was a transgender man and being a transgender man he wanted his breasts removed and so he had undergone some surgical procedure. He went for a follow up in an expensive private hospital in Kathmandu but the doctors there knew nothing about such surgeries. They started asking ‘Why does a man have such big breasts? Did he have it removed because he had cancer?’” I’ve been to many hospitals for medical check up but in many instances doctors do not know he needs of the LGBTI community. There is a separate group of people in our community called the Intersex. Doctors mostly have no clue about them.” **Intrusive questioning**

Theme: SELF STIGMA

Sub Theme: Feeling Unworthy

(Participant 2): “So in such a society it is certain that people will have comments if you come out, but I believe that we have to create our space by ourselves. We should not let people point fingers at us because of some activity that we have done so there should be some restraint on the things we do and the ways we behave while living in a society as well. I think we should live like any other man and woman and behave and similar way so that people will not be able to point their fingers at us. We have to always choose to do the right thing. This is because no one is going to create that space for us. If there is something you want in life then you will have to learn to sacrifice some other things for it, you have to be willing to sacrifice your bad behaviours or certain desires if you want to live in a society in which you can be yourself freely.” **Self-acceptance**

(Participant 2): “I think my friends were my major support system throughout the process of me coming out. Yes, my mother has been supportive but not to a great

extent because the society is always involved in family matters. So I would say that my friends who are just like me, friends from the Blue Diamond Society we're the ones who helped me and are also the ones that I rely on." [Seeking peer support](#)

(Participant 2): "We also organise orientation programs in the various municipalities with the help of the government. These programmes extend up to the provincial level and there are many stakeholders involved including the ministers that help to spread the awareness programme create. I have seen mayors and ministers being influenced and showing a positive response after hearing about our awareness programmes and knowing the basic information through our storytelling." [Coming out](#)

(Participant 2): "By the time I was in a relationship I had already opened up and it had already been quite some time. My partner always motivated me to work in an organizational setting and told me that I could learn a lot. He always encouraged me to go to the organization and get involved in its various activities." [Seeking peer support](#)

(Participant 2): "After I left home and came to Kathmandu I used to work in a lady's home. She knew I belonged to this community so she taught me how to do yoga and meditation and told me that it will be very helpful for me to learn it. I miss her very much. If it was not for her then maybe I would have gone into depression." [Seeking peer support](#)

(Participant 2): "There are so many things that we feel and we experience what we are not able to share it with anyone. So when I get to express what I feel and tell my stories to someone who listens then it gives me a great sense of relief personally. It feels nice to know that someone is listening to you, after all this is something that I have gone through." [Coming out](#)

THEMES: PARTICIPANT 3

Themes and Codes

Theme: SOCIAL STIGMA

Sub Theme: Family Issues

(Participant 3): “Initially my family was not supportive. When I went back home dressed like a girl it was almost like a circus, all my neighbours would gather around my home just to look at me. They would tell my mother what happened to your son why is he coming home dressed like a girl. My mother used to be frustrated because she felt that I was born as a boy, she used to tell me, “You were born normal why are you behaving in this manner?” It took me 3 to 4 years just to make my parents understand this. I brought them here in the blue diamond society and showed them around. I told them that I was not the only one like this nor am I spoilt it is just who I am.” **Challenged family relations**

(Participant 3): “After that I even went to my home, but home is not just the same as the office. They will always fear what the society will say, it is obvious that they will not accept you.” **Non-acceptance**

Sub Theme: Stereotype Gender Views

(Participant 3): “He knew that I was a sex worker and told me to stop after we got into a relationship. But sometimes I do go to work without letting him know because the economy is tough. It's not that he has a lot of money, he also works every day to earn his living and I do not want to be a burden to him. I want to take care of my own expense so that things do not get very difficult for him as well. So sometimes I go to work without letting him know.” **Instability of romantic relationships**

(Participant 3): “I did not know I was different at first. But over the years, I wanted to wear girls' clothes and all my friends were only girls. Even in school the teacher used to tell me to sit in the boys' rows because the class was divided into the girl's section and the boy's section. I would listen to my teacher but I completely disliked it when I had to sit with the boys.” **Forced dress-code**

(Participant 3): “I remember the time when I wanted to grow long hair but I would have to stand in the boy's queues so the teacher would tell me to cut it short.” **Forced dress-code**

(Participant 3): “Well in that case I would like to be called as Bahini (sister), because I look like a girl, sometimes I look very feminine, but when I speak my voice is not feminine.” **Sexist comments in community**

(Participant 3): “Earlier I used to change my clothes halfway before going home and dress up like a boy, and change back again into a girl when I came back to the office.

I always carried a set of boys clothing with me whenever I went to visit home. Now my parents are very understanding, they fully support me. Even the neighbours do not call me names or tease me. I think it is because of social media that people are being more aware.” **Forced dress-code**

(Participant 3): “I have not been forced to go into a man's queue in the hospital, but most of the people who talk to me say that I look like a girl but have a man’s voice. so I tried to adjust my voice and talk softly. I think I do it because I feel that my voice is too loud.” **Sexist comments in community**

Theme: STRUCTURAL STIGMA

Sub Theme: Discrimination at School

(Participant 3): “Actually I do not feel like going school because I used to get teased a lot.” **Bullying at school**

(Participant 3): “Even while going to the bathroom. I do not feel like going to the boy’s bathroom. My friends started talking about me saying that they have never seen me go to the bathroom, neither in boys nor in the girls.” **Toilet use**

(Participant 3): “So they would talk to themselves if I was a Chakka or a Hijra. Because of all of these reasons I did not feel like going to school, I dropped out when I was in the 7th standard.” **Drop-out**

(Participant 3): “I remember the time when I wanted you to grow long hair but I would have to stand in the boy’s queues so the teacher would tell me to cut it short. The teacher used to beat me a lot too because of such things, so I felt I just wanted to drop school.” **Classroom seating**

Sub Theme: Discrimination in Healthcare

(Participant 3): “When I went to Kathmandu Medical College (KMC) add to stand in the registration queue, and when I presented my documents it was registered in my male name. When the staff would see my male name they would say that I look like a girl but I have a voice of a man, why was it so? People would then tease me, stare at me and start talking about me.” **Intrusive questioning, Queuing**

(Participant 3): “In the hospital I have had experiences of being discriminated in the queue.” **Queuing**

(Participant 3): “Another incidence was when I was in in Birgunj. I had an accident and I went to the emergency but the doctors and nurses did not show up or attend to

me. I think it is their job to look after patients but they do not do so, they just neglect us.” **Ignoring**

(Participant 3): “I had wounds on my body from the accident but the doctors would try to touch me in other places including my breasts, they really did not care about the accident.” **Ignoring, Refusal, Intrusive questioning**

(Participant 3): “To be honest, I don't feel like going to the hospital, I wish I did not have to. Sometimes when I have stomach ache and when I go for a check-up they start asking me questions like “When was your periods?” I think most of them cannot recognise us so the questions they asked us are very embarrassing.” **Intrusive questioning**

(Participant 3): “I have not tried to myself or kill myself in anyway but there is a constant fear. When I go to the hospital I am constantly afraid whether the hospital will admit me or not, whether the doctors will come and attend me or not. If they do not come to attend me and I need to leave the hospital, then I do not know where else to go. I also feel very scared when I'm going home. I'm afraid what will my parents and my family members think. Sometimes I am scared that they are going to say something and I will get hurt.” **Anxiety**

(Participant 3): “One of the members from our community she was raped the case was very big. It was published in the newspaper. So her body I was taken to the hospital for post-mortem examination. But the doctors there completely denied to do the post-mortem, they also said that they were scared. This is because they had never seen someone who had both breasts and penis. They did not know what to do with the body. So the post-mortem never happened in that hospital. If the doctors knew about us then maybe they would not have behaved in that manner.” **Refusal**

(Participant 3): “For minor illnesses like cough and cold I get medicines from the local medical shop, or I just stay at home and treat myself with whatever I have.” **Self-medication**

(Participant 3): “I did surgery of my breast in India. But when the doctors examined me here they are surprised they ask me questions like “What is this (in the chest), what have you put in your breast why was the surgery done?” I think the people in Birgunj do not know about it.” **Intrusive questioning**

Theme: SELF STIGMA

Sub Theme: Feeling Unworthy

(Participant 3): “For young people trying to come out, I would not suggest them to come out in a haste. Because they do not know what their future will look like after they transition. I know they will want to turn into a girl and have that experience but I do not encourage this because there is a lot of things that you will have to listen to and

a lot of comments that you will have to bear. Also the life after coming out is not as easy and glamorous as they see on social media. I'm not discouraging them but I would want them to really think about it first.” **Social withdrawal**

(Participant 3): “Whenever I have problems in the hospital or I need to talk to the doctor I always take my friends along with me. They have been my biggest support system, whatever the situation it is my friend's help me.” **Seeking peer support**

(Participant 3): “Whenever any discrimination happens to me in the hospital or when doctors do not come and attend me I get very angry. Sometimes I even scream at them and leave because I feel I do not need to stay in a place where I am not looked after.” **Aggression**

(Participant 3): “I took part in this interview because it felt really nice to have someone to talk to. There are so many things that I have not shared with my friends but I told you because it was easy to talk to you. I hope the interview becomes successful and more people will get to learn about our community. But it is nice to have someone listen to you in such a positive note.” **Coming out**

(Participant 3): “My friends from the Blue Diamond Society helped me open up. I was at home doing nothing after I left my studies, some of the community members happened to come to the area where I lived. For some reason the people from my community instantly recognise each other. They came and told me that I am just like them, also said “You are so beautiful, you should come to the office we will help you”. I was really happy to go. They would tell me that I was so beautiful if I transitioned into a girl I would be even more beautiful. In the beginning I did not know how to behave so much like a girl, I used to have short hair. They took me shopping I started learning how to do makeup and grow my hair long and everybody would say that I looked very beautiful. I was very happy to dress like a girl and go out freely like that.” **Seeking peer support**

(Participant 3): “Regarding to how I feel about being a transgender, I think I'm very happy the way I am. Some may wish to be born as a man some may wish to be born as a woman. Whatever I am I am happy.” **Self-acceptance**

THEMES: PARTICIPANT 4

Themes and Codes

Theme: SOCIAL STIGMA

Sub Theme: Family Issues

(Participant 4): “Everyone in my family knows that I walk around like a girl and I dress like a girl. Ever since I transitioned I have not gone back home per say, and in the rare instances that I do go home I dress up as a boy.” **Challenged family relations**

(Participant 4): “They told me that I was dead for them and that I should assume that they are dead for me as well. They told me that they had no relationship with me anymore.” **Loss of support**

(Participant 4): “When my parents found out they told me not to come back home.” **Loss of support**

(Participant 4): “I think it was 2 or 3 years ago during the time of the Dashain or Tihar. I was in my room alone at that time, I missed my parents. My parents told me that I have already brought shame to the family, now I have no face to come back home. So they asked me not to come home at the time.” **Non-acceptance**

Sub Theme: Stereotype Gender Views

(Participant 4): “Everyone in my family knows that I walk around like a girl and I dress like a girl. Ever since I transitioned I have not gone back home per say, and in the rare instances that I do go home I dress up as a boy.” **Forced dress-code**

(Participant 4): “Yes, many times during (sex)work. They called us names and blame us of all sorts of things that we have not done. I don't mind them calling us Hijra or Chhakka but sometimes they even call names to our parents. I don't like it when they involve our parents and shame them unnecessarily. They have even said how must your dad have sex with your mom to give birth to you.” **Sexist comments in community**

(Participant 4): “Yes, sometimes when we go to the clubs, people tease us a lot. Even when we go to the bathroom the girls literally get scared as if they've seen a ghost, we're just as human as they are but they react in that way. They scream Aaahh! (laughs)” **Sexist comments in community**

(Participant 4): “We are mostly treated with disrespect. Let me tell you a story about my friend Ajita. She had died because of some reason and we had to take her to a nearby hospital in Birgunj to do her post mortem. When the doctors came to do her post-mortem they would look at her body and laugh, they would look at her breast then at her genitals and then talk to each other and laugh. That is not a laughing

matter, we had gone to get justice for her it was not a joke.” **Sexist comments in community**

Theme: STRUCTURAL STIGMA

Sub Theme: Discrimination at School

(Participant 4): “I have a lot of experience being bullied at school. There is too much of memories that I don't want to remember. They used to tease me a lot and call me by so many names. They called me Chakka and Hijra” **Bullying at school**

(Participant 4): “The school hours where from 9:00 AM to 4:00 PM. During this time I did not even go to the toilet, I used to hold my pee the whole day.” **Toilet use**

(Participant 4): “I joined the 11th grade as well but still I don’t know the results, joined the 12th grade and got admitted but never attended classes. I was bullied in college as well so I did not want to go. I wished people did not talk or tease us in our face, I think everyone gets talked behind at their backs even the kings but it is hurtful when people say things to our face.” **Drop-out**

(Participant 4): “So by the end of the 11th standard I left college, I don't even know what my exam results were. I paid for the 12th standard entrance fee but never joined the classes, I just dropped out.” **Low literacy**

Sub Theme: Discrimination at Work

(Participant 4): “I used to work in the bus park, there a hotel which was meant for trans genders specifically. The police would come uninvited and unexpected, and grab us and start hitting us in front of the crowd. They have publicly humiliated us many times. I have known a few cases of my friends in which the police have beaten them until they bleed, they had fractured arms and head even though they were not engaged in sex work at that time. This was around 2 years ago. I know incidences where the police had been very brutal even though we had not made any mistakes. They were locked up for days without any reason.” **Bullying co-workers/ clients/police**

(Participant 4): “There are many such instances. This is a very risky job. There have been times when I have thought that I would not be back home alive after I have left my house in the morning. I fear people might just stab me or a car might just hit me. People feel we have taken their money and at times I feel that they will get angry.” **Bullying co-workers/ clients/police**

(Participant 4): “I will not say all my friends are good, some do good things while some have done bad things. And when the police chase us, because of the hormones I get a lot of palpitation when I'm running, I can feel it in my chest. Sometimes the hormones make it difficult to eat anything, and sometimes I even vomit after eating food. I think there is a lot of weakness.” **Job & career challenges**

(Participant 4): “I had a friend. She was just returning after making an agreement with a few boys. I heard she was killed and thrown away somewhere. People throw rocks at us and call us names and when we answer back sometimes they come to hit us, throw beer bottles at us at night on the streets.” **Job & career challenges**

(Participant 4): “People are not the same, they are just like the 5 fingers in our hands, everyone is different. Some people are very nice and treat us nicely when we treat them nicely. They just want to relax and have a good time with us. Some of them think that if they sleep with us their bad luck will go away, it’s some sort of astrological belief.” **Job opportunities**

Sub Theme: Discrimination in Healthcare

(Participant 4): “Yes, I think in the hospital where I was admitted there were queues for male and female. As I was standing in the female queue, I was told by the workers that the line was not for men it was meant for females only. I was asked to shift.” **Queuing**

(Participant 4): “After that I felt that I should not come to such big hospitals.” **Avoidance & delays**

(Participant 4): “But even in such a big hospital the staff and the workers were very impolite, they used to give a bad look and talked a lot when they saw us. The doctors were fine, we do not have any problems with the doctors but the nurses and the receptionists were very rude to us. They used to make faces even when I asked simple questions about the directions to the doctor's room.” **Rude remarks**

(Participant 4): “We are mostly treated with disrespect. Let me tell you a story about my friend Ajita. She had died because of some reason and we had to take her to a nearby hospital in Birgunj to do her post mortem. When the doctors came to do her post-mortem they would look at her body and laugh, they would look at her breast then at her genitals and then talk to each other and laugh. That is not a laughing matter, we had gone to get justice for her it was not a joke.” **Ignoring, Refusal, Intrusive questioning**

(Participant 4): “I collapsed on the ground. I was taken to a nearby hospital but they said that they do not accept trans people. Later we found a hospital called Bhawani Hospital, the only place that admitted me.” **Refusal**

(Participant 4): “They did not agree to do the post-mortem in that hospital so ultimately we had to go to the Teaching Hospital in Kathmandu to get the post-mortem done. We are just like any other man or woman but that is not how we are treated, trans genders do not have that environment to be treated well. It's usually the lower level of staff in the hospital, the cleaners and the workers who bully us the most. Some of the doctors they ask us very personal questions about our sex life when

we go to get checked. We do not go there to discuss our personal lives but to get checked.” **Intrusive questioning**

(Participant 4): “So whenever I am sick I go to the pharmacy and buy some medications but I don’t go to the hospital. No matter how sick I am I don’t go to the hospital, I get medications from the medical shop across the street. Whether I recover quickly or not I just stay at home.” **Self-medication**

(Participant 4): “Once when I was returning from work the police started chasing me and I fell on to the road. I injured my leg very badly and I got high fever after that as well. But I did not go to the hospital because the same thoughts came into my mind again and again that I would be embarrassed going there so I treated myself at home despite the high fever.” **Anxiety , Avoidance & delays**

(Participant 4): “I left the hospital and many incidences. I have never answered back or fought back, I just leave the place and go.” **Avoidance & delays**

(Participant 4): “I’m hoping that these interviews will reach the hospitals and hopefully someday the health workers and the people in the hospital will not treat us with so much of disrespect and ignorance.” **Ignoring, Rude remarks**

Theme: SELF STIGMA

Sub Theme: Feeling Unworthy

(Participant 4): “Third gender people like us, we are very hungry for love, we crave for love and affection. We have not got love from our family, our friends or even with the people we are in a relationship with. So we are very hungry for love we crave for it. When people tease us we rely our friends to support us but not even our closest friends supports at time.” **Seeking peer support**

(Participant 4): “I would like to tell you about my friend Akanksha. I called her Didi. Actually we call our seniors our Didi (Elder sister) or Mummy(Mother) because we live in a community where all of us stay like a family.” **Seeking peer support**

(Participant 4): “I don’t really know what to tell but I would advise them that if they are going to come out then talk to your family properly before doing that. Don’t hide it from your family and your parents like I did. Make plans and arrangements about your future and if everything turns out alright then only come out.” **Coming out**

(Participant 4): “As I told you we trans genders always look for love because we do not get love from our family. Normal people have their families to turn to in times of need but we have no one. At such times I have slit my wrist, maybe tried it a couple of times.” **Self-harm**

THEMES: PARTICIPANT 5

Themes and Codes

Theme: SOCIAL STIGMA

Sub Theme: Family Issues

(Participant 5): “After my parents and grandparents passed away I was with my Mama (maternal uncle). But he did not care for me and humiliated me. So I stole ₹1000 from his purse and ran away to Kathmandu. Mama had a TV in his home where I used to see things about Kathmandu and I knew the name of different places like Jorpati, Chabahill, bus park. I assumed Mama was discriminating me because I was a third gender that's why I fled.” **Challenged family relations**

Sub Theme: Stereotype Gender Views

(Participant 5): “When I was 6 or 7 years old I already knew I was different, some people understand some people don't. Kathmandu is modern so they know what transgender is, back in my village and back in my time there was not such a word. They called us “Napunsak” (hijra) but people did not really understand what that meant. I did not know people having both genitals were called intersex, I knew about that after I came to Kathmandu.” **Sexist comments in community**

(Participant 5): “Since I was young I was never inclined to making friends with, I was always inclined to having girls around, whether it was to collect firewood or to take the cattle to graze I used to hang around with girls.” **Losing friends**

(Participant 5): “My friends used to tease me saying “what kind of a fellow are you, only hanging out with girls and making friends only with girls.” Actually they did not understand that I was not really interested in making friends with them. I was something else from the inside and nobody understood it, I did not know whom to tell. Many people don't understand, even when I'm walking on the road they are confused whether I tried to grow up as a boy and became a girl instead or whether I am Napunsak, and if so they did not know what that meant either.” **Losing friends**

(Participant 5): “Only family members understand these kind of things of course, but the neighbours don't. I might put on a wig or a long hair and do makeup or even do surgeries but the people around the neighbourhood are still going to talk.” **Forced dress-code**

(Participant 5): “And in some places they ask me whether I am a Dai(man) or a Didi(woman). Once they asked me to give the fare, but I said I would not give the fare, I told them “If you are confused whether I am a man or a woman then why are you asking? You already know”.” **Sexist comments in community**

(Participant 5): “People tell me why does a man have a woman's voice, they tell me a lot of things. But I tell them that I am a third gender, I'm not a woman and I don't

want to behave like one. Sometimes we go out to eat. I also feel hungry I have to eat to and when we order food the waiters keep staring at us. I ask them what are you looking at brother(laughs) I have a feminine voice and I wear kurta when I go out, I also have long hair now so people don't recognise me anymore. I have been to places like Dolakha and stayed there for over a month but they did not recognize me there. I wear lungi and t-shirt when I'm at home, I wear kurtha while going out." **Sexist comments in community**

(Participant 5): "When I reached Kathmandu the conductor asked me "Little girl where will you go?" I was surprised he called me a girl. Maybe he recognised me. I told him "Dai I will go wherever the road takes me"." **Sexist comments in community**

(Participant 5): "The generation is very modern now. I don't understand why do girls dress up as boys and go to their homes, don't they know that their parents already know about it. We have been out in the media for such a long time and what will they do about their long hair anyway when they go home [laughs] "**Forced dress-code**

(Participant 5): "I lived with a man for 10 years but I felt like he will not get anything in life if he was with me. So I found a girl for him and I got him married off to her. They have a daughter of 3 years old I go and meet them sometimes. He was older than me. When I met him when I was very young. He was in a relationship with a woman but he got betrayed and was very down. So he used to come to the dance restaurant often and he blew off a lot of money. I was with my friends and he brought us a couple of beers, later he asked me for my number and even told me that he would come visit me at my home. His father had died and he lived with his stepmom. He already knew that I was a third gender and told me that if someone like me would give him company he would be very happy. So I asked him if he wanted to stay with me." **Instability of romantic relationships**

(Participant 5): "But I told him I would not leave my job because how else would I know for sure that he would not leave me after a couple of days, I asked him the same question. He told me not to worry about anything as such. Maybe that is what love was for me at the time. We stayed together for some time. We even went to the orphanage to get a child adopted. But on the way in the taxi I told him that I would want to postpone the idea of adoption, it had been a year that we were in a relationship by then. I thought to myself he is a man like any other. If he leaves me I would not have a job and this child will be for me to take care. How would I take care of a child without a job, if he left me I would be left with nothing. So I stepped back from the adoption." **Instability of romantic relationships**

(Participant 5): "10 years passed by just like that, I sat him down and told him that if he stays with me like this then he will lose a lot in life. I am a third gender I have no future for a family, I have girls who consider me their mummy and I have people to

take care of me even if I go with other people it will not matter. I told him you should not spoil your life, instead get married with a woman and start a family. He got very angry and did not even talk to me for a week. So I searched a girl for him who used to sing in the restaurant. I told him not to tell about our relationship, he agreed. So I introduced both of them and told them to start their life here on, and that their life is in their hands for good or bad. He came back to me after their marriage and stayed with me for 2 or 3 days. I told him not to do this because he is already married now. He used to call me for any small decision. I still meet with both of them sometimes and talk to them and remind him that we are already divorced [laughs].” **Instability of romantic relationships**

(Participant 5): “He told me that If he needed a girl he would have got another one as soon as he broke up but he had heard that girls like us help people when they are in depression, that’s the reason why he started talking to me.

I did not regret that I married him off. At least now he has a child who will do his funeral rights in the future. If he was with me then he would never have had a family. He had a good earning but his earning would have been of no use to me, it would have never been mine neither would I have my family, at least I made his life good.”

Instability of romantic relationships

Theme: STRUCTURAL STIGMA

Sub Theme: Discrimination at Work

(Participant 5): “I am not educated and the citizenship does not work so I cannot get a job either. These girls tell me what to do and where to go. I rely on them and they call me mommy. Whenever I need to get anything done it is always she (Participant 1) who helps me out.” **Job & career challenges**

(Participant 5): “Sometimes I met my friends late at night around 12:30 while picking up cardboards. They used to be dressed very pretty and they looked very beautiful. But as soon as the police showed up they would run inside the narrow streets. I did not know why they were doing so. Later I found out that people like us are not allowed to do many things. So I got scared and when my friends asked me if I was like them I said no, but they said they already knew how I was so told me to come with them. They said they will find a job for me.” **Job & career challenges**

(Participant 5): “I wanted to wear beautiful clothes too but I also had to eat so I took the job that they searched for me in a restaurant. At the restaurant I was paid ₹1500 per month but all the people there would look at me and laugh and tease me. So I told my friends that I do not want to work in the restaurant anymore, I would rather pick cartoons (cardboard boxes) from the street.” **Job & career challenges**

(Participant 5): “People used to tease me and call me Hijra or Chhakka while walking on the road, they still do but I do not care because these things are in their

minds and they will speak so I cannot go and fight with them.” **Job & career challenges**

Sub Theme: Discrimination in Healthcare

(Participant 5): “There was a girl Asmita who was sick and I took her to all the hospitals in the Lazimpat area including Bir Hospital and Teaching Hospital but she would not show her wound to any of the doctors. She had a big wound down there [genital area] and there used to be pus oozing out. When the doctors asked to see the wound she would never show, instead told them to give a medication that dries the wound out. And in home she would stuff pieces of clothes inside in wound in the genital.” **Avoidance & delays**

(Participant 5): “I took her to India as well but she would not show her genitals to any doctor. She would always behave feminine refused to show her genitals. But how would the doctor give medications unless he can see what is wrong. You might feel like a female in your heart but your body is still of a man’s. So you cannot go around acting like a girl in crucial situations like this.” **Avoidance & delays**

(Participant 5): “I think the main issue is that they ignore us in the hospital while they give time to other men and women. I think it's because we are third genders. But the doctors should understand that our community needs help as well. However, it's both ways, there are some like my friends who hide their disease too.” **Ignoring**

(Participant 5): “When I was at Manmohan Hospital to get my blood pressure checked none of the nurses attended to me. At the time I shouted at them saying “Aren't we humans too? Don't we not have a life like others?”. Then the nurses came and attended to me.” **Ignoring**

(Participant 5): “After a few days in India she (Asmita) died because of the infection only because she refused to show her wound. I am not educated but I know that this is not something to hide.” **Avoidance & delays**

Theme: SELF STIGMA

Sub Theme: Feeling Unworthy

(Participant 5): “Soon after my grandparents died I didn't go back to my village. It's been many years that I have stayed here with these transgender girls. I am not educated and the citizenship does not work so I cannot get a job either. These girls tell me what to do and where to go. I rely on them and they call me mommy. Whenever I need to get anything done it is always she (Participant 1) who helps me out. At times I go to give interviews, sometimes I go to offices also and when I o I always go with them. Previously I used to feel shy and did not give any interviews, now because I

have been with them and go around with them I don't feel shy anymore.” **Seeking peer support**

(Participant 5): “I do not know how to speak out but if I need to I will. I will not shy away from showing my body parts neither will I shy away from fighting with the doctor if he refuses to see them. I feel there is nothing to hide.” **Self-acceptance, Aggression**

(Participant 5): “I had a very good friend who was a few years older than me and she was also somewhat educated. I used to tell her everything. I told I told her I like wearing girl’s clothes only. I don't like wearing boy’s clothes and I don't like making friends with boys either. She told me,” This is the age when you figure out what you want to be, whether you like wearing only girl’s clothes or not. And if this is how you feel then wear girl’s clothes and come around with us, don't worry”. **Seeking peer support**

(Participant 5): “People used to tease me and call me Hijra or Chhakka while walking on the road, they still do but I do not care because these things are in their minds and they will speak so I cannot go and fight with them. The thing is you have to be courageous and not be scared whether people are looking at you or not, or saying something about you.” **Self-acceptance**

(Participant 5): “There are so many people who have settled in Kathmandu and did not go back home they had surgeries done and settled here but have never gone back home, you should not do that. It's enough if your family understands no one else needs to understand. People will say what they have to, don't be afraid or shy.” **Self-acceptance**

(Participant 5): “People trust me a lot and I am very happy with that. I haven't done any mistakes except for one. Once when I was walking a man started taking my video from his phone so I took his phone and broke it. They(police) detained me for one day and I had to pay for his phone. Apart from that I have done nothing wrong.” **Self-acceptance, Aggression**

(Participant 5): “Of all these years I have never felt that I would want to hang myself, cut myself poison myself, jump into the river. I am never felt that. I never felt so when I lost my parents and grandparents either because I knew that they considered me different. This is one life that I am getting at least I get to see the world I don't know what will happen in another life will there be another life or not so I do not ever think of taking my life.” **Self-acceptance**

(Participant 5): “In my village I was a very happy go lucky person. I used to love dancing, my grandma used to put her sarees on me and I used to dance with joy. Grand mom said that if a man wore woman's clothes his life would shorten but I told her “Grand mom I think my life will become longer because I'm happy to be wearing

this”. I was neither afraid of girls nor afraid of boys because I knew I was different and I did not care what they said. I knew they would not understand what is going in my mind. Whatever other people said about me never mattered to me.” **Self-acceptance**

(Participant 5): “ I have not received any privileges from any place. I went looking for a job in the Blue Diamond Society as well, but they had no job offers for me. I did not get anything from there as well. The only privileges I get are from these girls they look after me like family, that is all.” **Seeking peer support**

(Participant 5): “I would like to tell the youngsters not to suppress the desires and not to live in fear or shame. I would like to ask them to open up so that our community will also grow bigger and it will be good for all of us as well. I would welcome them. We are there for you.” **Seeking peer support**



BIOGRAPHY

Name	Prarthana Koirala
Date of Birth	May 26, 1991
Educational Attainment	2010-2015: Bachelor of Medicine, Bachelor of Surgery (M.B.B.S)
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