HEALTH DISPARITIES AMONG TRANSGENDER WOMEN: ACCESSIBILITY OF SEXUAL HEALTH SERVICES IN KATHMANDU, NEPAL

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ABSTRACT

Transgender people in Nepal like in many countries worldwide are vulnerable to HIV, and this leads individuals to experience health disparities in accessing sexual health services. Due to the involvement of receptive anal intercourse, transgender women population's severity towards HIV infection and transmission plays an important factor in their sexual health. Significant research has focused on the high vulnerability to HIV prevalence. However, it should not be forgotten that transgender women also face gender-transition related or/and gender-affirming health care services. The achievement of the highest attainable sexual health has a direct correlation with the protections of human rights. High experiences of health disparities and enabling factors among transgender women affect their access to sexual health services. Thus, this research identifies the key factors that affect transgender women's access to sexual health services. Human Rights-Based Approach (HRBA) to health is used as a conceptual framework for studying and analysing the social, cultural, and personal factors to sexual health rights of transgender women by using the four principles of accessibility, namely non-discrimination and quality, physical accessibility, information accessibility, and economic accessibility. This study uses qualitative narrative approach to understand the underlying factors of sexual health services. This paper draws primary data from in-depth interviews as well as secondary data from various research articles, journals, organisational reports, and news articles. This paper argues that physical accessibility was not a challenge in the given study; however, due to the overall inaccessibility of health services, transgender women continue to face disparities in the health settings. The research findings show that the common factors associated with these principles that hinder the accessibility of transgender women to utilise the health care services, both public and private effectively are social neglect, exclusion, and legal bureaucracy in the gender recognition process. These factors result in health care discrimination, weak service provider-user relationship, lack of knowledge on transgender-specific issues, lack of sexual health literacy, poor trans-specific services, and reported medicine intake without prescription. This research is grounded on a human-rights based approach to health, which focuses on the role of duty-bearers to meet their obligations and rights holders to claim their rights. Despite reforming laws and constitution guarantee to transgender women, Nepal's stance in the protection of their rights to sexual health does not meet the international human rights standards. The efforts of the state to realise the human rights obligations, in particular, to transgender-specific sexual health needs and services are not adequately addressed in Nepal. Therefore, both governments and state actors should comply and cooperate to work effectively to enhance the accessibility of services at both the private and public health care settings in Nepal.

KEY WORDS: HEALTH DISPARITIES/ ACCESSIBILITY/ SEXUAL HEALTH/ TRANSGENDER WOMEN

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
BDS	Blue Diamond Society
CLT	Community-Led HIV Testing
FSW	Female Sex Workers
HIV	Human Immunodeficiency Virus
HRBA	Human Rights-Based Approach
ICESCR	International Covenant on Economic, Social, and Cultural Rights
KP	Key Populations
LGBTI	Lesbian, Gay, Bisexual, Transgender, and Intersex
MLW	Male Labor Workers
MSM	Men Who Have Sex With Men
MSW	Male Sex Workers
MTF	Male to Female
OPP	Out-Of-Pocket-Payments
PLHIV	People Living With HIV
PWID	People Who Inject Drugs
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TGW	Transgender Women
UDHR	Universal Declaration of Human Rights
WHO	World Health Organization
YP	Yogyakarta Principles
YP+10	Yogyakarta Principles + 10

CHAPTER I
INTRODUCTION

A developing country sandwiched between the two largest economies, China and India, Nepal is predominantly a patriarchal society. The acceptance towards diverse gender and sexual minorities in the conservative society of Nepal has been a struggle in guaranteeing and exercising full fundamental human rights. The traditional norm that gender is binary comprising of “male” and “female” and the notion that sex assigned at birth determines one’s gender, which is “man” or a “woman” is highly prevalent in Nepal. However, the idea of binary sex has questioned due to the long and continuous efforts of human rights activists and organisations. The 2007 Supreme Court decision on the legal provisions for sexual minority and gender identity in Nepal gave full fundamental rights to the Lesbians, Gay, Bisexual, Transgender, and Intersex (LGBTI) community in Nepal. The verdict of *Sunil Babu Pant V. Government of Nepal* was a remarkable achievement in recognising the rights of gender and sexual minorities (Bochenek and Knight, 2012). The Court ruling promoted the rights of LGBTI people, which included “anti-discriminatory laws, the establishment of a committee on same-sex marriage, and the explicit recognition of transgender people” (UNDP, USAID, 2014).

Furthermore, Nepal made a significant impact on the lives of the LGBTI community through the 2015 Constitution of Nepal by establishing legal protections for the minorities. Article 18 of the 2015 Constitution of Nepal recognises LGBTI population as gender and sexual minorities who are among the disadvantaged groups besides other minority groups and also mentions right to equality regardless of their gender identity (Constitution of Nepal, 2015). However, among the three areas of the court ruling, only the third gender category had some implementation (UNDP, USAID, 2014). These included issuing of citizenship documents and passports with the “other” category. Despite legal gender recognition, equal opportunities for the third gender category in terms of education, employment, and access to healthcare is still missing.

The global burden and prevalence of HIV among transgender women are significantly high. The overall transgender population list among the five key populations who are at high risk of having HIV along with “men who have sex with men”, “people in prison and other closed settings”, “people who inject drugs”, and “sex workers” (WHO, n.d). The World Health Organization (WHO) reported that “Transgender women are around 49 times more likely to be living with HIV than other adults of reproductive age with an estimated worldwide HIV prevalence of 19%; in some countries, the HIV prevalence rate in transgender women is 80 times that of the general adult population” (WHO, n.d). This data and number show that transgender people worldwide have a higher prevalence of HIV, and similar data is replicable in the case of Nepal as well.

Transgender people in Nepal like in many countries worldwide are vulnerable to HIV, and this leads individuals to experience health disparities in accessing sexual health services. The latest data in 2014 showed that the prevalence of HIV in Nepal was 0.2, which is relatively low compared to 0.35% in 2005 (UNDP, 2017, p. 7). Within the estimate of 26% of people living with HIV, 8% population is comprised of transgender people (UNDP, 2017, p.7). “Within Nepal’s sexual and gender minority populations, those who identified as the third gender and were assigned male at birth were economically vulnerable, and those who were third gender, whether assigned male or female at birth, were the most likely to experience discrimination, harassment, and violence” (UNDP, Williams Institute, 2014). Transgender women who are often identified as “*meti*” in Nepal and is assigned male at birth and portrays feminine self-identity and “are archetypically associated with the penetrated role in anal sex” (Boyce and Coyle, 2013).

Although the provisions and articles in the Constitution support the right to equality for the minorities, the translation of implementation of laws, in reality, is a far cry. “Discrimination in the state-funded health care facilities, along with discrimination from citizens regarding their perception that transgender people are all sex workers and HIV positive although sex workers and HIV positive individuals are still entitled to health care regardless of the health status” (Blue Diamond Society, Heartland Alliance for Human Needs & Human Rights, 2013). Due to the involvement of receptive anal

intercourse, transgender women population's severity towards HIV infection and transmission play an essential factor in their sexual health.

Also, the long unchallenged binary gender system (man and woman) and cissexism perpetuate the idea of dichotomous gender, which is why many Nepalese are still not tolerant towards the transgender community. The family members and society do not want to accept transgender for the "sake of protecting their families' prestige in the society" (Chhetri, 2017). Such situations leave many to leave their house, school and migrate to other places which in the case for Nepal, travel to the capital, Kathmandu city. The perception of transgender women having socially unacceptable sexual practices along with their HIV status leaves them marginalised and stigmatised.

Transgender people also often get rejected or mistreated while seeking services in the health care settings, and this may result in them to avoid visiting the health clinics as well. According to the report by the World Health Organization, "Services are particularly inaccessible for those who are poor" (WHO, 2015). The services for transgender people, including primary health care, gynaecological, obstetric, urological, and HIV care. Violations and inaccessibility of sexual health services are associated with the right to health.

Right to health codified in the UDHR, ICESCR, YP, and many other human rights instruments provide a framework for the implementation of health-related policies and programmes. Article 25 and Article 12 in the Universal Declaration of Human Rights (UDHR) International Covenant on Economic, Social, and Cultural Rights (ICESCR) mentions the right to health, respectively. General Comment 14 and 22 of ICESCR provides a comprehensive comment on the right to highest attainable standards of health, including mental, physical health including sexual and reproductive health as well. It also provides how the state should respect, fulfil and protect the right to health. The element of accessibility of sexual health includes, "the enjoyment of facilities, goods, services, accessible to all individuals and groups without discrimination and free from barriers" (General 22, OHCHR, 2016).

Besides the significant covenants on human rights, YP (Yogyakarta Principles) is the set of principles and the standards of international human rights law concerning sexual orientation and gender identity. Article 17 and 18 of YP mentions the right to the highest attainable standard of health and protection from medical

abuses which the states should comply. Also, the YP +10 document has additional recommendations and provisions on the right to highest attainable standards of care that addresses the several human rights systems, national human rights institutions, and non-governmental bodies. Thus, the achievement of the highest attainable sexual health has a direct correlation with the protection of human rights. Substantial health disparities and enabling factors among transgender women affect in accessing sexual health services and therefore, are the main focus of this research.

Research Objectives

The main research objectives of the study are:

1) To identify the key factors that affect transgender women's access to sexual health services in Kathmandu, Nepal.

2) To analyse transgender women's access to sexual health services from a human rights-based approach.

Research Questions

The main research questions of the study are:

1) What are the factors that affect transgender women's access to sexual health services in Kathmandu?

2) How does a human rights-based approach affect transgender women's access to sexual health services?

Research Methodology

a) Research Design

The research design was used in this thesis is Narrative inquiry. The study investigated on studying the research participants through storytelling and narratives of their lives. The data was collected by gathering their stories and reporting their life experiences.

b) Research Methods

Face to face in-depth interviews was conducted with research participants, where each interview lasted from 30 minutes- 60 minutes. In-depth interviews were conducted with transgender women who have an affiliation with the Blue Diamond Society (BDS). Affiliation with BDS included transgender women working in the organisation or had previously worked at the organisation as a volunteer, staff, or an advocate of BDS. Also, in-depth interviews were conducted with health care providers working in health clinics or hospitals or NGOs like BDS in Kathmandu, Nepal.

BDS, founded in 2001 is an umbrella organisation which works for the rights of Lesbian, Gay, Bisexual, Transgender, and Intersex population in Nepal. Currently, more than 700 staffs at BDS work in more than 40 offices all over Nepal (Cousins, 2018). “It is a registered health promotion and HIV prevention organisation that works for rights and advocacy of for sexual and gender minorities in Nepal (Boyce and Coyle, 2013)”.

Sample Size and Sampling Method

The sample size was determined through data saturation, which is the criterion to discontinue the collection of further data. Point of data saturation has been considered to be the “gold standard” in determining the quality of the data (Saunders et al., 2017). The research identified the saturation at an early stage, and the sample size of the respondents was guaranteed with:

i) In-depth interview conducted with six transgender women affiliated with BDS,

ii) In-depth interview conducted with two key informants: Pinky Gurung, President of BDS and Swastika Bhattarai, Health Staff at Cruise Aids Nepal-Branch of BDS,

iii) In-depth interview conducted with two health care workers working at Cruise Aids Nepal and one Clinical Psychologist working at the Abbal Women Entrepreneurs. The health care workers were lay care providers for Community-Led HIV Testing (CLT) program at Cruise Aids Nepal.

Data was collected through snowball sampling, which is a form of purposive sampling. An open-ended, semi-structured questionnaire with an interview guideline was prepared regarding the factors that affect the accessibility of sexual health services of transgender women. The sample was first purposively selected based on the criteria that all the respondents should be transgender women. The BDS and its branches was a central meeting point where the respective respondents were interviewed through a snowball sampling technique to further get the potential respondents for the study.

Study Population

The target population is divided into two categories with their inclusion criteria:

1) Inclusion Criteria (Transgender Women): All the respondents had an affiliation with BDS in terms of work, volunteer or service users of the organisation. The transgender women who are members of the BDS were chosen as research participants as they have more support network within the organisation. The members of BDS also have experiences of access to both public (state governed) and private (NGOs/CBOs or health programs) services which were very resourceful for the research in determining the accessibility of sexual health services in Kathmandu, Nepal.

2) Inclusion Criteria (Health Care Providers): All the respondents were working in clinics or hospitals or NGOs of Kathmandu city, Nepal.

Data Analysis Tools

Narrative Analysis was conducted for this narrative study design. “A form of qualitative analysis in which analyst focuses on how respondents impose order on the flow of experience in their lives and thus make sense of events and actions in which they have participated” (Schutt, 2017). Handwritten notes/ field notes, voice recordings and text documents were used for data collection. The collected data was transcribed and checked. Once the transcription was completed, the data was coded. Deductive coding was used as a data analysis tool for access to sexual health services based on the principles of accessibility in Fig 2. Finally, several themes were drawn out from the code, which further helped in analysing and interpreting the collected data.

Hypothesis/ Assumptions

The research assumes that there will be various factors, which lead to the inaccessibility of the sexual health services among the transgender women living in Kathmandu, Nepal.

Ethical Issues

A combined version of the written consent form and Participant Information Sheet (PIS) was explained verbally to the participants before the study. The participation information sheet was included with the details of the study and its main objectives. The Consent Form (CF) was included with the consent of the interviewee to participate in the study and the potential risks that they might face while undergoing this research. The research participants were not being forced to take part in this study; hence, participation in this study was voluntary. Study participants had the full right to withdraw from participating in the study if they faced any difficulty or discomfort.

Information provided was kept confidential. The data findings were only accessible and available to the lead investigator at the time of the study. The soft copy of the findings was kept private and stored in a fully protected file with the password which was available only to the lead investigator. It was up to the participant's will to participate and to withdraw from revealing information at any time of the interview.

Implementation of the thesis was conducted after getting approval from the Institutional Review Board (IRB) from the Institute of Human Rights and Peace Studies (IHRP).

Conceptual Framework

Health disparity and Accessibility are the key concepts used in this research.

The two main concepts used in this research are health disparity and accessibility. To understand the relationship of transgender women's experiences of health disparities in the health setting, the association of social stressors such as differential access to sexual health plays an important role. Social stressor related to transgender women is further explained in by the Gender Model of Health Disparities developed by Sari L. Reisner (Health Disparities, Transgender People, 2016).

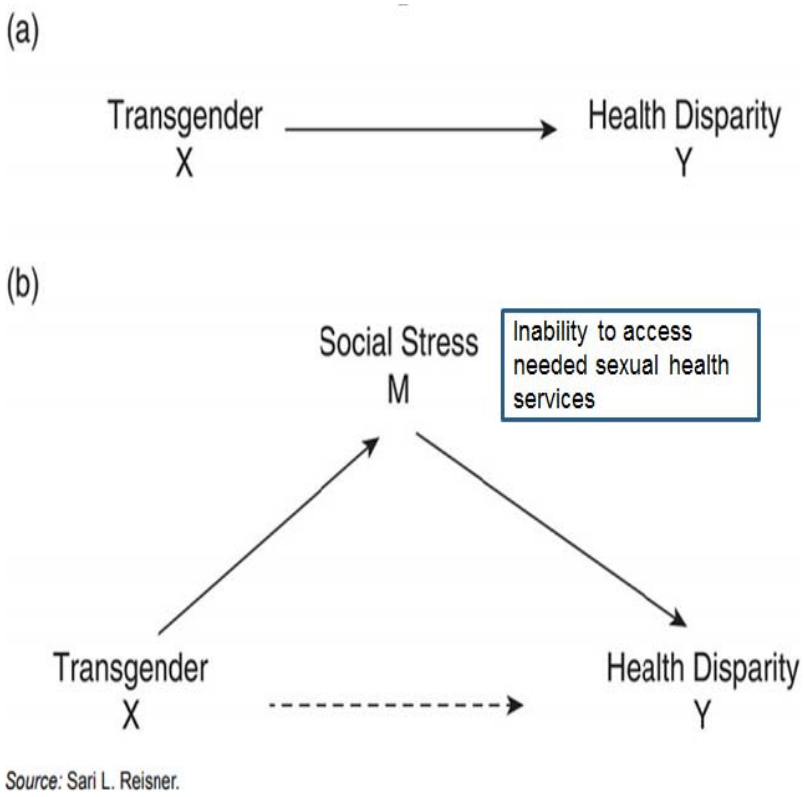

Figure 1.1 Gender Model of Health Disparities

According to Braveman (2006), "Health disparity/inequity is a particular type of difference in health. It is a difference in which disadvantaged social groups—such as the poor, racial/ethnic minorities, women, or other groups who have persistently experienced social disadvantage or discrimination—systematically experience worse health or greater health risks than more advantaged social groups (or in the most important influences on health that could potentially be shaped by policies)". In this research study, the disadvantaged social group is studied in terms of health disparity is the transgender women community.

For this paper, the research will use the definition Accessibility provided in the Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) on "General Comment 14: The Right to the Highest Attainable Standards of Health". The elements of Accessibility include non-discrimination, physical accessibility, economic accessibility, and information accessibility. Despite the recent approach in addressing the right to sexual and reproductive health in General Comment 22, the matrix of accessibility is limited to only three elements, which include

physical accessibility, affordability, and information accessibility. Hence, the paper will use General Comment 14 in addition to including quality as another indicator in determining the accessibility of services provided by the service providers. The paper will look at the matrix of accessibility and how health care workers provide these services. The research will also look into the additional environmental factors such as social and cultural factors which might play a role in the relationship between transgender women's health disparity in health settings.

Hence, to provide more attention and detail on the elements of Accessibility, the research selects Accessibility defined in the General Comment 14 "The Right to the Highest Attainable Standards of Health" over Gen Comment 22 "The Right to Sexual and Reproductive Health".

Accessibility defined in General Comment 14 states that "Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party" (General Comment 14, OHCHR, 2000). Accessibility consists of five overlapping dimensions:

Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalised sections of the population, in law and fact, without discrimination on any of the prohibited grounds;

Quality: health facilities, goods and services must also be scientifically and medically appropriate and of good quality;

Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalised groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities;

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are

affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households;

Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, the accessibility of information should not impair the right to have personal health data treated with confidentiality (General Comment 14, OHCHR, 2000).

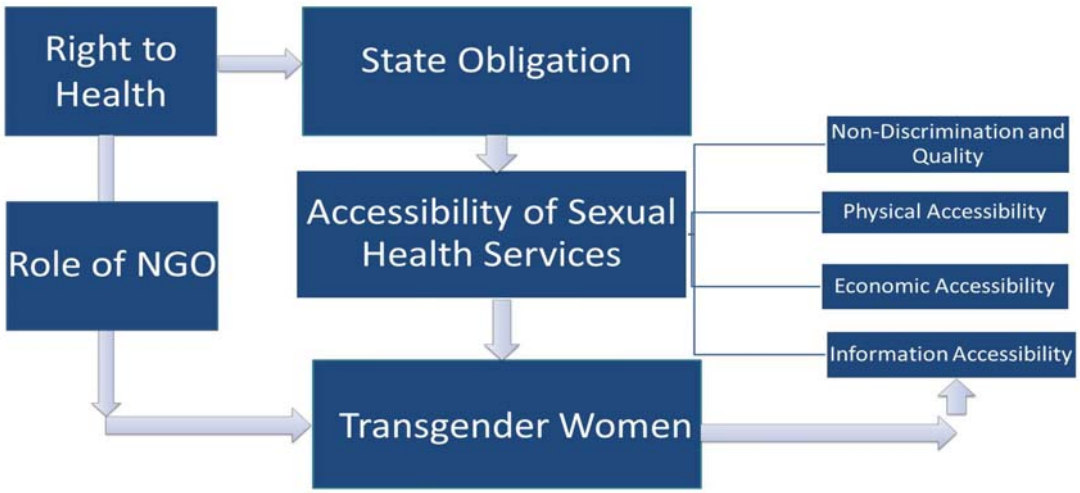

Figure 1.2 Conceptual Framework

Significance/ Rationale of the Study

Numerous studies and organisational reports are conducted on human rights violations and abuses based on gender identity and sexual orientation in Nepal. Few studies have addressed barriers to as well as the factors which facilitate the access to sexual health by transgender women from an institutional, human rights-based approach. By taking a rights-based approach, this paper examines the role of the state as the "duty-bearers" whose responsibility is to respect, protect, and fulfil the human rights of the "rights holders" who claim their rights. "A human rights-based approach (HRBA) aims to support better and more sustainable development outcomes by analysing and addressing the inequalities, discriminatory practices (de jure and de facto) and unjust power relations which are often at the heart of development

problems" (WHO, OHCHR, n.d). A human rights-based approach to health aims to realise the right to health as the core value and its determinants of health identified in the General Comment 14 of International Covenant on Economic, Social and Cultural Rights (ICESCR). The principle includes availability, accessibility, acceptability, and quality. In this paper, the research aims to focus on the elements of accessibility. Discussions on the principles of accessibility are detailed in the Conceptual Framework above. Hence, this research explores and fills in the gaps on the factors that affect the access to sexual health services among the transgender women population in Kathmandu city, taking a human rights-based approach (HRBA).

Scope of the Study

The current research includes only transgender women living in the Kathmandu city, the capital of Nepal at the time of data gathering process. All transgender women participants are currently working or had worked at BDS. Also, an in-depth interview was conducted for the health care providers working in the health clinics or hospitals or NGOs in Kathmandu, Nepal. Health-care providers, who have worked with the transgender women community along with a clinical psychologist, have been interviewed so that the perspective could be broadened to not just the health care users but also, health care providers in the Kathmandu city. Hence, the study focuses on the narrative of transgender women and health care providers living in Kathmandu city.

Limitations of the Study

There are two limitations to the research study. Due to the time and resource constraint, the researcher was only able to take the interview of the one public health care worker who is a clinical psychologist providing emotional and physical support to many individuals, including transgender women. Interviews with NGO health care providers from Cruise Aids Nepal were taken. Cruise Aids Nepal, a branch of BDS is the only sexual health organisation providing services to the transgender people and men who have sex with men community in Kathmandu. In the following chapters, more significant reasons to why transgender women chose their community

to get services are mentioned and when and how did the process of community lead testing started among the transgender community living in Kathmandu Valley, Nepal. Secondly, there might be a result bias as most information gathered is through the lens of the transgender population and only one respondent who was the clinical psychologist, identified as the outside member of the community. The study also signifies that there has been less involvement of other state actors in working towards the sexual health and accessibility of services among transgender individuals.

Terminology

Throughout the dissertation "transgender women" is used as an umbrella term to describe individuals who are assigned male at birth and identify as women, third gender, or their indigenous terminologies which have been discussed in the terminologies section. "Transgender women" could identify as diverse sexual orientation including heterosexual, homosexual, bisexual, and many more. Hence, in this research, transgender women encompass all the definitions mentioned above.

Explanation of Chapters

This research begins with an intensive literature review, which explains the terminologies, key challenges, existing gaps and limitations in the existing literature. The chapters are explained accordingly to understand the flow of the research. After the introduction of the study, Chapter 2 focuses on the literature review. This section discusses on the Third Gender category, which is the legally recognised category in Nepal, defining sex, gender, and sexual orientation of transgender women in Nepal, and finally, focuses on the common sexual health issues that are commonly faced by this minority population. Chapter 3 focuses on the Human Rights-Based Approach and how the study connects to sexual health rights of transgender women in Nepal. Chapter 4 discusses the main findings of the thesis with a focus on the thematic findings gathered from the various study participants. Chapter 5 discusses the primary analysis based on the Conceptual Framework, which is the Principles of Accessibility of sexual health services and how it is related to the context of Nepal. Finally, Chapter 6 ends with a conclusion

and recommendations to the duty-bearers based on the findings, which act as a value-added source to this dissertation.

CHAPTER II
LITERATURE REVIEW

2.1 The Third Gender/Third Sex: Transgender Women in Nepal

The establishment of the third gender category in Nepal, which is the legally recognised category, need to be understood in order to find out the factors that affect transgender women's access to sexual health services. In Nepal, the third gender category was established after the court ruling of *Pant VS. The Government of Nepal*. Knight (2012) provides a comprehensive definition of the third gender category in Nepal which states that "The third gender in Nepal is an identity-based category for people who do not identify themselves as either male or female. It includes people who want to perform as a gender different than the one, which was assigned to them at birth, based on genitalia or other criteria. It also includes people who do not feel the male or female gender roles that their culture dictates to them match their true social, sexual, or gender role preference". The third gender is a term used "to describe biological males who have a feminine gender identity or expression and biological females who have masculine gender identity" (Bochenek and Knight, 2012). Nepal officially recognises the third gender category, including transgender or gender variant as the "*Other*" or "*Anya*". Hence, the identity of gaining the third gender in official citizenship documents means- "it is the keystone of accessing of all state services in Nepal" (NJA L. J., 2008).

2.2 Understanding Sex, Gender, and Sexual Orientation of Transgender Women

The difference in sex and gender and the diverse sexual orientations that transgender women have is vital in understanding their sexual health needs and issues. Understanding the unique sexual health of transgender women is crucial in also identifying the social, cultural, and personal factors underlying in their access to

sexual health services. Hence, this section will further discuss the sex, gender, and sexual orientation of transgender women in Nepal.

Firstly, understanding and familiarising various terms and their differences in the transgender discourse such as biological sex, hormonal sex, genital sex, social gender, gender identity, and gender vector is necessary to understand the unique lives of transgender individuals, including transgender women. Bauer and Hammond, in their research on "Toward a broader conceptualisation of trans women's sexual health" have clearly distinguished these terminologies clearing out many misconceptions regarding transgender population's lives.

As biological sex and social gender are different in regards "to a sex assigned at birth (male or female or intersex), a hormonal sex (based on a preponderance of estrogen or testosterone), genital sex (based on morphology of genitalia), chromosomal sex (XX, XY, XXY, XO), lived gender (male; female; sometimes male; sometimes female; or something else), gender identity (their internal sense of being a woman, man, both, neither, or something in between), and a gender vector (their gender identity's relationship to sex assigned at birth, i.e., cis or trans)" (Bauer and Hammond, 2015).

Thus, the concepts of sex and gender, though interlinked with one another have different meanings. In Nepal, the national/ local language has a single term which defines both terms and does not differentiate between the two (UNDP & APTN, 2017). Such definitions of sex and/or gender can have an impact on the laws and policies as it is a means to acquire a legal recognition through citizenship in the name of third gender category, including transgender individuals.

Transgender women individuals who are assigned male at birth identify themselves with various gender identities. Gender identity is an understanding of one's gender. "Gender identity refers to a person's deeply-felt internal individual experience of gender, which may or may not correspond to the sex assigned at birth. It includes both the personal sense of the body, which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical, or other means, and other expressions of gender, including dress, speech, and mannerisms" (UNDP, 2013). An individual's gender identity ranges in a spectrum and can be fluid, which applies to the transgender population living in Nepal as well. However, in Nepal, there has been

confusion in terms of clustering a whole 'LGBTI' community as the third gender community.

There is also some misconception where 'LGBTI' as a whole is a sexual minority which perpetuates the idea that transgender individual also falls into the sexual minority (Bauer and Hammond, 2015). It should be clear that while 'LGB' constitute a minority in terms of sexual orientation and 'T' transgender individuals constitute a gender minority.

In Nepal, transgender individuals who were assigned male at birth or male to female (MTF) identify either identify themselves as a third gender, woman, or transgender woman. The local terms such as "metis, kothi, fulumulu, hijara, and nachaniya" are often used, however "meti" is the most common term for individuals who were male assigned at birth (Boyce et al., 2018). "The term "meti" designates a feminine self-identified biologically male subject who has sex with other men and who is archetypically associated with the penetrated role in anal sex (Boyce and Coyle, 2013)". In other countries, they identify as "kathoeys in Thailand, kinnars in India, and mak myahs in Malaysia" (Sood, 2009).

The sexual orientation of transgender women varies according to their identity as well. Even among those who identify themselves as women, not all want to undergo gender-affirming care such as sex reassignment operation or/ and feminising hormonal treatment. A large proportion is "attracted to men, some to women and other genders" (Sood, 2009). Unlike in other countries, transgender in Nepal can identify their gender based on their "self-feeling" and do not need to undergo any sex reassignment surgeries. In the sexual activity, transgender women can play both the active (penetrating) and passive (penetrated) role (Sood, 2009) which is a crucial factor in understanding the susceptibility of HIV and sexual health practices.

2.3 Overview of General Transgender Women-Specific Sexual Health Issues

Addressing transgender women-specific sexual health issues need to consider various other issues that transgender women encounter over their lifetime. Transgender women have many of the same health needs as a general population;

however, there are some needs which require specific care. Unlike cis-gender individuals, transgender women's sexual health needs vary accordingly and depend on whether an individual chooses to undergo transition. Transition-related care or gender affirmation refers to "the process of being affirmed and recognised in one's gender identity or expression" (Reisner, 2018).

There are four core components of gender affirmation such as social (e.g. name, pronoun, dressing), psychological (e.g. internalised transphobia), medical (hormones, surgery), and legal (e.g. change of name and gender marker on identity documents) (Reisner, Radix, and Deutsch, 2016). Some chose to transition socially but not medically, some legally but not socially, so all in all, not all transgender women's gender affirmation is the same. Significant research has been focused on the high vulnerability to HIV prevalence. It should not be forgotten that transgender women also face gender-transition related or/and gender-affirming health care services. Many transgender individuals, including transgender women, lack access to gender-affirming services, including hormonal treatment, surgeries, and counselling services. Furthermore, there is a lack of researches on the "HIV risks linked to gender-affirming healthcare (Winter, 2012)".

Gender affirmation service is also linked with health outcomes such as HIV. Researches also indicate that transgender women who have an unmet need to gender affirmation in ways that "increase the risk for HIV and other health outcomes such as engaging in sex work, pursuing dangerous silicone injections, having sex to obtain gender affirmation" (Sevelius, 2013). Thus, gender affirmation services trans-specific needs as respectful and appropriate transition-related care have an impact on the physical and emotional health and wellbeing of transgender women.

The adverse health outcome proves that transgender communities prioritise medical transition in their daily lives (Reisner, Radix, and Deutsch, 2016). "The lack of information and ignorance on the risks associated with neo-vaginal intercourse and lubricants, and of how trans* women use cross-sex hormone, hormone blockers and silicone injections, or their cis partners' use of penile implants and drugs for erectile dysfunction" increases the vulnerability of transgender women to HIV (Winter, 2012). Hence, the trans-specific sexual health issues encompass not only the HIV prevalence

but areas of STI's, STD's, and most importantly, gender-affirming services such as sex-reassignment surgery or/and hormone treatment.

2.4 Sexual Health Risks, Needs, and Health Disparities of Transgender Women in Nepal

Due to the involvement of receptive anal intercourse, transgender women population's severity towards HIV infection and transmission play a principal factor in their sexual health. Transgender women are at sexual health risks due to the high prevalence of HIV and other sexually transmitted diseases, and infections (STDs/STIs). Their health needs vary among the key population as well. Due to the high sexual risks and needs, transgender women also face barriers to health care in various health settings. Thus, the three aspects of transgender women's health are briefly discussed.

In Nepal, transgender people including transgender women's sexual health risks of the epidemic of HIV transmission through sexual contact and activity fall among the key populations (KP) alongside People Who Inject Drugs (PWID), Men who have Sex with Men (MSM), Male Sex Workers (MSW), Female Sex Workers (FSW), and Male Labor Workers (MLW) as well as their spouses (Government of Nepal, Ministry of Health, 2016). Transgender women disproportionately carry the burden of HIV. Data and information aggregation have often included transgender women along with MSM due to the biological risks such as the anal intercourse during sexual intercourse that transgender population share with MSM (Beyer et al., 2012). Baral et al., (2013) suggest that "transgender women are a very high burden of burden population of HIV and are in urgent need of prevention, treatment, and care services".

According to the country report from the Government of Nepal in 2015, the transgender population, including transgender people and transgender sex workers was approximately 9,474 (Ministry of Health and Population, 2015). The following year, the government released another report in 2016, which estimated 21,460 transgender individuals in the 2016 Mapping and Size Estimation (Ministry of Health and Population, 2016). Even though the numbers vary widely, however, the transgender

population remains as the sexual and gender minority among the 30 million Nepalese populations. According to the UNDP's Report on "Breaking New Ground: the Municipal review on HIV and rights programs and services for men who have sex with men and transgender people in Kathmandu, Nepal", the estimated size of Transgender people living in the capital, Kathmandu is in between 2,327-2,719 (UNDP, 2017, p. 7).

Secondly, the sexual needs of transgender women vary accordingly. Most transgender population face a lack of legal recognition and identity papers which reflect their gender identity. As mentioned in the earlier section, without legal documents, transgender women are not recognised before the law, thus hindering their access to state-based services. The absence of proper identification papers or cards results in the exclusion from various sectors, including accessing sexual health services as well. These factors contribute to the overall health disparity among the transgender population. Respondents in the "Surveying Sexual and Gender Minorities in Nepal" reported that the common form of discrimination was the denial in health care settings and among the minority population, the highest percentage (30%) were population who were assigned male at birth (UNDP, Williams Institute, 2014).

Similar cases were also reported while accessing HIV testing and treatment in health care settings from people who were assigned male at birth. Among the many barriers, stigma related to their gender expression and identity act as a dominant barrier. The gender binary system of "male" and "female" considered as natural persons and transgender being something "unnatural" or "not normal" is highly prevalent in Nepal. Hence, such discrimination hinders access to healthcare for transgender individuals.

Finally, the transgender population is among the many that experience health disparities in various places and at different levels. LGBTI community experience similar health care barriers; however, the barriers and challenges are magnified for transgender women in particular. Research in the USA suggests that transgender people face barriers at different levels such as individual (e.g. age, gender), interpersonal (e.g. provider discrimination) and structural (restrictive insurance policies) (Hughto et al., 2017). These health disparities lead transgender people to face difficulty in accessing health care services needed in their daily lives. Also, "the biggest barrier to

health care provided by the transgender individuals is lack of access because of “the paucity of knowledgeable service providers” (Safer et al., 2016).

A study of human rights violence against sexual minorities included transgender women experience discrimination from healthcare providers. “Name-calling as “two organs” and being laughed at for their physical appearances” were some experiences of discrimination faced by the third gender in the health care settings. Also, some reported lower quality of care and denial of services based on their gender identity and sexual orientation (Singh et al., 2012). Some of the barriers healthcare access listed in the literature review conducted in South Asia is “discrimination from the health care providers, limited availability of trans-specific and sensitive health care services, and refusal to provide care often concerning to sexual health (London School of Hygiene and Tropical Medicine, 2015)”.

The sexual health services provided to the key populations and People Living with HIV (PLHIV) in Nepal are adult anti-retro therapy (ART), elimination of vertical transmission (EVT), pediatric anti-retro therapy, and operational, service delivery (Government of Nepal, Ministry of Health, 2016). The anti-retro therapy for coverage in 2016 was 39.8%. The low coverage of ART denotes that many missing individuals were living with HIV. Due to the barriers, which were identified in the country report “lack of accessibility of services, stigma and discrimination towards PLHIV, migration and mobility, drug dependence, unmanaged co-infections, and mental health issues among KPs” (Government of Nepal, Ministry of Health, 2016).

Many transgender people require access to proper sexual health services. However, due to various factors, transgender people are unable to access the basic services. Some factors include poverty, decreased government funding, lack of education, poor access to the rural areas, and pro-rich bias lack in the health equity and universal coverage (Garha, 2016). Nepal ranks 11th position out of 15 countries in the Asia Pacific and 50th place among 60 countries in Global Rank for Access to Healthcare in General (Access to Healthcare in the Asia Pacific, p. 4, 2017).

Despite the advancement in some areas of the health sector, Nepal lacks a universal health insurance system due to which many citizens are obliged to spend out of the pocket expense. Although general government revenue and international aid organisations contribute to Nepal’s health care financing, three-quarters of funding is

derived from out-of-pocket payments (OOP)" (London School of Tropical Medicine, 2015). OPP results in patients bearing the overall cost of the health services, which the insurance companies would have provided it. The argument presented by Dr Bishal Gyawali on "Health Insurance System: An Urgent Need" argues that the personal expenditure on health care services and facilities exceeds government; private and non-governmental organisations spend on health care system (Gyawali, 2015). The accessibility of insurance program all over Nepal is itself a challenge for Nepal in the universal health coverage and improving the health of its citizens in general. The OOP leads transgender women who come from lower socioeconomic status more vulnerable as they are not able to easily access the sexual health services. Hence, this study aims to identify and understand the factors that affect the transgender women's access to sexual health services in the Kathmandu city, Nepal.

2.5 Legal Recognition of Sexual and Gender Minority and Existing Gaps in Nepal

A new health guideline for transgender individuals declared on May 25, 2019, by the World Health Organization (WHO) where 'gender identity disorder' is no longer considered a mental disorder (Anon, 2019). While this initiation will counter-argue to the governments and states that discriminate people based on their gender identity and where many individuals require medical certification, medical diagnosis, and a medical procedure in order to legally identify them before the law (Anon, 2019). This significant change brings a new light to the transgender community paving a pathway in recognising their human rights.

Initially, a two-set of guidelines are used by Health care providers in various places to diagnose patients, which include "International Classification of Disease (ICD), published by the WHO, the revised 11th version known as ICD-11 reframes gender identity disorders as gender incongruence and moves it from the list of mental disorders to a chapter on sexual health. Secondly, the Diagnostic and Statistical Manual (DSM), published by the American Psychiatric Association (APA) wherein 2012, the document removes the term gender identity disorder and instead added gender dysphoria with specific definition that it refers to emotional distress over

a marked incongruence between one's experienced/expressed gender and assigned gender" (Anon, 2019)". Medical evidence for recognition is not required for such an edition of guidelines as it protects the rights of transgender individuals. Nepal is one the country which has legally recognised transgender individuals and does not require a medical diagnosis.

The 2007 Supreme Court ruling repealed the discriminatory laws against the sexual and gender minority group, including transgender people in Nepal. The ruling was influenced mainly by the Yogyakarta Principles adopted in 2007, the first document to put forward principles for on sexual orientation, gender identity, and human rights (Ghoshal and Knight, 2016). "In 2013, the Ministry of Home Affairs directed that citizenship documents be issued in three genders – male, female, and other – without requiring any medical or other expert certification" (UNDP, Williams Institute, 2014). Following, in 2015, the government also issued passports for the third gender category. The amendment in the constitution included the establishment of the third gender category, counter pushing the stereotypical "male" and "female" category. "Thus, in 2015, Nepal became only the 10th country in the world to enshrine specific protections for LGBT people in its constitution" (Knight, 2015).

Albeit the recognisable legal provisions and protections enshrined in the Constitution of Nepal, examples of weak implementation have been observed for the third gender in Nepal. The Nepalese government has enforced the assignment of third gender citizenship, yet not all have been able to obtain legal gender recognition. In the report of "Surveying Nepal's Sexual and Gender Minorities", out of the people who attempted to change their gender marker in their citizenship cards, only five people were successful in changing their legal documents among whom four individuals were male assigned at birth (UNDP, Williams Institute, 2014). Chhetri (2017) mentions that although the third gender category is visible in human rights documents, in reality, the implementations of these rights have been denied. The third gender category was in deprived of citizenship certificates, Machine-Readable Passports, and inheritance of parental property. "Moreover, they were not even counted separately in the recent national census of 2011" (Chhetri, 2017).

In the absence of identification certificates, transgender individuals are not recognised before the law and are unable to exercise and enjoy their basic rights fully.

Individuals are “blocked from government jobs and pensions, driver’s licenses and passports, as well as government-run programs like secondary school exams and health services” (Blue Diamond Society, Heartland Alliance for Human Needs & Human Rights, 2013). Lack of identity documents can increase the risk of exploitation as where transgender women might subject to unnecessary questionings and invasive comments (Ghoshal and Knight, 2016). Such situations might lead to more humiliation towards among transgender women as their gender identity is different from their assigned sex at birth. Also, the ESCR has stated that the absence of legal gender recognition “is a barrier to transgender persons having effective access to work, education and health services” (UNDP and APTN, 2017). Hence, the identity documents, which is the keystone to accessing state services, including healthcare services, are mostly absent among the third gender individuals, including the transgender women residing in Nepal.

Many gender and sexual minorities experience human rights violations in health settings, including educational and work settings as well. Human rights violations are associated with health outcomes, including mental health and physical health outcomes, including sexual health. In the health domain, various human rights violations have been observed in Nepal. Singh et al., (2012) in the qualitative investigations, mentions that the priority aspects for the gender and sexual minorities in Nepal include lack of legal protections and improvement in the healthcare system.

Among the gender and sexual minority, transgender people are viewed as a gender minority and often considered to be of lower status. Among the hierarchy within the LGBTI community, transgender people are placed at the lower bottom alongside the intersex community, with gay men assuming the most power (Sood, 2009). Some human rights violations among the LGBTI community in the health care settings also includes “name-calling, laughing, negative attitudes, lack of respect by the health care workers, denial of admission, and most importantly double discrimination of PLWHA” (Singh et al., 2012). The lower socioeconomic status, along with the HIV+ status of transgender people, including transgender women intensifies the hierarchy and lack of support within the LGBTI community and beyond.

This chapter gathers various researches on the transgender women's lives and their sexual health needs, risks, and issues, which affect their overall right to the highest attainable standard of health. In other words, transgender women's health issues are similar to the general population, yet they have unique health needs such as transgender-specific health care for HIV, anal STIs, STDs, and mostly gender affirmation health care for their proper transition. While many of the sexual health services can be easily accessible to the general citizens, however, for transgender women, they experience health disparities in accessing the sexual health services, which is why the research is undertaken. Thus, this research explores to identify the underlying factors affecting the accessibility using the principles of accessibility. Therefore, the study examines the health disparities among transgender women who face different factors in accessing sexual health care services in Kathmandu, Nepal.

In the following chapter, a Human Rights-Based Approach (HRBA) is examined in the study to provide a foundation for discussing the findings and analysis of the study. Further, the chapter discusses various international human rights, which enshrines the right to sexual health. The section looks beyond the national level human rights law, giving more importance on the Yogyakarta Principles, Universal Declaration of Human Rights, and International Convention on Economic, Social, and Cultural Rights. Overall, HRBA to health guarantees that standards and principles are integrated into human rights mechanism, ensuring the accessibility of health services. Thus, in general, HRBA promotes and protects the human rights of transgender women.

CHAPTER III
TAKING A HUMAN RIGHTS-BASED APPROACH TO RIGHT TO HEALTH

3.1 Sexual Health Rights of Transgender Women enshrined in the International Human Rights Law

Human rights and instruments have pertained on the right to highest attainable standards of health, including the right to sexual health. HRBA to health aims states to build capacities to respect, fulfil, and protect the rights at all levels, including the local, regional/federal and national. The essential categories of state actors include “policymakers, hospital managers, health professionals, inspectors and parliamentarians, among others” (WHO, OHCHR, n.d). State actors have three levels of obligations: respect, fulfil and protect.

According to the UNFPA (2014), to respect a right means “to refrain from interfering with the enjoyment of the right”, to protect a right means “to prevent other parties from interfering with the enjoyment of the right”, and to fulfil a right means “to take active steps to put in place, laws, policies, institutions and procedures, including the allocation of resources, to enable people to enjoy their rights”. Thus, HRBA focuses on duty-bearers and rights holders where duty-bearers, the state, meet their core obligations while rights holders, transgender women, make their claims.

There have been many human rights documents, which promote the full enjoyment of rights on sexual and gender minority. These human rights laws are rules and act as a framework in the protection of transgender women if appropriately implemented. Right to health is also inseparable from provisions to right to life. “The right to health does not guarantee the right to be healthy” (McLemore, 2018). However, the right to health guarantees the state citizens to have affordable, available, and accessible health services without discrimination based on sexual orientation and gender identity.

This section discusses various international human rights laws and mechanisms where the human rights-based approach has been taken to address the health rights of the transgender population, including transgender women in general. One of the critical components of accessibility of health services, including sexual health services of transgender women is also ensuring the gender-affirming, and transition-related care, which is enshrined in the YP and YP+10 Principles discussed below. The first section will discuss the Yogyakarta Principle (YP), the first set of principles addressing the rights of individuals with diverse sexual orientation, gender identity, gender expression, and sex characteristics. The second section will provide emphasis on the UDHR and ICESCR, including the General Comment, where the health rights of gender minority have been discussed accordingly. Finally, the last section will discuss the role of Nepal as a state in implementing these rights for its gender minority population.

Firstly, YP and additional document YP+10 is the first significant document which addresses the rights on sexual orientation, gender identity, gender expression, and sex characteristics including various principles on sexual health as a core right. Even though YP is not a legally binding document, however, primarily states still have an obligation to protect the rights of sexual and gender minority.

YP adopted in 2007, Principle 17 and 18 clearly defines states obligation where “everyone has the right to attain highest standards of physical and mental health, without discrimination based on sexual orientation or gender identity” (Yogyakarta Principle, 2007). Principle 17, which is on the right to highest attainable standards of health, offers nine sub-principles (A-H), and Principle 18, focuses on the protection from medical abuses with six sub-principles (A-F). These principles address how states have the responsibility to respect, protect, and fulfil the health rights of sexual and gender minority. Following are some of the sub-principles of Principle 17 and 18, which emphasise the sexual health rights based on sexual orientation and gender identity.

Principle 17: Sub-Principle B

"States shall take all necessary legislative, administrative and other measures to ensure that all persons have access to healthcare facilities, goods and services in relation to sexual and reproductive health, and to their own medical records, without discrimination on the basis of sexual orientation and gender identity".

Principle 17: Sub-Principle D

"States shall develop and implement programmes to address discrimination, prejudice and other social factors which undermine the health persons because of their sexual orientation and gender identity".

Principle 17: Sub-Principle G

"States shall facilitate bodily modifications related to gender reassignment to competent, non-discriminatory treatment, care, and support".

Principle 17: Sub-Principle H

"States shall ensure that all health care providers treat clients and their partners without discrimination on the basis of sexual orientation and gender identity, including with regard to recognition of next kin".

Principle 18: Sub-Principle A

"States shall take all necessary legislative, administrative and other measures to ensure full protection against harmful practices based on sexual orientation or gender identity, including on the basis of stereotypes, whether derived from culture or otherwise, regarding conduct, physical appearance or perceived gender norms."

Principle 18: Sub-Principle E

"States shall review and amend any health funding provisions or programmes, including those of a development-assistance nature, which may promote, facilitate or in any other way, render possible such abuses."

Principle 18: Sub Principle F

"States shall ensure that any medical or psychological treatment or counselling does not, explicitly or implicitly, treat sexual orientation and gender identity as medical conditions to be treated, cured or suppressed."

This central focus on both principles is the fundamental right to reproductive and sexual health (Yogyakarta Principle, 2007). Both Principle 17 and 18 have the right to equality and non-discrimination as a cross-cutting principle and ensures that the state should not discriminate its citizens based on their sexual orientation and gender identity. Failure to protect these rights enshrined in the sub-articles is a complete breach of State's obligation as a duty-bearer to its citizens.

Following the YP, in 2017, YP+10 was adopted and elaborates the international human rights law as it applies "on the grounds of sexual orientation, gender identity, gender expression, or/and sex characteristics" (YP+10, 2017). The YP+10 also addresses additional recommendations to the Principle 17 of YP on the highest attainable standards of health putting emphasis on the gender-affirming health services, health insurances, HIV/AIDS services, and other sexual and reproductive health rights on the grounds of sexual orientation, gender identity, gender expression, and sex characteristics in the health settings (YP+10, 2017). Along with that, Principle 31 on the right to legal recognition mentions sub-principle where states shall "ensure access to a quick, transparent and accessible mechanism to change names, including to gender-neutral names, based on the self-determination of the person" (YP+10, 2017). This sub-principle foregrounds that not only that a person can identify their gender marker on legal documents but should also be able to change their names according to their self-identification and self-determination.

Another human rights instrument, which provides a framework for sexual and health rights is the universally accepted UDHR. UDHR opens up with Article 1, which states that "All human beings are born free and equal in dignity and rights" (UDHR). This article also opens up the idea that there should be no grounds of discrimination based on caste, creed, race, sexual orientation, gender orientation and other sources. Treaties such as ICESCR have enshrined sexual and reproductive health rights in Article 12 along with an additional General Comment 14 on the highest

attainable standards of health and General Comment 22 explicitly focusing on the sexual and reproductive health rights.

Article 12 of ESCR mentions that state parties to the Covenant recognise the right of everyone to the enjoyment of the highest attainable standards of physical and mental health and also provides steps on how to achieve the full realisation of these rights (OHCHR, 1966). The General Comment 22 (2016) on the right to sexual and reproductive health also mention that LGBTI people have restrictions on "numerous legal, procedural, practical, and social barriers, access to the full range of sexual and reproductive health facilities, services, goods, and information" (OHCHR, 2016). Article 15 of the GC (2016) also mentions the principles of accessibility elaborating to three major principles, including physical accessibility, affordability, and information accessibility. The principles of accessibility also act as the conceptual framework for the thesis and analysis of the principle of accessibility will be further discussed based on sexual health rights among transgender women living in Kathmandu, Nepal.

Nepal is major parties to 7 major covenants, including ESCR in 1991 (OHCHR). Also, Nepal is a signatory to YP and YP+10, which is the first inclusive principle for SOGIE rights. Sunil Babu Pant, the President of Blue Diamond Society and the openly gay Constituent Member of the Parliament (MP) in 2007, was the founding core members in drafting the YP and YP+10 during its adoption (YP, 2007 YP+10, 2017). With this, as the MP, Sunil Babu Pant and many non-governmental organisations and community-based organisations played a vital role in pushing through the Supreme Court verdict to guarantee the constitutional rights for sexual and gender minority in Nepal. The eye-opening verdict was thus able to bring new laws and provisions in place, and thus, Nepal was quoted as "the global LGBT rights beacon" becoming 10th the world for protecting the LGBTI people in its constitution (Knight, 2017).

This chapter addresses a human rights-based approach to sexual health, which pertains to the right to the highest attainable standard of health preserved in the international human rights mechanisms. These laws ensure the protection and promotion of human rights based on sexual orientation, gender identity, gender expression, and sex characteristics. The human rights-based approach to health also

encourages state as the duty-bearer to respect, promote, and fulfil the rights of the rights holders, which in the current study are transgender women. Thus, this approach to health enhances the accessibility of health services, including sexual health services among transgender women.

The following chapter explores the findings on various perspectives, narratives and stories of the study participants. Various factors that affect the accessibility of transgender women are discussed. The perspectives of both health-care service users and service providers are documented to provide a holistic perspective on health disparities experienced by the transgender women living in Kathmandu, Nepal.

CHAPTER IV
FINDINGS

This chapter highlights the demographic findings and thematic findings of the data gathered during the fieldwork process. The primary purpose of this chapter is to provide the results gathered from the participants, which act as the empirical data for this study. The findings are divided into two parts: Demographic findings and thematic findings.

4.1 Demographic Findings

Only the demographic information of transgender women was taken for the study. Participants from this target population identified themselves as Nepali. Among the six participants, all of them came from ethnic minorities (Janajati community), which include Newar, Gurung, Thakali, and the Lama community. Majority of the participants were aged in between 20-40 years and had some educational background, the highest being able to join the Bachelor's degree. Two participants dropped out of their SLC (School Leaving Certificate), which is the national examination for high school students in Nepal. All the participants had either worked in the BDS or its branches or were staffs, volunteers or close affiliates. Only two participants mentioned Kathmandu city as their original hometown, whereas the rest had migrated to the capital from nearby districts due to their personal, family, and financial reasons.

4.2 Thematic Findings

The thematic findings are categorised based on the factors and effects caused by the social, cultural, and personal factors on transgender women's access to sexual health services in Kathmandu.

4.2.1 Social, Cultural and Personal Factors Affecting Transgender Women's Access to Sexual Health Services in Kathmandu

Coming Out of the Closet: Stories of Transgender Women in Kathmandu

Participants shared their stories of coming out and recalled their journey as a child. For most of the LGBTIQ community, coming out of the closet is a phrase where one reveals their true self or gender identity or sexual orientation publicly. Most participants shared that it was during their teenage and school years when they first realised their identity to be different from others.

> *Coming out is not a black and white process; it is not like getting out of the house. It is a process where at various steps of life, the idea of revealing your identity keeps occurring. So for me, I first came out with my friends in grade 9. At that time, my friends did notice my behaviours (Transgender Woman Interview Participant 1, age 20).*

Friends, close relatives were few people most came out to first. Also, BDS for many was a home, a place where they could feel safe and live without any judgment. Many participants, after knowing their gender identity came to BDS to understand more about themselves and get to know the community. Many felt alone when they first realised who they were but eventually at BDS; they felt that they were not the only one. While for some, it was an initial realisation process whereas, it took quite a while to understand their preference, attraction, and eventually their identity for the rest. One participant came out of the closet at the age of 24 much later than most participants.

> *When I was 24 years old, I was confused and wanted to know what is it and who I am as a person? I questioned myself [who am I, and what do I identify myself?] I knew I was different; I was not attracted to female but was attracted to male. If I looked from the external/physical features, I was a male. I had many questions in my head. Then I met a brother who worked in*

> *BDS then got to know that I am not the only one. Many were like me. Their representation made it much was easier for me to identify myself. Whoever I am, and whatever I am, I have the right to live. I am not a male, neither a female, but I am different, so I have my right to live freely and with no discrimination. Now, I am happy as a transgender woman (Transgender Woman Interview Participant 4, age 40).*

Overall the most common answer that participants shared was that coming out of the closet was not an easy process. However, they felt liberated after publicly identifying themselves openly, despite the rejection from family, friends, and society.

Social Stigma and Exclusion

The traditional Nepalese society still lags in fully accepting transgender people. Gender binary and heteronormativity as concepts are ingrained in the attitudes of the Nepalese community. Hence, it is difficult if anyone deviates outside of these boxes. Negative attitude and behaviours towards transgender people increase when society excludes them from the general population. Some participants shared their day to day harassment and the attitude of people whom they encountered in public places.

> *When I walk on the road, people call me "chakka, hichada, napungsak" (derogatory terms for the third gender in Nepal). I look like a woman and wear feminine clothes, wear kurtha (casual clothing designed for women in Nepal), wear makeup, but people do not treat me as a woman. They think that a boy became a girl. So, because of this, I get discrimination based on my gender identity (Transgender Woman Interview Participant 3, age 31).*

Another participant expressed that being assigned particular sex at birth and identifying different gender than biological sex is considered to be a curse in the Nepalese society.

> *In Nepal's context, they still consider the community as "Sarap-Curse", at some point perspective changed, but there is still more to go (Transgender Woman Interview Participant, age 25).*

The discrimination and social stigma come from not just the society, but within the family and close relatives as well. Participants expressed that their close relatives and family members rejected them because of how they identified themselves.

> *At first, they (extended-family members) told me; I should be given electric shock in the hospital, should be locked up in the room, and not be given food for 1 month. They said a lot of miserable things to me. They still have those creepy expressions and the way they look at me, and I think it is still there. I do not understand what is going on their mind, and I do not think it is right for them to do those actions to me (Transgender Woman Interview Participant 1, age 20).*

Another participant shared that she even had to migrate from her original hometown because her own family did not accept her gender identity. Family rejection is one of the common consequences that transgender people face. When their own family rejects their gender identity, then they have no choice to shift or travel to places in search of help and assistance.

> *I have my mom, dad, and 3 three siblings. After disclosing as a trans, I got a rejection from my family members. It was difficult for me to live in that society that's why had to shift and come to Kathmandu (Transgender Woman Interview Participant 2, age 33).*

Another participant, who is a Clinical Psychologist herself and has had around eight transgender women in her clinic, shared that transgender women face many struggles while coming out. Even after that process, they do not have enough support to face the challenges in their lives. Hence, this leads many to face stress,

anxiety, and mental health-related problems, which is the reason why many seek help from her.

> *For many transgender women, the coming out process is difficult for them. They have their own lives and have their wishes. They tell me that they are more comfortable being a woman. For this transition, they need support and cannot take the decision alone. They have explained this either to their family/ friend. They do come out, but family members have locked them up in their houses and have beaten them as well. They are not able to talk about their identity openly and have to bear violence from their family members instead (Health Care Provider Interview Participant 3, Clinical Psychologist).*

Social neglect and family rejection are some of the problems that transgender women face including in Nepal, however, no matter how conservative and closed off some members of the were, some participants shared that their support from their family and friends played a vital role during their transition phase.

> *All the time, my family never questioned me because, from childhood, I did household chores, washed clothes, wearing makeup, and that is what my family members saw. Even my relatives are supportive of my gender identity, so I feel lucky (Transgender woman Interview Participant 3, age 31).*

Another participant shared that family acceptance and support was helpful for her. Due to the support of her family, she also wants to change her gender marker in the legal documents.

> *In the legal documents, my gender marker is Male, and I have not processed to change it yet. I made my citizenship certificate as Male in the beginning so, in order to process it for the 2nd one, it is much more difficult. However, my mom and dad supported me by telling me that they will help me to make*

one to whatever gender I want to have in the citizenship card (Transgender woman Interview Participant 5, age 22).

Bureaucracy in the Legal Gender Marker Process

The role of a legal gender marker is beyond just papers, as this is an identification marker where people recognise an individual's name and the assigned gender. Even though, Nepal has recognised the rights to identify the gender according to the "self-feeling", translations of these laws do not comply, accordingly. Participants share their difficulties in acquiring their gender marker in the citizenship certificates and passport accordingly. The lengthy and complicated bureaucratic processes make some to delay acquiring their citizenship certificate or not acquiring at all.

Before, I had "M" in my citizenship certificate. In my first citizenship picture, I had a "Dhaka topi"- Nepali cap designed for men. When I went to the (Central District Office) CDO office to get my citizenship, I told them "I want third gender citizenship and to have O as my gender marker". The officers responded that there are no such policies, so I had to get it as a male. At that time, I took off my makeup and earrings, and that is how I had that citizenship card. Due to my first citizenship card, I got into a lot of troubles and problems later because the citizenship photo showed that I was a male, but in reality, I was a woman. However, in 2015, due to the constitutional provision, I changed my citizenship gender identity (Sex) to "Others, but still, the name is my previous name. There is no provision in changing the name after you have received your first citizenship card (Transgender Woman Interview Participant 3, age 31).

Transgender women face barriers to accessing public services during the legal gender assignation process and after acquiring the "Other" category. Another participant shared even though her gender marker in the citizenship and passport is "O", she still faced hurdles while getting registered in one of the top government university in Nepal.

> *The case with Tribhuvan University (TU) was that they did not give me the admission because I had two names. Even in +2 (college years grade 11 and 12), I did the same process while getting admitted. Even though I had to show SLC certificates which show my previous names and gender as M, I still got into with two names as I had the permission letter from the ward saying that this person is (her real name), however, the same process did not work out at TU. They said, "The ward certificate does not work here". Changing SLC certificates are too hectic as one of my friend told me that "it is like crying tears from your eyes" with never-ending bureaucratic processes where they tell you to go to "this number room then this number room". I have been advocating with the Ministry of Education about it, but still, it is challenging. Hence, these bureaucracies in the process create many barriers among the transgender population in Nepal (Transgender Woman Interview Participant 1, age 20).*

She added that there is a problem with dissemination of information throughout the governmental bodies. She believes that even if in one sector, her citizenship certificate and permission letter work; however, in other sectors, it does not. This bureaucracy in governmental offices is the biggest problem in Nepal. She pointed out in frustration:

> *So, it works in +2 but does not work in TU; it's the same country, same government (Transgender Woman Interview 1, age 20).*

For some participants, they do not want to have "others" as their gender marker as they believe this creates many controversies when they travel outside of Nepal or countries where there is no provision for the transgender community. Hence, they prefer if the government would be more lenient in allowing the transgender community to identify transgender women as "Female".

> *I have "Others" in my citizenship certificate. "O" means we are neither man nor woman, so it is different. If they had given us the identity as a*

> *"Female" that would be good as it becomes a problem when we travel to international countries, they might ask me, who is others and I have to give justifications. I am in the feminine clothing which they might think I am a "Female". The Nepal Government has not even given women to live freely then who are we to demand such rights? (Transgender Woman Interview Participant 4, age 40).*

Another participant shared the same concern and told that she does not prefer to opt for the "Others" category as this is not she wants to identify.

> *I want to change to my gender marker to Female. I have not opted for others as I am not yet comfortable to identify myself as "others" in my legal documents. Hence, I have not processed it yet (Transgender Woman Interview Participant, age 25).*

Greater Visibility: Greater Vulnerability

Participants shared that they were personally harassed or verbally abused due to how they expressed their gender through clothing, makeup, and behaviour, leading them to be vulnerable to such visible attacks.

> *Once I came out to my family, I could live the way I want. I started transitioning and started putting up the clothes I want. It became much more comfortable; however, I got more visible attacks as well. These attacks happened before, but after the transition, it increased at a high rate due to my visibility as a transgender woman. I received comments like "what kind of a boy is walking like a girl" (Transgender Women Interview Participant 1, age 20).*

Participants believe that the increase in visibility as a transgender woman has led to more visible attack hindering their safety and security. Behaviours and comments of people is also a result of how society views at transgender women.

> *Even after transition, life was not easy. When I was a boy and got dressed up, people did not look at me in a certain way, but when I started wearing transgender woman get up; people looked at me in a certain way. I used to silently avoid those stares (Transgender Women Interview Participant 2, age 33).*

Another participant shared that "people will keep on telling, and I will keep on moving" meaning that these comments no longer matter to her. She also feels that the society has been the same way since the beginning.

> *When I changed from male to female, it was difficult. They called me "chakka hichada napusank"- derogatory terms for third gender people in Nepal. I still get comments from people when I walk on the road. The abuse of words will go on, as this has been there since a long time in the society but what you should know is despite all these obstacles, you should know how to go on with life and not get disturbed by it (Transgender Women Interview Participant 4, age 40).*

Lack of Sexual Health Literacy and Comprehensive Sexuality Education (CSE)

Participants share how topics of sexual health were taught in their school. Sex is considered a taboo, and often time topics related to sexual health were neglected by teachers. Even though students would want to learn about it, they would either talk to their friends, peers or get information from the internet, newspapers and other forms of media.

> *I did not know what sexual health was before as the school never taught and never discussed it, there was in the book, now if I think of it, it is very creepy. For, e.g., do not have sex before marriage. Use condoms, what are condoms and how to use it is not mentioned in those books, so I had no idea. I got to know about sexual health through the internet and not even BDS (Transgender Women Participant Interview 1, age 20).*

There were confusing times for the participants as a child regarding their gender identity. Lack of understanding and difference between sex, gender, and sexuality made them seek help from other sources such as media leaflets, newspapers, and also internet technology.

> *When I got that kind of feelings [attraction towards men], I did not know about transgender women. I thought I was gay because I knew the definition of only gay (being a man getting attracted to man) and lesbian (being a woman and getting attracted to a woman). However, when I learned the true definition of gay, I did not fit into that category. Then I started searching on the internet, even when I did not know the word "transgender". However, one day, when I read the weekly newspaper "Saptahik", they covered the topic on transgender and the definition matched with who I was" (Transgender Woman Interview Participant 2, age 33).*

Participants mentioned that since the educational curriculum did not contain much information on sexual health, hence, many got to know about sexual health from BDS.

> *I got to know about sexual health from BDS. I used to work for HIV prevention before. We worked for basic awareness and training program where we took classes once a week. Various topics, such as HIV AIDS, STDs, and safe sex, were covered. Before coming to BDS, I did not know anything regarding sexual health and services (Transgender woman Interview Participant 3, age 31).*

BDS was a place for many participants where they gathered sexual health information, got to know about their gender identity, and meet with people who were like them. However, for some, this was not the case. A participant shared that even at BDS, the information sharing was inappropriate, which affected how she initially thought about sex and sexuality.

> *Talking about sex, they talk it in a very inappropriate way. I went there as a child when I was 15 years old, and they had no sensitivity on how to talk with minors regarding sex. They used indirect kind of words such as social slangs and did not use formal terms. There is an incident I want to share. On the 1st day when I went to BDS, a person came and started talking about having fun, for them it was like education on having how to have safe sex, but that was not the way, I did not even have sex partner when I was 15. They assumed that at the age of 15, teens are sexually active, and they should educate them about it. They were showing it through their hand gestures and using slang terms and were saying some people like it this way and others like it the other way and then "your man will get pleasure" and all of it. Also, the more I worked on sexuality and got involved in feminist circles, I knew the appropriate way of talking about sexuality and being sex-positive. Topics about sex are talked but talked only among boys and in a very inappropriate way. Moreover, this happened to me in BDS. That is the way how I got exposure to sexual health as a child (Transgender woman Interview Participant 1, age 20).*

Participants also shared how CSE could make an impact in not just improving the conscience of people regarding sexual health but also minimising many health-related issues such as sexually transmitted infections and diseases.

> *In order to have the provision of required sexual health services in the country, it starts from our educational curriculum. Our curriculum should have comprehensive sexuality education as it addresses the issues of young people such as unwanted pregnancy, HIV AIDS prevalence, STI, depression, relationship, love, gender, sexuality and many more. Also, CSE should be taught not as an optional subject but as a regular and compulsory one. Students at an early age or teenage level have the eagerness to explore their sexuality, and we could minimise many health-related issues through CSE (Transgender Women Participant Interview 2, age 33).*

Participants also shared that even within the LGBT community; many do not have much knowledge on the use of condoms, thus highly increasing their vulnerability to many health-related issues.

> *Many people think that condom is to avoid pregnancy and just for male and female. They think we do not need it as the population is hidden. Even in the mainstream media does not portray the use of condoms for the LGBTI community. People should know that the third gender also can use condoms, and the mentality should change (NGO Health Care Provider Participant Interview 1).*

Therefore, the above findings examine various social, cultural, and personal factors that affect transgender women's accessibility to health services in Kathmandu, Nepal. Many transgender women struggle with various factors in accessing proper sexual health services. Some factors, which were proved from the study findings are difficulty in coming out as a transgender women, getting rejected by family members, peers, along with social exclusion, lengthy bureaucratic process for the legal gender marker process, increasing visibility of transgender women leading to visible attacks which are some the social, cultural, and personal factors, which transgender women living in Kathmandu face.

4.2.2 The Effects of the Social, Cultural, and Personal Factors on Transgender Women's Access to Sexual Health Services

Preference of BDS Services over Public Health Services

Almost all participants got their sexual health services from the Cruise Aids Nepal, which is the only health organisation for the LGBTI community in Kathmandu, a branch of BDS itself. Primarily focused on HIV prevention, Cruise Aids Nepal provides other services such as counselling services, referral of HIV patients to other ART centres/hospitals in Kathmandu, and finally Community Lead Testing (CLT). Participants shared that many got services from the health organisation as they felt comfortable to ask for services. They believe, the organisation has people of their

own community “LGBTI community”, which is a safer and secure place in terms of acquiring their needed services.

> *I am not comfortable to get services outside. People think we (transgender people) are different and are from a different world; however, here at BDS; it is much more comfortable. At Cruise Aids, we have we only have HIV screening, and we can come for follow up as well. People here know us, and it is much easier to get services as well (Transgender Women Interview Participant 5, age 22).*

Despite the comfort, at Cruise Aids, services are free of cost as well. Hence, the LGBTI community, especially the study participants had greater accessibility of services at this health organisation. Participants shared that it saved a few pennies to buy condoms and lubricants, which they got for free at Cruise Aids Nepal.

> *In BDS, I know most people, so it is better if I take condoms and lubricants from there than places where I do not know the service providers. I think in other places they might take money (e.g. Bir Hospital) for condoms and lubricants, but in BDS they do not, and it is free (Transgender woman interview participant 1, age 20).*

New Initiative of HIV Prevention Program through Community-Led HIV Testing (CLT)

Community Lead HIV-Testing (CLT) is the initiative where Community led the HIV- Testing for their community. Cruise Aids being the organisation working for HIV prevention through the funding of the Global Fund- Save the Children. The organisation works in providing health services, including sexual health services to TGW, TSW, MSM, and MSW.

> *Most TGW involved in nightlife, so it is challenging to meet them, they spend the whole night, difficult to meet in the day time as they will be sleeping and*

would not want to come out of their room, problem to get in touch with them. They do willingly come here. CLT: they go to their room and check, and there are these services (Key Informant Participant Interview 1).

The CLT is not only limited to HIV testing but other sexual health services as well. Participants share their work and more about CLT in detail.

In CLT, we go to their workplace or even their room to do an HIV screening test where we have reactive and non-reactive cases. We cannot directly confirm whether the patient is HIV positive or negative. This process of confirmation is in done in Teku or Bir hospitals- Public Hospitals in Nepal. After that, if the case is positive, then they start ART. With that, we also provide free condom and lubricant distribution to the community (Health Care Provider Interview Participant 1).

Despite the ongoing HIV prevention from Cruise AIDS, participants also share their challenges while working as the lay providers or outreach providers.

Sometimes the sex kits, condom, and lubricants do not come promptly. The delay in such services is also the problem of funding. Before the organisation got funding from UNDP, but now it is from Save the Children (Health Care Provider Interview Participant 2).

Initiatives to CLT in battling the HIV prevalence in Nepal have made a considerable impact. However, there are challenges to CLT and other sexual health services in Nepal, which has resulted in limited services. Cruise Aids has been helping a lot of transgender people, including the LGBTI community in getting health services. However, the services are limited as the organisation runs on donor funding. Funding also depends on when a project is formulated and for how long. Participants share that funding has been a challenge since its inception as well.

> *Funding has been one of our biggest challenges as an organisation. Before, we had both a doctor and a lab here in this building. Right now, our donor organisation is the Global Fund-Save the Children, and the program is limited to strictly HIV testing. We are working with them for almost four years. So, currently, there are no STI cases here. We either have to give a referral to Teku or Bir hospital or SACTS VCT. Since we work on donor funding, this has impacted a lot in the health services that we provide to our community (Key Informant Participant Interview 1).*

Some participants shared that not only the funding was a huge challenge for the organisation, but it was a burden on their economic life as well. Recruitment of health care workers depends on donor funding and with their associated projects. Thus, funding also affects health care providers' employment status.

> *Since we work in the community, if there is no funding, then we lose our work as well. We cannot go and get another job because society discriminates us based on our gender and sexuality in the workplace (NGO Health Care Provider Interview Participant 1).*

Also, the closure of the project could affect the overall HIV scenario. There might be an increase in the HIV prevalence rate in Nepal.

> *Since our community is hidden, not many use condom, so that becomes a problem. We get nothing from government, neither condoms nor lubricants. In my opinion, once the funding stops in 2022, HIV in Nepal might go high. That is a massive challenge for all of us (NGO Health Care Provider Interview Participant 1).*

Health Care Discrimination and Lack of Knowledge by Health Care Providers on Transgender Issues.

As Cruise Aids Nepal provides many individuals with free HIV related health services, there were times when participants visited the general health service

outside of the NGO services. Participants shared that they got discriminated when they visited the public services where they got an outright denial of service by the doctor.

> *The experience took place in 2013 when my friend had some problems with her health. She could not sleep all night, and her legs hurt a lot. So we went to the Teaching Hospital to check-up in the joint section. The doctor did not even look at us and directly sent us to the counselling centre from room 3 to room 6. When we went to the centre, they told us about "sex change, Santas Panta's son case (Nepali actor's child who is now a transwoman) and many things. At that moment, we felt that oh they care for us and they think good for us. However, later, we understood that they discriminated us and sent us to the counselling centre. We did not go there for counselling; we went there for a proper health check-up (Transgender Woman Interview Participant 2, age 33).*

Participants shared that when they visited the clinic or hospital, health care providers did not know transgender health issues and this lead to involuntary outing and exposure of their gender identity.

> *Actually, most people do not know me. I went for a full-body check-up a few days back. I had gastritis, and I got a video x-ray. The doctor pushed the machine on my belly and went down near my stomach and asked me if I get period regularly. In my head, I thought "I am not a female, and I do not have a uterus, how will I have my period?" There were many people around, so I told him "Yes". He asked me, again and again, saying not to lie to me. I said "Yes" again. Later, when everyone went, I told the doctor that "I am a transgender woman". The doctor's reply was "Oh Really? You do not look like one. You look like a woman". There was not any discrimination from the doctor, but many people do not know about us and do not understand our issues (Transgender Women Interview Participant 4, age 40).*

Another participant shared that the health care settings lacked trans-friendly services, and the health care providers were not culturally competent towards transgender women. Participants described that they received additional questions, which were unrelated to their health care visit.

> *If you go to a general clinic, first, I have to go and teach them what a transgender person is, and they ask so inappropriately like "why did you become like this?" There was one particular experience I faced. I went to a homoeopathic, and they asked me "why did you choose to be like this?" "Do you marry or not?" I said, "I did not choose to be like this?" I had to explain about my gender identity to my doctors, which is, of course irritating. I do not have any such experiences where I got direct discrimination, but whenever I visit clinic/ hospital, they keep on asking questions, but that is not like for us to explain to doctors (Transgender Women Interview Participant 1, age 20).*

Also, another participant shared that since the STI and STD issues are unavailable at Cruise Aids. Hence, participants have to seek help from outside of BDS. While accessing health services for STIs, many transgender women face discrimination in medical settings.

> *Especially getting the services outside, the service taker does not feel comfortable, and the service provider is not aware of transgender women issues. There is no expertise on anal STI. Many face negative comment by the service provider for their sexual behaviours, and there has many been cases as such (Key Informant Interview Participant 2, President of Blue Diamond Society).*

One of the youngest participants shared that she had never faced such health-care discrimination as she had never had the chance to visit the health care clinics or hospitals. She never faced any big health problem. She also described that

even though she goes to a nearby hospital for the general clinic, but since the doctors know her well, she gets treated properly.

> *I have not joined hospital for a significant health problem, so I have no such experience regarding health care provider discrimination. I usually go to Grande hospital with my friends if I have to get a general health checkup. The doctors have known me for long, so they have not questioned me yet about my gender identity (Transgender Women Interview Participant 5, age 22).*

Avoidance and Self- Denial of Health Care Services

Participants also shared that they self- deny the services and only visit the doctor or health care provider at the final stage of their infection or disease. Many hesitate to visit the health care providers and build internal stigma inside them. They fear what if the health care providers will not treat them properly, leading to further complication in their sexual health and wellbeing.

> *It is difficult for transgender women as we many sex-related diseases. Transgender women communities do not want to be exposed, and there is no proper exposure environment as well. We have a female appearance, and when there are diseases related to the sexual organs, they do not want to visit the services because the outside gender is different from the sex assigned at birth. So there is always a question of "How will people treat me and take me?" There is much hesitation, as well. Hence, there have been cases where they self- deny to take the services. I know a person who had anal STI and problems and denied to treat it, and later it developed into anal cancer, and she died because of it. Many visit the clinic or hospital only at the last stages (Key Informant Interview Participant 2, President of Blue Diamond Society)*

Participant, Bijaya, Clinical Psychologist shared that at her clinic, they follow the bio-psycho-social model in order to provide counselling for those who do

not want to access services outside. Also, she shared how this model works and is an interconnection of not just physical, emotional health but the overall development of health in general.

> *Many transgender women avoid health services. During these instances, we tell them at what stage they should visit a specialist and get medical facility treatment. We follow the bio-psycho-social model where we look at the interconnection of the endocrine system, nervous system, thought the pattern of a person, emotional arousal, the social, economic, and environmental setting, and also discuss on various sexual diseases, HIV and aware them on safe sex practices as well. (Health Care Provider Interview Participant 3, Clinical Psychologist)*

Inadequate Trans-Specific Sexual Health Care in Nepal

Sexual health services for cisgender male and female are adequate in Nepal. However, for the transgender population, it is inadequate, often not available and accessible at all. Participants' shared that sexual health for the transgender population is limited, which leads them to rely on self-medication and services for the transition.

> *Transgender people, both women and men, are into hormone therapy. In Nepal, there is no place anywhere with a specific endocrinologist for transgender individuals. There are endocrinologists providing services to the general public but not specifically for TG. Hormone therapy is the starting point for TG because it is a beginning step for our transformation (Key Informant Interview Participant 1).*

Gender-affirming services such as specific endocrinologist for hormonal therapy and related counselling are inadequate along with sexual organs reassignment surgery or gender-affirming surgery. Participants share their frustration in the inaccessibility of such services, which lead many transgender women to travel abroad for gender-affirming services.

> *I need to have a place where I am open to talk about my penis, but most of the time, I feel awkward. Many transgender people are transitioning, where they have breast implantations. Even though breast implantation is not available in Nepal, many people go and do sex-change surgery in Bangkok. There are trans-specific needs. These needs are not as same as people born with a vagina. Trans-specific services need to know how to treat such cases. For the case of transitioning, my body does not work the same as another male body, and there is no understanding of these services in Nepal. There are many cases where the penis is formed to create a vagina. There is a chance that there is a growth of another part and if it is not sexually active or if something is not inserted, then it gets closed. So these specific needs are not there in Nepal. Because it is not there, transgender women have to go to Bangkok again and again, which is not possible. Trans people already come from an economically marginalised group (Transgender Women Interview Participant 1, age 20).*

The problem is not only getting the gender affirming services but also the extra cost of travel, visa, and many more

> *There is no sex-change surgery. There might be chest implantation surgery, but the rate is very high. So, people commonly go to Thailand or India. The air cost is highly expensive for us. These services should be readily available in Nepal rather than travelling outside (Transgender Women Interview Participant 4, age 40).*

Another participant shared that due to the inadequate trans-specific health services, many transgender women still fight to acquire their gender identity. Moreover, this results negatively as transgender women opt for medicine without prescriptions.

> *Firstly, there are no health services for transgender women. We are still fighting for our identity. When identity is not established properly, it is*

tough to fight for the health sector. Though, Nepal has worked a lot in South Asia in the constitution. However, if you see, there are many gaps. These laws are in the paper, but it is ineffective in implementation. Because of the lack of health services, people have been sick by taking many medicines without a prescription (Key Informant Interview Participant 1).

Reported Not Prescribed Self-Medication

Most of the gender-affirming services related to transgender women's transition are readily not available. Most transgender women felt the need to take self-medication or buy medicines without a prescription, which is highly dangerous for their overall health.

In 2007, people had contraceptives, and they still do. We import from Thailand, which is not a hormone, but it just has a high level of estrogen in the contraceptive, and we have those in cities. So, we do not have health counsellors. If we take that contraceptive, what are the pros and cons, no one knows about it? We do not know the effects on mental/physical health. I know because I have used it. It increases dizziness, hungry, makes fat, sleepy, lazy. There is no service where they would tell all of the effects of such contraceptives. There is no access to such health service. (Key Informant Interview Participant 1)

Another participant shared that these services were not only unavailable, but if taken, were financially and economically high at cost.

In Nepal, we do not get it. Proluton and Proteus, we get it from Bangkok (most of my friends bring it from Bangkok), and then we inject it through a nurse. We have to buy everything, and one Proluton costs 500-600 NRs per small bottle. We have to put it every 15 days. Right now, I do not use it due to the financial crisis, per month I have to spend 2000 NRs ($20), and there are others as well so stopped using it for almost six months (Transgender Women Interview Participant 2, age 33).

The above findings show that the factors mentioned in the previous section have several effects on the lives of transgender women living in Kathmandu, Nepal. These factors led many transgender women to have a higher preference to access NGO-led services such as Cruise Aids Nepal, which distribute free condoms, lubricants, and HIV screening to its community, including transgender women community. Also, there are inadequate trans-specific sexual health services in Nepal with a specific lack of knowledge on transgender health issues by the health care providers.

There is also discrimination in health care settings, which lead to transgender women to deny services. Individuals resort to the dangerous use of self-administered medicines without a prescription, such as contraceptives and hormone dosages for feminine physiological changes. These various factors contribute to inaccessibility of affordable and quality sexual health services contributing to the health disparity among transgender women in Kathmandu, Nepal. Therefore, understanding these social, cultural, and personal factors is crucial in improving the overall health of transgender women.

The next chapter focuses on the discussion of the above thematic findings, where the in-depth analysis will be studied. The underlying determinants of the human rights-based approach to health with the principles of accessibility will be further discussed in detail, examining the various factors established in the findings section.

CHAPTER V
ANALYSIS AND DISCUSSION

The analysis of the findings mentioned above is discussed in this section. This section is analysed based on the interconnected principles of accessibility, namely, Non-Discrimination and Quality, Physical Accessibility, Economic Accessibility and Availability, and Information Accessibility. The analysis will further discuss the environment as a factor affecting the sexual health services and the underlying intersectional issues such as class and age the transgender women's access to sexual health services.

5.1 Non-Discrimination and Quality

Principles of non-discrimination and quality encompass the findings discussed in chapter 5. Participants mentioned various factors that affected the principle of non-discrimination and the quality of health-care. Firstly, transgender women struggled a lot during their early age as they did not know about their gender identity. During their coming out stage, in particular, they experienced rejection and isolation from their family members and neglect from their peers. Participants also shared that they experienced stigma and exclusion from their society, and this was further magnified due to their visibility as a transgender woman.

Overall, these social, cultural, and personal factors had a significant impact on their accessibility to health services, as they often faced discrimination in health-care settings. Health care providers had a lack of knowledge and were not culturally competent to provide services to a diverse population, including transgender women. Absence of appropriate health competency delivered by health care providers resulted in the overall, denial and avoidance of services among transgender women.

The following section addresses the principle of non-discrimination and quality and how these several factors contribute to the accessibility of sexual health

services, which affect the health disparities among transgender women in Kathmandu, Nepal. For this dissertation, the Principle of Non-Discrimination and Principle of Quality are combined and analysed together. Both of the principles are interlinked with one another and focus on non-discrimination on any prohibited grounds. Hence, the principles relate to the culturally competent care of service care providers to transgender women accessing health care services.

Non-Discrimination states that “health facilities, goods, and services must be accessible to all especially the most vulnerable and marginalised section of the population, in law and fact, without discrimination on any prohibited grounds”.

Quality states that “health facilities, goods, and services must be scientifically and medically appropriate and of good quality (General Comment 14, OHCHR, 2000)”. Quality also means that the services provided by the health care providers should be culturally competent. Cultural competency is a critical foundational element in reducing health care disparities through the “culturally sensitive and unbiased quality of care”. Culturally competent care is defined as “the care that respects diversity in the patient population and cultural factors that can affect health and health care, such as language, communication styles, beliefs, attitudes, and behaviours (Anon, 2014). Hence, in the discussion for non-discrimination and quality, the topic of culturally competent care will be further discussed.

5.1.1 Health Care Discrimination (Service Users-Service Provider Relationship)

Lack of knowledge by health care providers on transgender issues and the lack of cultural competence in the health care settings were significant factors affecting the accessibility of sexual health services among transgender women in Kathmandu. Most transgender women participants shared that while accessing the general health services in public hospitals or clinics, they face discrimination because the health care providers were unaware of their health problems.

Health care providers lacked knowledge on transgender-specific health issues, which led most transgender women to educate their providers instead of getting themselves treated. Most of the studies on transgender health had similar results where transgender individuals seeking health care in the medical settings were the ones to

educate their doctors (Bockting, Robinson and Rosser, 1998; Grant. et al., 2011). The results show that there has been a significant gap in knowledge and gender sensitivity among health care providers to transgender issues, resulting in health care discrimination.

According to the findings above, one of the transgender women participants faced an outright denial of service by the doctor because of her gender identity. She along with her another transgender woman friend, was sent to the counselling centre instead of getting treated. They were sent to another hospital room where they were further discriminated. Such experience of discrimination in the health care settings led them to decide not to revisit the hospital again.

Lack of sensitivity, transphobic attitudes and behaviours to transgender identity among health care providers resulted in many to discontinue care with the providers. In another study, about “19% of transgender individuals denied health care by a provider because of their gender identity, 28% postponed care because of discrimination and disrespect, and 33% postponed preventive care” (Stroumsa, 2014). There were also cases in the current study where transgender women had to declare their identity or be out during in the medical setting because she was “misidentified”. Many studies have shown that transgender individuals face subtle forms of discrimination which included “being called the wrong pronoun, name, or gender” or being “outed by the health care providers” (Vermeir, Jackson, and Marshall, 2017).

The current study participants also experienced invasive, irrelevant, and inappropriate questioning about their gender identity, their body, and sexual life. Such interrogation led to the health concern of service users as a secondary concern. Such experiences and encounters in their interaction in the health care settings were the primary basis for transgender women to avoid, deny, stop, or postpone their health care. Many participants living in Kathmandu discussed facing health care discrimination. However, for some, they were lucky not to have been discriminated on any grounds.

Some participants shared that they did not face discrimination in the public health care settings as the health care-providers were mostly people whom they had known for a very long time. Some health care providers knew participants since their childhood. Hence, it did not matter what their gender identity was. Some also shared

that they felt attached to the health care providers because they felt like they treated them as their family member. Such was the case for primary health care settings.

Lack of transgender-specific and transgender-friendly services was a factor to the access to sexual health services in Kathmandu, Nepal. Participants shared that there were no trans-specific specialists or providers such as endocrinologist, sexologist, and counsellors, who had expertise on transgender issues. Shortage of health care experts in sex-reassignment surgeries, hormonal therapy, anal STIs, and counselling services during their transition phase was a repeated answer from the participants. According to the newspaper article on Kathmandu Post, the daily national newspaper, there is no team, especially for gender-affirming care or transition-related care in Nepal (Manandhar, 2019). The availability of transition-related care in Nepal, such as sex-reassignment surgery and hormonal therapy, will be further discussed below in principle on Economic Accessibility.

5.2 Physical Accessibility

Principle of physical accessibility encompasses the findings discussed in chapter 5. Participants mentioned various factors that affected the principle of physical accessibility. Physical accessibility for the current participants was not a challenge in accessing sexual health services as most interviewees worked in BDS as a staff or volunteer. Most had access to sexual health services, which were provided by the BDS.

Most transgender women preferred BDS services over the services from the public health system as they felt safe and secure. Also, initiatives of HIV prevention program such as CLT was an effective way to reach the key populations, including transgender women as they did not have to travel distance to acquire for services. The following section addresses the principle of physical accessibility and how several factors contribute to the accessibility of sexual health services, which affect the health disparities among transgender women in Kathmandu, Nepal.

According to the conceptual framework of the study, Physical Accessibility refers to “health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized

groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS" (General Comment 14, OHCHR, 2000).

5.2.1 The Initiative of CLT in Enhancing Physical Accessibility

Studies suggest that "the cost of transportation and long distances to HIV testing services" were some of the reasons for poor health service uptake in Nepal (Government of Nepal, Ministry of Health, 2017). However, this was proved to be different for the current study. The current study was conducted in the capital city, Kathmandu. All the participants were currently living in the capital during the time of the data collection. Thus, physical accessibility was not an issue for them. Among the six transgender women participants of the study, five of them were affiliated with BDS either for work or volunteer purpose. One of the participants was a past member of BDS. Hence, the services were physically accessible to them as most of them had worked with BDS for a long time, and they could easily access those services in their workplace.

Participants in the study mentioned that they preferred BDS health service, i.e. Cruise Aids over the general health services as it was more comfortable for them to access these services. Also, for primary and general health services, most participants visited their nearby clinic, which was a maximum of five minutes of walking distance. Hence, physical accessibility was not an issue for the participants of the study. Hence, accessibility in terms of distance was not a problem.

The health care providers who were working at Cruise Aids- Branch of BDS also shared that due to the initiative of CLT, i.e. Community led-HIV Testing, it was much easier for transgender women in terms of accessibility. The health care providers and outreach officers went door-door for service users to provide effective HIV screening. This way, many transgender women did not have to travel long distance for getting HIV screenings, getting condoms, and lubricants. These services were readily accessible right at their doorstep.

CLT is a part of the Community-Based HIV-Testing Service (CBT) and is the National HIV Strategic Plan (NHSP) 2016-2021. CLT is called the 'Test for Triangle strategy' where there is HIV-screening and referral accompanied approach

(Government of Nepal, Ministry of Health, 2017). According to the participants, Cruise Aids Nepal/Branch of BDS had CBT service before, and it was only in 2018 that they started CLT as a service to reach out more key populations including transgender women. CBT, which includes CLT, helps in "reducing prejudice and discrimination, encourages greater uptake of services and ensures greater protection of human rights (Government of Nepal, Ministry of Health, 2017)".

Key population and peers often trust community organisation and individuals within the community like transgender individuals who led the HIV testing (Government of Nepal, Ministry of Health, 2017). CLT is a unique approach "to expand and uptake of community-based HIV testing services among populations with a higher risk of HIV, particularly those who may not otherwise test for HIV" (Government of Nepal, Ministry of Health, 2017). CLT has also resulted in higher uptake of services improving the treatment and care as well. Participants in the study who were health care providers served as the trained lay providers perform functions related to health care delivery and do not involve in lab training (Government of Nepal, Ministry of Health, 2017, p.5). Hence, once they conduct HIV screening, they identify the case as reactive or non-reactive and further refer the patient for HIV testing. There is various evidence of success when lay providers perform the CLT.

The WHO's 2015 Consolidated Guidelines on HIV testing provides some of the evidence of the success of lay providers. These include, "accurate HIV testing, clients' satisfaction and support for services increase in sensitivity in the culture of community offered in HIV testing services as lay providers are culturally competent at talking with their peers, particularly people from key populations and adolescents" (Government of Nepal, Ministry of Health, 2017, p.5). Hence, CLT was an effective way in reaching to key populations, including transgender women with easy access to HIV related services as it focuses on areas where transgender women worked or lived without the need to travel distance.

5.3 Information Accessibility

Principle of information accessibility encompasses the findings discussed in chapter 5. Participants mentioned various factors that affected the principle of information accessibility.

The factors influencing information accessibility was one of the critical findings of the study. Study participants mentioned that there was a lack of sexual health literacy and comprehensive sexuality education taught in the educational curriculum. There were no policies and awareness regarding health services for transgender women at the institutional level in Nepal, which affected the accessibility of information they received from in the public health system. Participants also shared that at the institution level, there was bureaucracy in the legal gender marker process due to institutional erasure, which is further discussed in the section.

According to the conceptual framework in the study, Information Accessibility includes “the right to seek, receive and impart information and ideas concerning health issues. However, the accessibility of information should not impair the right to have personal health data treated with confidentiality” (General Comment 14, OHCHR, 2000).

5.3.1 In Need for Comprehensive Sexuality Education

Participants in the study shared that the primary sources of information that they received were from their school textbooks, media outlets such as newspapers, internet, and finally from BDS. Most participants mentioned that it was very difficult for them during their transition phase as they did not know what was happening with them. They did not even know and understood the word ‘transgender’. The school textbooks did not mention such terms. Teachings on sex education are mandatory in the curriculum and are included in the Environment, Health, and Population (EHP). Despite having topics such as sexual and reproductive health in their textbooks, participants shared that teachers often skipped those chapters related to sex education. Comprehensive Sexuality Education (CSE) was completely missing in education curricula when the participants were studying in high school.

According to the review from United Nations Populations Fund (UNFPA), Nepal formally introduced CSE in the school curricula and 2014, UNFPA and Ministry

of Education in Nepal, reviewed the status of CSE in Nepal which was published in 2016. The report shows that CSE in Nepal includes six key concepts such as relationships, values, attitudes and skills, culture, society and human rights, human development, sexual behaviour, and sexual and reproductive health (MoE and UNFPA Nepal, 2016). CSE in Nepal does not meet the international standards set by International Planned Parenthood Federation (IPPF) and Asia-Pacific Resource and Research Centre for Women (ARROW) which contains elements such as gender, sexual and reproductive health, sexual rights and sexual citizenship, pleasure, violence, diversity, and relationship (Timilsina, Gautam, and Maskay, 2017).

If we compare to the international standards, CSE in Nepal lacks the core fundamental aspect of sexuality and is not inclusive towards diverse gender identity and sexual orientation. The EHP as a subject only covers certain aspects of the environment, health, and population. HIV/AIDS is addressed as a 'disease' with its underlying emphasis on causes, prevention, and treatment. (Timilsina, Gautam, & Maskay, 2017). The CSE curriculum in EHP, in general, has failed to address various issues. These include, "human rights, concepts such as virginity, abstinence, faithfulness, proper use of condom and other family planning devices, adequate information on adolescent-friendly health services, sexual rights and sexual citizenship, pleasure, violence linked to sexuality, non-consensual sex, gender and sexual diversity, and topics related to relationships such as dealing with relationships, healthy and unhealthy relationships, trust issues and friendship" (Timilsina, Gautam, & Maskay, 2017).

Hence, topics on the sexual and reproductive health right in EHP course is addressed solely as a health issue and not as a human rights issue. Human-rights based approach to CSE is excluded in the education curriculum of Nepal. The lack of trans-specific information in the educational curriculum indicates that there has been a lack of institutional awareness and educational policies on gender identity issues from the school level. Such a lack of inclusive policies impacts the physical and social environment, which results in the lack of adequate trans-specific information service at the health settings.

Secondly, participants shared that when they did not have any place to seek information; BDS was their primary source for collecting information. BDS currently works on various programs such as HIV/AIDS prevention, capacity

development, constitutional and legal issues, care and support, income generation, human rights documentation, and media advocacy (BDS Nepal).

Many got to know about sexual health and services when they formally got engaged with the organisation. After getting to know the work at BDS, some also started working at HIV prevention programs, as peer health educators, and information providers. However, for some, the information gotten from BDS was inappropriate. There was a lack of gender sensitivity among the information providers and lack of knowledge on the proper way of teaching sexual health education to minors. Hence, there is no institutional awareness on the dissemination of information at the policy level, which influences informational and institutional erasure on transgender issues in Nepal.

"Informational erasure" encompasses 'both the lack of knowledge on trans people and trans issues and the assumption and such knowledge does not even exist when it may" and "Institutional erasure" is defined as "the lack of policies that accommodate trans identities and trans bodies, including the lack of knowledge that such policies are even necessary" (Bauer et al., 2009, pp. 352-254).

Informational erasure and institutional erasure are interconnected as both erasures have an impact on transgender individuals and their lives. In short, informational erasure in Nepal includes lack of information in the education curricula and training on transgender lives and their health issue which results in the lack of subsequent research and information synthesis in the existing literature for the transgender community in Nepal. Even though some institutional policies regarding gender marker in citizenship and passports, voter ID cards are implemented in Nepal, however, there is a lack of safe, inclusive, transgender- friendly, and transgender-specific spaces in the health care settings.

Participants mentioned that institutional erasure occurs while attaining the gender marker process. Even though policies have been in place, however, these do not cover the rights of transgender individuals. In Nepal, amending the gender marker as "Others" is possible; however, amending name is not. The Supreme Court directed to develop a policy to enable transgender individuals to change their name (UNDP and APTN, 2017). According to the study participants, the name change in the legal

documents has not come into force yet, thus affecting their right to acquire legal documents with their identified name and gender, together.

These erasures on transgender individuals promote the failure of the state to recognise transgender individuals in the physical and social environment. Thus, information and institutional erasures enhance inaccessibility of potential health care services among transgender women in Kathmandu, Nepal.

5.4 Economic Accessibility (Affordability)

Principles of economic accessibility and availability encompass the findings discussed in chapter 5. Participants mentioned various factors that affected the principle of economic accessibility and availability of health-care. Firstly, transgender women favoured to get health services from Cruise Aids Nepal, a branch of BDS as the services were free of cost. However, the services were only limited to CLT and distribution of condoms, and lubricants. The public health system in Nepal lacks transgender-specific services such as gender affirmation care.

Transition-related care such as sex-reassignment surgeries and hormonal treatments are not readily available in Nepal. Few transgender women had to travel abroad for surgeries and some; they had to order feminising hormones from abroad, which were both not affordable. These factors influenced transgender women in opting for contraceptive pills with higher estrogen level and hormones injection. The following section addresses the principle of economic accessibility and availability and how these several factors contribute to the accessibility of sexual health services, which affect the health disparities among transgender women in Kathmandu, Nepal.

Economic Accessibility in General Comment 14 of ICESCR states that “health facilities, goods, services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households (General Comment 14, OHCHR, 2000)”.

5.4.1 Free but Limited Services of BDS: Unavailability of Trans-Specific Services

As mentioned in the discussion for Principle 3: Physical Accessibility, CLT includes Community-led HIV testing and lay providers/ health care providers also disseminated educational pamphlets, condoms, and lubricants to the key population including transgender women in Kathmandu. Hence, participants shared that these services provided by Cruise Aids/ Branch of BDS are free of cost and did not pay extra for sexual health services. However, the supply of services depends on donor funding, hence limiting the services to only HIV related services.

For other services such as acquiring transition-related services and getting top-bottom surgeries, the cost was very high as participants had to travel abroad and those were not readily available in Nepal. According to the report, which featured the interview of Executive Director of BDS, she shared that since Nepal does not have sex-reassignment surgery, many transgender women relied on sex work to save money and travel to Thailand and India for surgeries (Cousins, 2018). As transgender women already come from an economically marginalised community, they also have a burden of affording for services such as hormonal therapy and sex-reassignment surgeries as they are expensive. Participants in the study shared they not only have to pay for these services but also have to cover visa costs and travel costs, which everyone cannot afford.

Since many cannot afford the high cost of sex-reassignment services; they rely on non-prescribed medications such as injecting hormones and eating high estrogen level contraceptives. Firstly, feminising hormones are not readily available in Nepal. participants either import it from Thailand or India. One of the participants also shared that she stopped injecting these hormones as she could not afford to buy it every month.

Secondly, participants shared that they imported high estrogen level contraceptives from Thailand. Though these were quite cheap, however, they faced side effects due to no medically prescribed dosage. Participants also shared that there was no specialist in Nepal whom they could discuss on the consequences of these contraceptives. Hence, most participants self-relied on transition-related services as they were not readily available in Nepal.

Participants shared that sexual health services in Nepal should also cover the transition-related cost. These gender affirming services are a critical component of sexual and reproductive health rights for transgender individuals. One participant mentioned that transgender woman might also undertake other surgeries such as vaginoplasty (creation of a vagina and/or removal of the penis) and facial surgeries for feminisation. In Nepal, there are no transition-related facilities such as gender-affirming care. There are no teams for transition-related services and no clear laws on the procedures according to the endocrinologist, Ansu Mali Joshi (Manandhar, 2019).

Unlike in other countries, transgender individuals in Nepal can identify their gender based on their "self-feeling" and do not need to undergo any sex reassignment surgeries. Nepal is one of the countries, which has legally recognised transgender individuals and does not require a medical diagnosis. However, a recent backlash occurred due to the new citizenship bill to the parliament, which demands proof of a medical certificate stating the sex-change operation in order to get citizenship with a changed gender (Manandhar, 2019).

This bill is a repressive act, which will infringe the rights of the transgender population who identify themselves based on their self-feeling. The amendment of the bill is against the Supreme Court ruling in 2007, which allowed citizens to be entitled to choose their gender identity based on their "self-feeling" and also paved their way to choose "others" in the legal government documents, including citizenship cards and passports (Manandhar, 2019). Therefore, such provisions in the bill push transgender individuals who are already marginalised in the Nepalese community and thus, affect their access to services in the health care settings.

Transition-related care is related to the overall physical and mental wellbeing of individuals. Gender-affirming or transition-related care is "designed to align physical characteristics with gender identity" (Vermeir, Jackson, and Marshall, 2017). Hence, for many transgender individuals, gender-affirming is their primary factor in transition. However, these services are not readily available in Nepal, which hinders the overall accessibility of sexual health services among transgender women in Nepal.

In summary, the interrelated principles of accessibility discussed in the section are associated with the findings mentioned in Chapter 5. Principles of non-

discrimination and quality cover the relationship of service users and service providers and how there is still a gap in knowledge by health care providers on transgender-specific issues. Principles of physical accessibility cover the preference of BDS over the public health service system and how new initiatives like CLT enabled services to be accessible at the doorstep. Principles of economic accessibility and availability cover the free but limited dissemination of condoms, lubricants, and CLT for transgender women. It also discusses the lack of trans-specific services, including gender affirmation care. As such services were not readily available in Nepal, many transgender women had to travel abroad or order the hormone injections, which are not economically challenging to them.

Finally, the principle of information accessibility covers the importance of comprehensive sexuality education. It also discusses the various institutional and informational erasures of transgender women at the legal, policy, and education level. Hence, the existing disparities in the health outcomes influence the factors associated with the principles of accessibility. To further understand the factors, intersectional issue to accessibility is discussed in the following section.

5.5 Intersectional Factors to Understand Access to Sexual Health Services for Transgender Women

Intersectional issues are vital in addressing disparities in health outcomes and access to health care services among transgender women. A holistic approach to the socioeconomic status as intersection issue is taken to understand the factors that influence access to sexual health services among transgender women.

5.5.1 Socioeconomic Status

Among six transgender women interview participants, only two participants had completed their higher secondary school and had joined the Bachelor's degree. Among the six participants, four of them were working at BDS as a staff during the interview process. Most participants were employed at BDS to work in various programs. Socioeconomic status of two of the participants was higher; however, they had a low educational degree. With low education and high economic

status, one participant worked with BDS and was a well-known figure in the Nepalese film industry. Another participant was a volunteer at BDS and owned a restaurant. Research shows that "higher educational levels tend to be associated with higher income levels; members of the community who are more educated may live in better neighbourhoods with better access to healthcare and ability to lead healthier lives" (Institute of Medicine, 2011). Socioeconomic status of the participants is associated with access to health services as the participants with higher economic status could afford to pay for the services, including gender-affirming care services.

Socioeconomic status was an intersectional issue identified in this research. As transgender women already come from an economically marginalised community; however, few could economically access and afford for sexual health services than other transgender women who come from the low economic background.

5.6 Accessibility of Sexual Health Rights: A Component of Right to Highest Attainable Standards of Health

Sexual health "is a fundamental right relating to both physical, mental health and wellbeing of individuals, couples and families, and to the social and economic development of communities and countries" (WHO, 2010). The achievement and attainment of sexual health encompass wide ranges and does not limit because of one's sexual orientation, gender identity, gender expression or/and sex characteristics. There should be availability and accessibility of a diverse and inclusive sexual health promotion and programmes addressing various communities, including transgender individuals. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." (WHO, 2006, cited in WHO, 2010).

Hence, sexual health cannot attain without having components such as: "access to comprehensive good-quality information about sex and sexuality, knowledge about the risks they face and their vulnerability to the consequences of sexual activities, access to sexual health care and an environment which affirms and promotes sexual health" (WHO, 2010). Therefore, achieving the highest attainable

standards of health is connected to human rights as these could be further fostered by states by protecting, respecting and fulfilling the right to access health services, right to privacy, right to information and education, and other fundamental health rights. Thus, the right to the sexual health of transgender women overall relates to the right to highest attainable standards of health.

Transgender women worldwide, including Nepal, experience significant disparities in the health care sector and various factors affect their accessibility to sexual health services. Factors such as social stigma and exclusion, legal bureaucracy for gender marker process, lack of comprehensive sexual education result in the overall health care discrimination of transgender women. The social, cultural, and personal factors act as barriers which impede the access to good and quality health care, including sexual health.

Human rights standards broadly look at the principles of accessibility enshrined in the ICESCR General Comment 14 and other human rights instruments. If we look at health from a human rights perspective, then those who seek services should be treated with respect, dignity, free from discrimination (WHO, 2015). States play a crucial role in fostering the promotion and protection of human rights related to sexual health of socially and economically marginalised community of transgender women. It is essential to consider the importance of sexual health and human rights. Therefore, the right to sexual health is a fundamental human right of a person and inaccessibility to good and quality sexual health affects the overall right to health care. Thus, the identified factors in the research act as barriers to accessing sexual health services among transgender women, which impede the right to health as a whole.

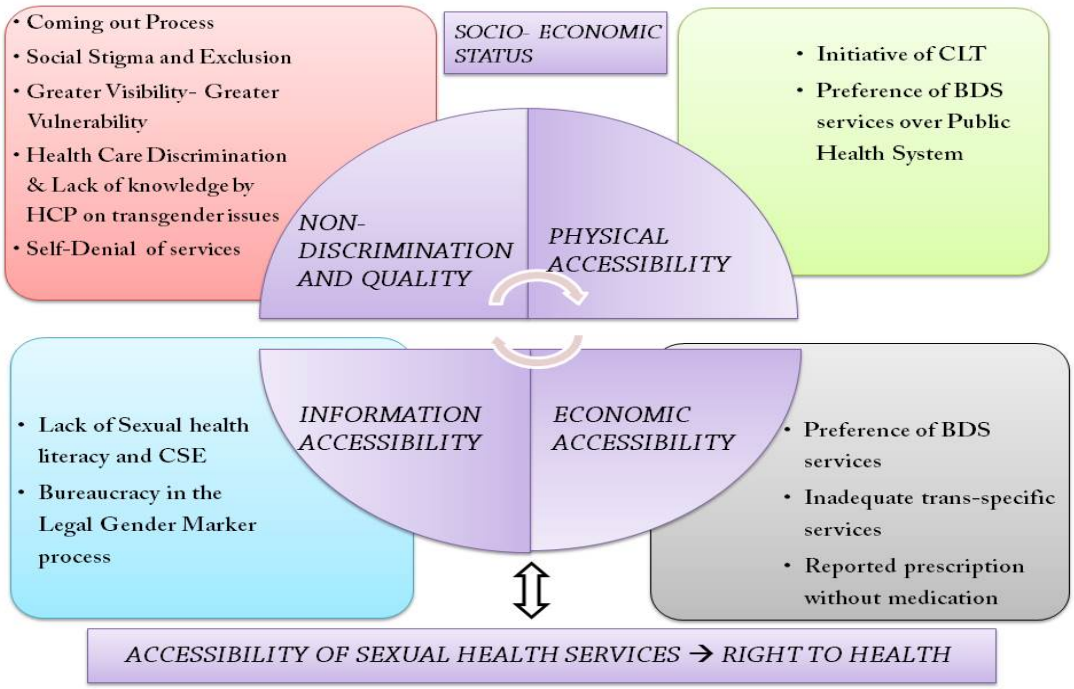

Figure 5.1 Summary of Findings and its Relation to the Conceptual Framework

To summarize, the chapter addresses the main principles of accessibility, including principles of non-discrimination and quality, physical accessibility, economic accessibility and availability, and information accessibility. The factors associated with these principles hinder the accessibility of transgender women to utilise the health care services, both public and private effectively. Also, the chapter discusses the intersectional issue of socioeconomic status, which was another factor influencing transgender women's health care. Finally, the factors identified in the research lead to inaccessibility of sexual health services, which affect the overall right to health of transgender women.

CHAPTER VI
CONCLUSION

In conclusion, transgender women experience substantial disparities in the health sectors of Kathmandu, Nepal. Even though Physical Accessibility was not a challenge in the given study, however, due to the inaccessibility of health services, transgender women continue to face disparities in the health settings. This research argues that the social, cultural, and personal factors act as barriers in the accessibility of sexual health services among transgender women. The research findings determine the common factors that influence inaccessibility include social neglect, exclusion, and legal bureaucracy in the gender recognition process. These factors result in health care discrimination, weak service provider-user relationship, lack of knowledge on transgender-specific issues, lack of sexual health literacy, poor trans-specific services, and reported medicine intake without prescription.

Many transgender individuals reported suffering from health care discrimination by health care providers, which is a violation of their health rights. According to the YP, all transgender individuals have a right to access to health services without discrimination based on their gender identity. Discrimination from health care workers affects the overall health and wellbeing of transgender women. Health care workers and professionals have a primary role in reducing health disparities, which lead to adverse health outcomes of transgender women. Hence, to improve the cultural competency of health-care professionals, gender sensitivity training and education about transgender-specific issues is crucial.

This research is grounded on a human-rights based approach to health, which focuses on the duty bearers to meet their obligations and rights holders to claim their rights. This approach to health includes holding states and other actors' accountable, developing programmes and policies that align to human rights of the transgender women, who are the rights holders in the given study. In the context of Nepal, the efforts of the state to realise the human rights obligations towards the health

of transgender women, in particular, to access sexual health services are lacking. The state is unable to fulfil the minimum obligations under the international human rights law, which address the sexual health rights of transgender women.

Nepal is a signatory to numerous conventions and international human rights laws. However, there is inefficiency in the implementation of the ratified international human rights treaties and laws. These human rights standards are not incorporated adequately in the domestic laws of Nepal. As a duty-bearer, the state has been unable to put forward these human rights principles and standards in practice for the institutional awareness and health policy and programming of the sexual and gender minorities.

To explain in detail, Nepal has failed its duty as a state to respect, protect, and fulfil the rights of transgender women. The state has failed to implement the minimum core obligation of the non-discrimination principle stated in General Comment 14 on the Right to Highest Attainable Standards of Health. The education curriculum of Nepal fails to address the transgender health issues, with informational and institutional erasure at the state-level. The state has not addressed health care discrimination by health care providers on transgender women. There is a lack of safe and trans-gender friendly services for transgender women in public health clinics.

Secondly, the recent bill requires transgender individuals to have a medical certificate proving their sex-change operation to change their gender marker. This bill has proven that the state has taken two steps backwards in guaranteeing the constitutional right to gender and sexual minorities. In this way, Nepal has failed to fulfil the rights of transgender individuals, including transgender women.

The failure of state obligations should be addressed adequately. There needs to be an effort in terms of advocacy, amendment in education curriculum, public health programming, and public policy at the institutional and informational level. Comprehensive Sexuality Education in the educational curriculum should meet the international human rights standards, and the course should be reviewed yearly. There needs to be an emphasis on the importance of the right to health as a human right. Gender sensitisation training and programs need to be put in place to train the key actors in the health care settings. Also, transgender-specific issues and studies should

be included in medical students' curriculum, as they are the ones who will serve the diverse population of citizens.

The state and other duty-bearers lack assistance "to develop the capacity, the resources, the political will to fulfil their commitments to human rights (UNFPA, 2014)". The state's accountability and transparency in the decision-making process should concern the right to health of gender minorities as well. Both governments and state actors should comply and cooperate to work effectively to enhance the accessibility of services at both the private and public health care settings.

The role of civil societies, including the role of NGOs, is pivotal in reducing health disparities among the transgender population living in Kathmandu, Nepal. In Nepal, BDS, as an organisation is one of the key actors in the health initiatives of the LGBTI population. BDS works continuously with NCASC for the national HIV/AIDS prevention and awareness. NCASC is the national level intervention program, which works for the Ministry of Health and Population in Nepal. Even though there has been government involvement with NGOs like BDS, these efforts are highly centralised to HIV prevention programs and awareness only. The significant global focus on HIV prevention overshadows the rest of the transgender-specific sexual health services. Thus, such HIV centric national programs make the rest of the sexual health needs of transgender women invisible in Nepal.

Also, the dependence of BDS on donor funding from international organisations restricts the focus of sexual health services, limiting it to HIV- centric programmes and policies. Both the government and other state actors have been unable to provide health services, which are designed to address the needs of transgender women in Nepal. Transgender- specific sexual health services such as anal STIs/STDs, medical-transition related services such as hormonal therapy and sex reassignment surgeries are not readily available. Transgender women as rights holders are unable to access proper sexual health services. On the contrary, they are the frontlines in the development of health services.

Transgender women are recognised as key actors in their own development, especially in CLT prevention program, where the transgender community led the HIV-testing for their own community. In this case, transgender women are recognised as active recipients of sexual health services. Despite the

significant contribution of transgender women as active recipients of health services, transgender women are still fighting to gain their identity both socially and legally. Health issues are not politicised enough; thus, considering it as a secondary issue. Therefore, transgender-specific sexual health needs and services are not adequately addressed in Nepal.

Some recommendations needed at the policy level changes are the inclusion of LGBTI individuals in the non-discrimination policy of every public and private sector and inclusion of LGBTI representative as a focal person in the health sectors to assist the public health system, which will increase the effectiveness of the health sector. Such policies welcome transgender women in the public health care system, thus sensitising the clinics and hospitals. Therefore, the community involvement of the inclusion of transgender individuals, including the LGBTI community is vital in reducing the health disparities leading to positive health outcomes.

To conclude, Nepal is relatively progressive towards the LGBTI community in one way, but on the other hand, the country faces a long battle for the overall LGBTI equality. The verification of sex-change operation for acquiring citizenship for the third gender category is a requisite in the recent controversial bill to the parliament. The country has introduced measures, which halt the rights of transgender women and the third gender individuals. The retrogression of these rights demonstrate the failure to respect, protect, and fulfil the core obligations of the state, thus can result in the discrimination on gender and sexual minorities in Nepal. Despite reforming laws and constitution guarantee of the third gender category, Nepal's stance in the protection of transgender women's rights to sexual health does not meet the international human rights standards. Social, cultural, and personal factors still affect the way how society views transgender women, hence hindering their access to health services. Hopefully, with the continuous activism from the civil society groups and human rights activists, Nepal will be able to dismantle the traditional patriarchal society, challenge its legal system, and finally embark its name as the pioneers in the LGBTI movement worldwide.

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APPENDICES

APPENDIX A

Interview Guidelines

Target Population 1: **Transgender Women Population**

Demographic Questions:

1. Age:
2. Ethnicity/Race:
3. Religion:
4. Educational Status:
5. Occupation:
6. Dependent family members:
7. Original Hometown:
8. If not reason for migration to the capital:
9. Marital Status:

Gender Identity Related Questions

1. What pronoun do you prefer to use?
2. How do you want to identify yourself and why?
3. How long have you publicly identified yourself as who you are?
4. At what age did you realize your identity?
5. What has it been like after transitioning/coming out?
6. What is your identification in the legal documents? Have you tried changing it?
7. How do people respond to your gender identity?

General Sexual Health Services Related Questions

1. Where do you usually receive your primary health care?
2. When was the last time you visited a health clinic/hospital or NGOs for checkup?
3. What services were you intending to access when you visited?
4. What were the other purposes for your visit?
5. When you joined the NGO (BDS- Blue Diamond Society), what is your experience regarding the services and how does it compare to the general services?
6. Does the clinic/hospital/NGO know your gender identity? If not, why?
7. Do you think it is important for the clinic/hospital/NGO to know your gender identity?

8. How has disclosing your gender identity impacted your care at the clinic/hospital/NGO? Positive/ negative?

In-Depth Sexual Health Services Related Questions

1. What type of information have you received regarding sexual health services? Through what means or/and from whom? (**Information Accessibility)**
2. Are you able to always afford for the sexual health services? If yes elaborate? If not why? (**Economic Accessibility)**
3. Is it easy for you to get to the clinic/ hospital that you need to receive the services? If yes elaborate? If not why? (**Physical Accessibility)**
4. Could you specify the number of services/facilities that you can access from the place you live in and their estimated distance? (**Physical Accessibility)**
5. Were there times when you felt that you might need to seek some medical/health support, but you did not want to do it? What were the reasons? **(Non-Discrimination and Quality)**
6. While accessing the sexual health services, are the health care workers respectful towards you? Are the health care workers confidential of your information that you provide to them? Are the sexual health services that you seek satisfactory enough? If yes elaborate? If not why? **(Non-Discrimination and Quality)**
7. What sexual health services do you think should be provided in the health care centers /clinics? Are they readily available?

Target 2: **Health Care Providers/ Workers**

Background Questions

1. Name (Optional)
2. Work Area (Location)
3. How long have you worked in the health service sector? Do you like it?
4. What is your educational background?
5. Who are the patients you usually receive at this clinic? What are the common health problems? Are there challenges in providing these services?
6. Did you have any visitors who come from diverse gender identity and sexual orientation?
7. Is this a commonly understood term? If yes/no. Why?
8. If yes, what kind of health needs were they seeking? If no, then do you know someone who has provided services to this group? Or imagine a scenario if you will have visitors from this group? Would you take any visitors? If yes/no. Why?
9. Do you know the differences between LGBTIQ? Do you think they have different sexual health needs?
10. Will you be able to provide sexual health services to visitors with different gender identity? What makes it easy/ difficult for you to do so?

11.Are there challenges with working with diverse gender identity transgender women in particular?

12.Are there institutional awareness and arrangements taken in order to work with people with sexual and gender minorities?

13.Are there any policies and practices relating to working with people with different gender/sexual identity?

14.If not, do you think there is a need to have special policies/ practices? Why? Why not?

15.What do you think should be done at an institutional level, and at the service level to enable accessibility?

APPENDIX B

Part of Interview Transcript

TGW: Interviewee 1

	Questions	Responses
Demographic Questions:	1. Age: 2. Ethnicity/Race: 3. Religion: 4. Educational Status: 5. Occupation: 6. Dependent family members: 7. Original Hometown: 8. If not reason for migration to the capital: 9. Marital Status:	1. 20 2. Newar 3. Nothing 4. Bachelor's 2nd year (Running), Tri Chandra Campus, Bachelors of Arts: Sociology and Linguistics 5. Student 6. 4 7. Patan 8. Born since childhood 9. Single
Gender Identity Related Questions	1. What pronoun do you prefer to use? 2. How do you want to identify yourself and	She Transgender woman, because I was assigned male at birth. I always felt as a girl, so identity is a woman so my identity is a transgender woman.

	Questions	Responses
	why? 3. How long have you publicly identified yourself as who you are? 4. At what age did you realize your identity? 5. What has it been like after transitioning/coming out? 6. What is your identification in the legal documents? Have you tried changing it? 7. How do people respond to your gender identity?	Coming out: not a black and white process, not like getting out of the house, at various steps of life it keeps occurring, so when I first came out it was to my friends in grade 9, my friends did notice my behaviors. There were instances of bullying and picking due to some of my behaviors. I asserted myself and told of my identity when I was studying grade 9. In grade 10, there was an essay competition and we were given choices to choose the topic in which I chose to write about gender equality, so I wrote about trans people and non-binary people, hence teachers got to know about it. I did put up on social media about my identity, however, my family members didn't get to know about it as they weren't in my friends list. I opened up to my family years in grade 9, so everything happened during my school life. Once I came out to my family, I could live the way I want. I started transitioning, started putting up clothes I want, lifestyle, it became much easier. Also, got more visible attacks, happened before but after transition increased at a high rate due to the visible, comments like "what kind of a boy walking like a girl", it's still visible and strongly known that "this person doesn't fit into the gender norms" visibly know- attack. For me "it was a very liberating thing to live my life in my own terms". It's not like once I opened up and I became confidence, I just didn't want to hide. Still didn't have courage to walk to pass by among teenagers of my age, had a lot of hesitation, I did overcome, felt that should be strong, mentally strong, and now I don't even care about it, there are still people who know me for so long (5 years) for, e.g. my neighbors who still look at me in a way which still makes me uncomfortable, still stare at me. So, I just ignore In previous school documents, all my legal documents has M (i.e. before I took my citizenship at the age of 16), after that citizenship and passport now have "O"

	Questions	Responses
		with name "……..", have not yet changed any school legal documents, for the change in the name in the citizenship, there is a provision in the law so it is quite easy which I did as well. If you are taking 1st time citizenship, changing it to "O" and changing the name as well then you can do it. So the ward can make a "permission certificate/LETTER"- sifaris" where they state that the person with two names are the same person" so I can take the documents and go anywhere except in TU. If you already took "citizenship card" and want to change name later then you aren't allowed to do so. In 2073 (2015), Supreme Court verdict allowed but hasn't been the decision hasn't been implemented. The case with TU was that they did not give me the admission because I had 2 names. Even in +2 I did the same when admitting even though I had to show SLC certificates which shows my previous names and gender as M, I still got into with 2 names as I had sifaris saying that this person is……, however, this did not work out in TU. They said the ward certificate does not work here" Changing SLC certificates are too hectic as one of my friends told me that "it's like crying tears from your eyes" with never ending bureaucratic processes "this number, this number". I have been advocating with the ministry of education about it but still its very difficult. So hence these bureaucracies in the process create a lot of barriers among transgender population in Nepal. She showed her frustrations saying "So, it works in +2 but does not work in TU, it's the same country, same government!!!": "Dissemination of information not accessible in all" Additional Answers: **How difficult was it to come out to your parents?** With family did become difficult, my own family comprises of 4 members and

	Questions	Responses
		my parents were like “what’s happening?” Lot emotional and sad moments in the beginning of opening up. Eventually in a year, they got convinced. For my extended family members were very miserable, I won’t interact with them and I avoid them most of the time. At first, they told me, I should be given electric shock in Patan Hospital, should locked up in the room and not be given food for 1 month and a lot miserable things to me. They still have that creepy expressions and the way they look at me. I think it’s still there. I don’t understand what’s going on their mind and I don’t think it is right for them to do those actions to me.

BIOGRAPHY

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