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Invisible Patients: Exploring Discrimination in Healthcare Practices for Sexual and Gender Minorities in Kathmandu Valley

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Abstract

Sexual and gender minority individuals face systemic discrimination and prejudice in various facets of their lives, including in healthcare practices. In this study, I explored the discrimination and obstacles in healthcare practices experienced by the lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+) people in the Kathmandu Valley, Nepal. Using semi-structured, in-depth interviews with seven participants selected through quota sampling, I found that the discrimination experienced by LGBTIQ+ individuals varied based on their specific sexual identities. Similarly, this study showed that transgender and intersex individuals reported more stigmatization, inadequate care, and systemic ignorance faced while taking medical needs than others. On the one hand, trans men reported discrimination, including mandatory HIV screening, that further perpetuated negative stereotypes. On the other hand, gay males and lesbian females perceived fewer barriers that they would have encountered in those situations. So, these results emphasize the imperative for immediate systemic change, which includes policy-level changes in universal health care, concept-based cultural competency education for health care professionals, and collaboration with advocacy groups in order to promote patient-centered care. For example, public awareness campaigns and statutory protections are also imperative in terms of tackling social stigma. Therefore, the current study has proposed fair and equal access to quality health care systems that are respectful, dignified, and accessible for all sexual and gender minority individuals.

Keywords
Invisible Patients, LGBTIQ+, Healthcare inequities, Transgender health, Inclusive healthcare systems

Introduction

Sexual and gender minorities including lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+), are a spectrum of identities who challenge social norms related to gender and sexuality.

Lesbians and gay men are attracted to same-gender individuals, bisexuals are attracted to more than one gender, and transgender individuals have a gender identity that differs from their sex assigned at birth. Intersex individuals have biological characteristics that do not fit into binary categories; and "queer" is an umbrella term that opposes the idea of rigid identity categories (UNDP, 2014; Vijlbrief et al., 2019; Zambon, 2023).

Despite the legal and social changes, health disparities remain for LGBTIQ+ persons. In fact, patients face greater risk of poor mental health and barriers to treatment. Bias favoring heteronormativity in health systems has a tendency to cause providers to make heterosexist assumptions. As a result, this is the cause of withholding information about sexual or gender identity leads to perpetrating discriminatory practices (Neville et al., 2015; McCann & Brown, 2019). In addition, elderly LGBTIQ+ individuals are more at risk, living as individuals and are often outside of informal care systems. As a consequence, they become even more dependent on formal systems, which are often insensitive or discriminatory (Almack et al., 2010; Guasp, 2011; Heaphy & Yip, 2003).

Globally, stigma manifests as anticipated, internalized, and enacted discrimination. At the same time, these types of stigma lead to psychological distress and decreased healthcare utilization (Saraff et al., 2022; Gower et al., 2021; Major et al., 2017). Structural stigma to policy and cultural regulation in turn perpetuates these inequalities. As such, it reinforces the Otherness experienced by LGBTIQ+ people in health care contexts (Hatzenbuehler & Link, 2014).

Strivings to overcome these challenges also emphasize the importance of inclusive care paradigms. Such training, for example, on providers who are able to meet LGBTIQ+-specific needs, building positive doctor-patient relationship, and including LGBTIQ+ content into medical training has been effective (Knaak et al., 2017; Morris et al., 2019; Sekoni et al., 2017). Nepal, alternatively, provides a unique context. Despite the celebration of an evolving societal legal paradigm in favor of LGBTIQ+ rights, the country is facing into deeply ingrained societal prejudice. Sadly, these stereotypes also disempower sexual and gender minorities in public and clinical environments (Khadgi, 2024; Ojha, 2024).

This paper investigates the healthcare barriers experienced by LGBTIQ+ persons in Kathmandu Valley. The noun "Invisible Patients" summarizes the process of the systemic disinheritance, "forgetting" of these patients within the medical system, in which their appearance and demands are routinely disregarded, as they are often stigmatized because of their homosexuality and heteronormative attitudes and practices. By investigating their lived experiences, this research aims to illuminate the underlying factors contributing to their discrimination and marginalization.

Literature Review

Theoretical Review: Evolution of Human Sexuality

Human sexuality is a multifaceted interaction between biological, cultural and historical influences. Moreover, evolutionary psychology emphasizes reproductive strategies, where women show selectivity because of the higher dependence on reproductive success in women and men showing breadth of selection for greater chances of reproductive success (Buss, 2005; Kauth, 2006). Also, cultural innovations, including technologies for child-rearing also, contributed to the development of gender roles and sexual attitudes, focusing on the evolving interaction between biology and culture (Kauth, 2006).

Moreover, cross-cultural research sheds light on the ways in which ecology and social environments shape sexual behavior, and therefore threaten universal theories (Geary, 1998; Kauth, 2006). Similarly, same-sex behaviors, which originated from evolutionary selection, promote social cohesion and pairing, and express the differences among human beings (Vasey & Taylor, 1996). Nevertheless, methodological artifacts, most notably in Western binary models, understate the flexibility of sexual practices in cultures and through time (Foucault, 1978/1990; Stein, 1999). Thus, biological and cultural aspects combined provide a holistic understanding of human sexuality.

Foucauldian Analysis: History of Sexuality

Foucault (1980) challenges the "repressive hypothesis," arguing that modern societies have proliferated, rather than repressed, sexual discourse through institutions like medicine and law. His notion of "biopower" according to which the State controls populations and establishes control over sexuality, interconnects it with governance and the nation's well-being (Dean, 1994). Sexual identities are (social) constructions, which are mediated by historical scientific and medical discourses, and so define certain actions within certain environments while prohibiting others.

The criticisms directed at Foucault's work concern its relative lack of attention to issues of gender and to individual agency (Dean, 1994; Hunt, 1992). Although limited, the analysis of Foucault still provides a basis for understanding between power, discourse, and sexuality and sheds light on the regulation of sexual subjectivities.

Anthropology of Gender

Gender is a cultural mechanism, and it is not biological, but socially determined within anthropological constructs of gender. Moreover, examples of "two-spirit" people in North American indigenous cultures and Hijra in India highlight the evolving character of gender categories (Nanda, 1999; Mukhopadhyay et al., 2020). Furthermore, Butler's (1990) theory of gender performativity emphasizes how gender is established within cultural rules. Additionally, ideologies are often used in historical contexts to maintain inequality by contrasting men and women as being two opposing entities. However, anthropologists, such as Mead (1935) and Kaberry (1947), opposed them by providing instances of societies with gender roles differing from Western prescriptions. Similarly, other gender systems, like the Zuni Pueblo "two-spirit" identities, also point to the diversity of gender constructs (Roscoe, 1998; Hewlett, 1992).

Power relations can tend to give men an advantage in public over women in private (Ortner, 1974). Nevertheless, certain groups, e.g., the Lahu of Thailand and China, are organized around complementary gender systems, which invert or override assumptions of hierarchy (Du, 1999). The discipline denies biological determinism and highlights the cultural nature of gender roles as well as the interaction with race, class, and other categories (Crenshaw, 1991).

LGBTIQ+ Health and Healthcare Inequalities

LGBTIQ+ people experience many health inequalities caused by stigma and lack of access to good quality of care. Moreover, gay and bisexual men have greater rates of chronic disease, in contrast to bisexuals, who have worse mental health (Blondeel et al., 2016). Additionally, transgender and intersex patients have individual difficulties (Köhler et al., 2012). Inequalities can be perpetuated in healthcare settings via heteronormativity, which disadvantages LGBTIQ+ persons. Minority stress theory explains the association between stigma, discrimination, and poor health outcomes. Indeed, discrimination that occurs on the individual and institutional level, due to barriers (e.g., inconsistent policies and uninformed clinicians), exacerbates disparities (Zeeman et al., 2018).

Furthermore, intersectionality complicates these issues by making age, income, and location itself layers of isolation. For instance, rural LGBTIQ+ and refugee populations are most affected by the lack of access to care (Alessi et al., 2016). Protective effects, e.g., social support, are able to mitigate part of the health effects; however, they are rarely available in deprived areas. Zeeman et al. (2018) propose a multipronged strategy of general training of health care providers, a policy initiative, and community outreach to correct these inequities. Moreover, personalization of health interventions, e.g., anal cancer screening in gay men or bolstering support for transgender people, is critical. Thus, collaboration of policymakers, health workers, and the LGBTIQ+ communities is conducive to creating equitable and affirming health systems.

Methodology

In this paper, the discrimination in healthcare practices of the LGBTIQ+ community in Nepal, specifically the case of the Kathmandu Valley—a region known for its cultural richness and its urbanism—is deeply analyzed. I used a qualitative research design and conducted in-depth, in-person interviews with a

sample of seven participants selected through quota sampling. Moreover, in order to establish trust and encourage open discussion, I ensured anonymity and confidentiality by using pseudonyms to create a safe environment for participants to share their personal experiences without fear of social or legal repercussions. Similarly, I applied thematic analysis to code and analyze the data. In addition, I evaluated participants' perceptions of health rights and their experiences in a heteronormative healthcare context. As a result, the present study highlights the systemic issues experienced by LGBTIQ+ individuals and suggests the imperative for more inclusive and equitable healthcare delivery.

Results

Health Care Discrimination and Barriers Experienced by Sexual and Gender Minorities

In my research in Kathmandu, I stayed and worked with members of the LGBTIQ+ community in different contexts, building relationships and listening to their narratives. Gaining their trust was not easy at first—it required patience and genuine understanding. However, as they began to speak openly, they shared deeply personal and emotionally charged accounts of the struggles they face in their daily lives. In the subsequent paragraphs, I will go into those stories more in detail, emphasizing the specific obstacles that vary for people because of their sexualities and identities, and showing some of the obstacles that remain for them.

Hesitancy, Humiliation and Judgment Faced by Transgender Women

The hospital visit experience for transgender women is fraught with difficulties, even for routine experiences such as completing a registration card. I noted that Anshu (Pseudonym), a 43-year-old transgender woman I met while working with an organization in Kathmandu that supports LGBTIQ+ individuals, described her experiences navigating healthcare:

> *It always starts with the paperwork. The staff seem confused. They don't know which box to fill in or who to address. Their hesitancy makes me question my place as if I am some freakishly othered entity. Every visit reminds me how untrained the staff are regarding people like me. I need routine care (particularly for hormone replacement or medical conditions related to transition). However, rather than being made to feel loved, I often feel judged. They look at me; they speak to me, in and through the device, and it's clear that, out in the world, they don't get me.*

These repeated encounters have left Anshu emotionally drained and hesitant to seek care, even when she needs it. Reflecting on the toll this has taken, she said, "*I leave feeling anxious and exhausted. Despite knowing that I should seek help, I am afraid to return. It shouldn't be this hard.*" I found that Anshu thinks hospitals should go further to ensure inclusive and supportive settings. She believes that proper staff training may resolve the confusion and distress that transgender patients have been experiencing. She said hospitals are safe places to be, and everybody should feel safe there. Staff are required to be trained to understand and care for people such as me. It is not too much to ask for respect and dignity. I noted that she imagines a medical model in which she does not need to stop fighting to achieve simple information for her health. Anshu said, "*I just want to focus on my health and not worry about being judged. Everyone deserves that.*"

Tanuja (Pseudonym), a-33-year old transgender woman, shared a distressing story about an experience she had while supporting a friend, also a transgender woman, who had been injured in an accident. I noted that the opposite of professional care and courtesy, Tanuja and her friend found themselves pitied through mockery. Tanuja recounted, "*My friend suffered pain and we hurried her to the hospital. But instead of focusing on her care, the nurses started laughing and gossiping about her.*" This feeling of emotional lack of empathy converted what should have been a caring moment into a humiliating display. I found that Tanuja described the impact of the incident:

It was painful to witness her not only in the physical suffering but also being denigrated in a supposed place of care. Their behavior wasn't just rude—it was dehumanizing. Watching that, I kept thinking about how many others in our community avoid hospitals because of treatment like this.

Tanuja thinks this kind of discrimination is representative of a broader societal problem that discourages transgender persons from seeking medical care. She stressed the need for hospitals to build a safe and respectful atmosphere through greater awareness and skills. This experience showed so clearly that hospitals

so desperately need us to teach their staff compassion when caring for sexual and gender minorities. Everybody should be valued as an individual and treated with dignity and respect, regardless of their background. It was not only a personal putdown for Tanuja but a graphic illustration of the way systemic discrimination traps transgender people in their effort to get the treatment they are entitled to. I found that she called for cultural and organizational changes in healthcare:

> *This type of discrimination is not only painful but also denies people access to necessary care. Our identities shouldn't be a reason for judgment or neglect. It's time for real change in how the system thinks about us.*

The case of Anshu and Tanuja draws attention to the urgent requirement for hospitals to implement inclusive practices and to educate staff to be aware of and empower LGBTIQ+ people. I found that when healthcare systems promote respect and empathy, this can guarantee that transgender patients feel protected and validated. These changes are not only an issue for better individual experiences but also to achieve equal access and inclusivity in healthcare for all. The time has come to build a system in which empathy, fairness, and respect for everyone are prioritized.

Challenges in Government vs. Private Hospitals

For transgender people, the decision of whether to go to private or government hospitals is frequently based on accessibility and affordability. Although private hospitals, on average, offer more knowledgeable trans patient care, the considerable cost means they are not affordable for many. Consequently, the vast majority of transgender individuals rely on government hospitals, where discrimination, ignorance, and exclusion are frequent. I noted that Devika (Pseudonym), a 29-year-old transgender woman, described the extreme differences between private and public hospitals. Although she tends to perceive private hospitals as more accessible, their services are financially barred. This leaves her in the care of government hospitals, where her identity is often a source of disliking and confusion. She described her experience:

> *Being a transwoman, going to the hospital is always frightening. Widely, private hospitals treat me with respect, but I am not able to visit them every week. Therefore, I find myself in government hospitals, and that is where the real issues start. The staff there makes me feel disrespected, like an outsider. Their responses are cold and critical, and it's clear they don't want to spend any time understanding someone like me.*

I found that the medical care Devika receives in government hospitals often stems from damaging stereotypes and biases toward her identity. This process is not only emotionally painful but also deeply desensitizing. She explained:

> *The worst is that they judge me. They look at me and immediately assume I'm a sex worker or that I'm there for treatment for some sexually transmitted disease. It's so degrading. I do recall needing medical help, but the disrespect level with which I was treated made me never go back. I stayed home and suffered instead. That's how bad it was.*

These encounters turn every hospital visit into a fight for dignity and leave Devika reluctant to seek medical care, even during emergencies. Citing her experiences, I noted that she spoke about how systemic problems in government hospitals foster unsafe conditions for transgender individuals:

> *It's not just some bad apples—it's the whole system. The staff do not have the training or tolerance to identify or pay attention to people such as myself. Each visit is like fighting to be seen as a human being.*

I also found that Devika believes systemic change is necessary to promote inclusive and respectful healthcare environments. She suggests the importance of comprehensive staff training to address these issues and foster understanding:

> *Hospitals should be places where we feel safe and supported, not judged and condemned. It's a matter that they have to be educated, [and] they have to set up a better space for somebody like me, etc. Until that happens, going to the hospital will never feel safe—it'll always feel like a battlefield.*

Her experience is a strong example of how ignorance and systemic discrimination in public healthcare discourage many transgender people from undergoing lifesaving treatment. I found that addressing this

requires a hospital mandate for inclusivity, respect, and comprehensive staff education and training to allow all patients access to equitable and compassionate healthcare.

Healthcare Discrimination Faced by Gay and Lesbian Individuals

For certain members of the LGBTIQ+ group, for instance, gay men and lesbian women, hospital experiences are, on the other hand, more likely to be free from discrimination than those of the transgender population. I noted that Dhiren (Pseudonym), a 31-year-old, an openly gay man shared his overall good experiences with healthcare providers. He said, "*As a gay man, I've been lucky. I've never faced discrimination in hospitals because of my sexual orientation. Each time I go and visit, it's just anyone else. I haven't had any problems personally."* Since Dhiren has himself experienced respectful and uneventful encounters, he mentioned the contradiction within the LGBTIQ+ community, especially for trans people:

> *I know this isn't the case for everyone. Trans men and women, in particular, face a lot of discrimination and stigma. I've seen how differently healthcare staff treat trans individuals. While I've been treated fairly, my trans friends have shared stories that break my heart. They have been maligned, underestimated, and even ridiculed by doctors and nurses.*

I found that this contrast emphasizes the heterogeneity of the LGBTIQ+ community. Although there are people such as Dhiren who experience polite medical care, others face significant bias and stigma. Dhiren highlighted the need to implement an equitable care model for all, an inclusive health system:

> *Even though my experiences have been positive, I know that's not something everyone can count on. Healthcare should be safe and welcoming for everyone. No one should ever be made to feel disenfranchised and isolated just for the sake of health care while trying to manage their health as well as possible. Hospitals need to step up. Personae should be acquired by staff so that all patients' needs may be attended to regardless of gender identity or sexual orientation.*

I also noted that Anju (Pseudonym), a 37-year-old lesbian woman, commented on this issue in a similar vein as Dhiren. She reported her hospitalizations to be mostly routine and free of mistreatment:

As a homosexual woman, I haven't experienced any problems in hospitals due to sexual orientation. My experiences have been smooth, and I've always been treated like any other patient. Nevertheless, I'm also aware that this is not always the case for members of the population LGBTIQ+. Transgender people, for instance, continue to be increasingly victimized by discriminatory treatment in medicine.

While her own experiences have been positive, I found that Anju expressed strong concern for the injustices facing others in her community:

From what I've seen and heard from my friends, gay men and lesbian women generally face fewer issues in hospitals compared to transgender individuals. I've been fortunate to receive respectful treatment, but many of my trans friends have shared stories of humiliation, judgment, and neglect from healthcare staff.

Anju's reflections show the need for systemic change within healthcare institutions to ensure equitable treatment for all members of the LGBTIQ+ community:

> *Even though I haven't personally experienced these issues, I strongly believe that hospitals need to become more inclusive and sensitive to the needs of all sexual and gender minorities. Healthcare professionals have to learn how to provide care to all patients with dignity and respect so that not one person feels isolated when seeking treatment. My experiences have been positive, but I know the system needs to change to address the inequalities so many in our community still face.*

I found that these stories show a strong disconnect between the health experiences of the constituents of the LGBTIQ+ community in diverse ways. Although gay men and lesbian women, such as Dhiren and Anju, are less at risk of discrimination than transgender people, they are very sensitive to the discrimination the transgender community faces. Both Dhiren and Anju emphasize the urgent need for systemic reforms to create hospitals that are welcoming and respectful to everyone, ensuring that all individuals are treated with dignity, understanding, and care.

Healthcare Discrimination Faced by Trans Men Individuals

For trans men, a visit to the hospital is rarely straightforward. Even something as routine as registering can feel overwhelming. I noted that Suresh (Pseudonym), a 31-year-old trans man, described what these experiences are like for him:

It always starts at registration. They barely even look at me. They just tick the 'male' box, like it's automatic. At first, I try to brush it off, but it always ends up causing problems later. Like when I need to see a gynecologist—things get really awkward. No one knows what to do, and I'm left feeling like I don't belong. I found that this kind of assumption—filling out a form without asking questions—shows how little attention is given to the unique needs of trans men in healthcare. It's frustrating, sure, but it's more than that. It's isolating.

I found that the stigma does not stop with physical procedures. Suresh also explained how he is often forced to take an HIV/AIDS test during routine checkups:

Even if I'm just there for a blood test, they'll insist I get an HIV/AIDS test. It's so unfair—like they're assuming I'm at risk just because of who I am. That kind of discrimination is exhausting. The problem isn't the test itself—it's that they single out our community. This kind of stereotyping has to stop.

These experiences take a serious emotional toll. I noted that when healthcare workers assume trans people are automatically at higher risk for HIV/AIDS, it reinforces harmful stereotypes and affects the quality of care. Similarly, I noted that things only get harder when medical procedures involve physical exposure. Suresh further described how medical procedures, like X-rays, expose the lack of training among staff:

X-rays are so uncomfortable for trans men who haven't had top surgery. The staff don't seem to understand what we're going through, and their reactions can be awkward or even inappropriate. It's obvious they haven't been trained to handle situations like this. It feels dehumanizing and leaves us exposed—not just physically, but emotionally too.

After experiencing this kind of treatment repeatedly, I found that Suresh has started avoiding hospitals altogether. He explained, "*Honestly, I only go if I really have no choice. Even when I know I'm sick, I sit there and think, 'Do I really want to deal with this today?' Most of the time, I just don't. It's exhausting."*

I found that the weight of these experiences—stigma, misjudgment, and lack of understanding—often discourages trans men from seeking care. These problems do not just harm individuals—they erode trust in the healthcare system as a whole. Suresh suggested:

Hospitals need to make training their staff a priority. They need to treat people like us with respect. Doctors and nurses should care for everyone equally, no matter their gender identity. Healthcare should be about compassion, not judgment. It's time for hospitals to make sure people like me can get the care we need—without fear or stigma.

I found that Suresh's story shows how much the healthcare system still needs to change. This change is long overdue. Everyone deserves to feel safe when they visit the doctor, without worrying about being judged or treated unfairly. It's time to create a healthcare system that truly values empathy, equity, and dignity for everyone.

Healthcare Discrimination Faced by Intersex Individuals

Intersex individuals face profound barriers to accessing appropriate healthcare. The challenges span from medical professionals lacking information to the psychological burden of frequently having to explain their identity and requirements repeatedly. I noted that Sonam (Pseudonym), a 36-year-old intersex person, reported how inadequate understanding by medical personnel causes extra stress:

> *Attending the hospital as an intersex is always a stressful situation. The majority of the time I go in hoping I will be made notable, but I leave feeling irrelevant. Doctors and staff don't seem to understand me or my needs. They are not aware of which tests or therapies I might require during my transition and, in particular, hormones. It's as if they've never heard of a person such as myself. And that hurts. The worst part is when I have to explain myself—my body, my identity, my health needs. It feels so unfair. I am the one who needs help but I have to teach. Lately, whenever I do it, I can see the mistiming or a lack of naturalness on their face(s). It leaves me feeling insignificant as if I do not belong in a space where I am supposed to be cared for.*

I found that this paucity of information about intersex-specific medical requirements highlights a major gap in the training and education of healthcare professionals. For intersex individuals, it becomes emotionally taxing to constantly explain their medical and personal situation. Sonam further shared:

> *I come away from those appointments feeling stressed, defeated, and sometimes even ashamed. I don't have to experience this just for being an adherent to my health care. It's exhausting, mentally and emotionally. I absolutely hate even going back, even though I know I have to.*

I noted that the emotional toll of feeling unseen and unsupported makes healthcare inaccessible for many intersex individuals, even when they require urgent medical attention. Sonam emphasized the need for structural changes in healthcare:

> *Hospitals need to do better. Doctors and personnel must be informed how to care for patients like me—respectfully, and with empathy and consideration. We're not asking for anything extraordinary—just to be treated like human beings. Ideally, it is right to feel safe and taken care of in a hospital when ill or hurt. Without real changes, people like me will keep avoiding the care we need because of fear and frustration. That shouldn't happen to anyone.*

I found that these presentations demonstrate the urgent need for hospitals to educate and counsel their staff regarding intersex topics so that they can function in a fully inclusive, respectful environment. Without such changes, the healthcare system risks alienating and further marginalizing intersex individuals who deserve equitable and compassionate care.

Stigmatization in Healthcare Settings and Mental Health Issues

Individuals within the LGBTIQ+ community experience chronic stigmatization and discrimination within healthcare facilities, which can greatly restrict access to necessary medical care. I found that transgender and intersex persons, to name just two, are unduly subjected to mistaken and prejudicial beliefs by healthcare personnel, which have inevitable emotional and physical impacts. Suresh, a trans man, described one such disturbing experience:

A blood test, for example, can become a highly stressful event. More than once, I've been told that getting an HIV/AIDS test is mandatory for someone like me. It's not the test itself that bothers me—it's the assumption behind it. They single out people from the LGBTIQ+ community as though we're more likely to have HIV just because of who we are. That kind of stigma is humiliating and hurtful.

I noted that such stigmatization is based on negative stereotypes that portray members of the LGBTIQ+ community as naturally unhealthy or abnormal. These assumptions not only cause harm but also lead to serious psychosocial outcomes. Suresh reflected on the mental health impacts of these experiences:

These experiences leave me emotionally drained. It leads me to avoid going to the hospital, even when I suspect I'm sick and the case requires medical treatment. It shouldn't have to be this way. Hospitals must take the next step and equip their staff with the knowledge and respect to meet people's needs like mine, for example, rather than objectifying them.

I observed that the psychological burden of this kind of treatment frequently results in a vicious cycle of avoidance, where people procrastinate or neglect medical attention, leading to further deterioration over time. Suresh also raised concerns about the practice of adding unnecessary forms of medical intervention, particularly HIV testing, during routine appointments:

When we go for a blood test or a standard checkup, the doctors sometimes make it compulsory to do the HIV/AIDS test. I personally don't think screening for HIV is inherently unacceptable, but it is discriminatory to target us as a community for screening tests.

I found that these practices point to a broader problem of inequity in medical treatment, where some groups of people are treated differently solely because of who they are. Suresh and Sonam, another member of the LGBTIQ+ community, both stressed the importance of training medical professionals to prevent this form of discriminatory behavior. Sonam explained:

> *Doctors and nurses should respect gender identity and treat every person equally. Healthcare is about care, not about judgment and discrimination. Hospitals have to fulfill their mission and give people such as us the treatment we should not have fear and stigma for.*

I noted that both Suresh and Sonam emphasized the need for systemic changes to create a more empathetic and equitable healthcare environment. These changes include developing policies on gender diversity and training staff to provide caring, unbiased treatment to all patients. Without these adjustments, healthcare systems risk perpetuating harm and alienating those they are meant to serve.

Discussion

At the present time, I have disclosed the implicit systemic issues and discriminative processes suffered by sexual and gender minorities (LGBTIQ+) who come in contact with the healthcare system in the Kathmandu Valley. I found these barriers are strongly associated with structural and social injustices, stigma, and discriminatory healthcare policies. I noted that transgender and intersex individuals, in particular, face severe challenges. Transgender women Anshu and Tanuja reported painful experiences of being labeled, teased, and mocked by healthcare providers—paralleling patterns of global systemic neglect (Zeeman et al., 2018). Similarly, intersex individuals like Sonam reported a lack of understanding among healthcare providers regarding their unique medical needs, often leading to feelings of invisibility and exclusion (Saraff et al., 2022). I observed that trans men, such as Suresh, reported specific challenges of stigmatization, having to relive discrimination, and undergoing mandatory HIV screening. These are also practicing that reinforce harmful stereotypes and that illustrate widespread healthcare inequities (Sekoni et al., 2017).

By contrast, I found that gay men and lesbian women, including Dhiren and Anju, experienced fewer discriminatory encounters. But when telling their stories, they created a common commitment to support other LGBTIQ+ people coping with the difficulties they are confronted with and simultaneously emphasized the heterogeneity of this community, just as their own experiences were.

These results are confirmed in the globalist literature, which has documented structural stigma and heteronormative bias impinging on healthcare systems (Hatzenbuehler & Link, 2014). The lack of training and awareness among healthcare providers, as observed in this study, reflects similar shortcomings noted in contexts where LGBTIQ+ health issues remain absent from medical curricula (Morris et al., 2019). This highlights the urgent need for comprehensive systemic reforms. Health professional training programs to be provided must all be of a good standard to meet the specific demographics of LGBTIQ+ clients and cultural competence (Sekoni et al., 2017). Policies requiring implementation of LGBTIQ+-adapted medical guidelines are in order to achieve equality. Furthermore, the collaboration with LGBTIQ+ advocacy groups can be used to propose healthcare acts, which have a targeted application to the reduction of stigma and discrimination. These methods are a crucial part of the design for a health setting where equity and inclusion are the guiding principles.

Results from this study also emerged the critical need for system reform for the disruption of workplace discrimination of healthcare workers in healthcare environments. Developments of a healthcare system based on commitment to inclusivity and equity are not only good public policy but also an essential step towards improving full health outcomes for all people. At present, the focus in this work is on giving a voice to LGBTIQ+ groups in the Kathmandu Valley to highlight the need for policy action and into the ongoing discussions on health equity and human rights.

Conclusion

This study reveals the significant systemic barriers and discriminatory practices faced by LGBTIQ+ individuals in healthcare settings within the Kathmandu Valley. I found that the findings describe the mechanisms by which structural bias, the unacknowledged consequences of stigma embedded in society, and poor clinician education accelerate the denial of affirmation and marginalization of transgender and intersex individuals. I observed that people described experiences of judgment, victimization, and avoidance, exposing the extent of bias that permeates healthcare systems. They add to a growing base of health inequity literature and offer evidence of the confluence of institutional dysfunction and social prejudice. I argue that the recognition of these disparities necessitates immediate and systematic remedies, including but not limited to specific educational training for health workers to allow for cultural competency, designing policies that address inadequate care provision to the LGBTIQ+ population, and alliances with advocacy organizations to design inclusive patient-centered interventions.

I observed that the findings of this study have important implications that extend beyond personal stories, pointing to some of the structural weaknesses that result in unequal healthcare access and experience for sexual and gender minorities. Although the study provides some beneficial qualitative information, I recognize that the study is applied to the urban context of Kathmandu Valley and may not apply to other contexts of rural or periphery. I recommend that future studies use mixed-method designs to estimate the frequency and intensity of discrimination in varied geographic and social settings. Furthermore, longitudinal studies may be used to determine the lasting effect of policy changes and training programs that address healthcare inequities affecting LGBTIQ+ populations.

About Author

Netra Kumar Ojha is an Assistant Professor at the Department of Sociology and Anthropology, Padmakanya Multiple Campus, Tribhuvan University, Nepal. With extensive research on globalization, climate change, gender minority studies, and social behaviors, he has authored numerous books and international journal articles.

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