Journal of Racial and Ethnic Health Disparities (2024) 11:1124–1138
https://doi.org/10.1007/s40615-023-01592-8

Discrimination, Health, and Resistance for Thai Transgender Women

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Received: 2 December 2022 / Revised: 11 March 2023 / Accepted: 31 March 2023 / Published online: 10 May 2023

Abstract
There are clear linkages between discrimination and health for people across intersections of race, ethnicity, socioeconomic status, citizenship, sexual orientation, gender identity and expression, and other social identities. Yet, less research has examined discrimination and health for transgender people outside of the USA, who can face different cultural ideals, access to resources, and social structures. How might research on discrimination and health account for the interplay of diverse social identities, micro-level experiences, meso-level settings, and macro-level structural/cultural contexts? Based on 14 months of fieldwork in Thailand and interviews with 62 participants, this article bridges the minority stress model with an ecosocial framework to analyze how Thai transgender women navigate and resist structural and everyday discrimination across a variety of settings and encounters. Incorporating minority stress theory's attention to discrimination, stigma, and stereotypes, the article demonstrates how Thai transgender women face indignity, disrespect, and dehumanization based on gender. Incorporating the ecosocial framework, the article analyzes how discriminatory structural laws, policies, and rules—as well cultural hierarchies of femininity, interpersonal relations, internalized beliefs, and commodified health/medical technologies—are pathways to Thai transgender women's health and health decision-making. By merging these theoretical frameworks, the article goes beyond an "event-focused" approach to minority stress and discriminatory encounters, instead illuminating the interconnected micro, meso, and macro levels impacting Thai transgender women's health outcomes, decision-making, and everyday life.

Keywords Discrimination · Health · Minority stress · Ecosocial theory · Transgender women · Thailand

Introduction

Bee, a 22-year-old Thai transgender woman, found it "difficult to say" whether she had recently experienced discrimination during a medical checkup when she was treated as a male patient rather than female. Several years before, nurses had refused to wash her, unsure if the role should be assigned to a male or female nurse, and instead designated the task to Bee's parents. While Bee lives and identifies as a woman, her prior experience with medical care—or in this case, a lack of care—might have made it challenging for her to determine if her recent encounter being treated like a man was problematic. How do different forms of discrimination across multiple societal levels impact transgender people throughout the world? How do transgender people categorize and resist such discrimination?

Multidisciplinary research has focused on the vast "burdens and needs" of transgender people globally, as health care and social supports are typically inaccessible, underresourced, and unfunded [1]. While often categorized by institutions as "vulnerable" populations, transgender people worldwide are not innately vulnerable but are instead *made* vulnerable to various forms of systemic violence, exclusion, and erasure [1]. Importantly, amid various forms of cultural hierarchies, discrimination, and systemic barriers, transgender people mobilize through social networks and activism, exerting resistance and agency worldwide [2, 3]. Studied in the US context, transgender people can also experience joy in their identities by forming meaningful connections with others and embracing their identities [4].

Other scholarship has examined minority stress as a distinct cause of health disparities [5], analyzing how sexual, gender, and racial/ethnic minorities experience specific stigmas and ongoing stressors that impact health behaviors and

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outcomes [6–9]. Minority stress theory—initially researched in gay men in the USA—categorizes distal minority stressors, such as interpersonal violence and discrimination, which negatively impact mental health outcomes [10]. Proximal minority stressors are the psychological processes that ensue from societal stigmatization [8], and can involve internalized homophobia/transphobia, expectations of rejection, and concealment of one's identity [11, 12]. The theory has underscored that "[i]ncreased exposure to chronic and unique sources of stress due to membership in a stigmatized minority group is a key driver of health disparities among LGBT populations worldwide" [13]:665).

While the minority stress model proves valuable in assessing the linkages between stress, stigma, and prejudicial events, the ecosocial framework has problematized the separation of distal and proximal categories, as well as broadened the focus to include physiological outcomes. The ecosocial theory proposes a multi-level attention to power, empirically analyzing the embodied effects of one's "exposure to 'unjust ism's" ([14]:37), including racism and/or gender binarism. Previous research has integrated ecosocial theory with minority stress theory to offer a more fulsome analysis of embodied and psychosocial health amid discrimination [9, 15]. For instance, scholarship on older Latinx adults' experiences with type 2 diabetes showed how racial/ethnic discrimination impacts both their physiological and psychological health outcomes [9]. Yet, scant research has merged ecosocial and minority stress frameworks to better understand how discrimination manifests across societal levels and impacts transgender people's health, particularly in non-US settings. By shifting the focus to Thai transgender women, this article offers a deeper understanding of how gender-based discrimination impacts health outcomes and daily life, as well as how it is resisted.

Although Thailand is branded by the national tourism agency as a place where LGBT+ tourists are freely welcomed [16], Thai transgender people face various forms of stigma and discrimination across multiple settings, including workplaces, schools, and health care [13, 17]. While direct violence against transgender people is comparatively low in Thailand, Thai transgender people currently lack legal rights, as the 2015 Gender Equality Act—which makes illegal discrimination based on sexual orientation and gender identity—allows for exceptions and is not always enforced. Thai transgender people lack legal recognition as their self-identified gender, a form of structural discrimination that impacts their everyday life in many ways. Additionally, Thai transgender people experience a variety of health care challenges including medical uncertainty, while sometimes accessing lower-quality gender-affirming surgeries amid the growth of Thailand's medical tourism industry [18, 19]. Thailand's universal health coverage program does not currently cover gender-affirming services (such as hormones or surgeries), even though such services are essential for those who want them [20].

Based on 14 months of fieldwork in Thailand and interviews with 62 participants, this article analyzes how stigma, stereotypes, and stressors are baked into institutional structures, cultural norms, and everyday interactions, serving as pathways through which mental and embodied health disparities emerge for Thai transgender women. Incorporating minority stress theory's attention to discrimination, stigma, and stereotypes, the article demonstrates how Thai transgender women face and resist different exposures to discrimination across a variety of settings. Integrating the ecosocial framework, the article analyzes how discriminatory structural laws/policies/rules—as well interpersonal relations, internalized beliefs, and health/medical technologies—are pathways to Thai transgender women's health outcomes and decision-making. Integrating ecosocial theory, the article goes beyond an "event-focused" approach to minority stress and discriminatory encounters [21]:9), illuminating the simultaneous and interconnected micro, meso, and macro levels impacting Thai transgender women's health outcomes, behaviors, and resistances.

Much like there exist distinct "epidemiological worlds" in which people experience differential risks of disease exposure [22]:1), there also emerge "differential risks of psychosocial exposures" [23]:5) and disparate physiological health outcomes based on discriminatory laws, social structures, hierarchical cultural ideals, and available health and medical technologies worldwide. Given the diverse experiences of people across gender identities/presentations and settings, the article answers the call of medical sociologists to "decenter the West" in health research [24]:456), attending to a wider range of experiences in different social/structural and country contexts [25]. In what follows, I first provide an overview of discrimination, minority stress, and ecosocial theory, focusing on the experiences of and stressors for transgender people worldwide. I then provide a brief background about transgender health and gender norms in Thailand, followed by the methods used. After analyzing discrimination for Thai transgender women across macro, meso, and micro levels, the article concludes with implications.

Discrimination, Minority Stress, and Ecosocial Theory

There are clear linkages between stress, public policy, and mental/physical health for people based on intersections of race, ethnicity, socioeconomic status, citizenship status, sexual orientation, gender identity and expression, and other social identities [5, 13, 26–30]. Stigma—which involves labeling, stereotyping, status loss, and discrimination—is a

fundamental cause of health disparities, as it impacts social and material resources for people across a range of identities [28, 31]. While stigma is often studied interactionally between individuals, research has broadened the lens to focus on structural stigma, which involves the "societal-level conditions, cultural norms, and institutional policies that constrain the opportunities, resources, and well-being of the stigmatized" [32]:742).

Everyday discrimination—including aggression, harassment, and mistreatment—impacts physical and psychological health outcomes [33]. Experiences of everyday discrimination can include someone being treated with less courtesy, receiving less respect, receiving poorer services, being treated like they are not smart, perceiving others are afraid of them, being perceived as dishonest, perceiving others act like they are better, being called names or insulted, and being threatened or harassed [33]. These forms of unfair daily treatment have negative consequences on the physical and mental health of people across a range of identities and social/geopolitical locations.

Minority stress theory has shown how distal external prejudice events and proximal internal/subjective responses impact lesbian, gay, bisexual, and transgender people in various parts of the world [34–37] While research has problematized the word "minority" as outdated and victimizing [38], the minority stress theory usefully centers on how marginalized groups experience disparate psychosocial health outcomes due to discriminatory events. Gender-diverse people can experience greater levels of social stress due to structural discrimination, stigma (both outward and internalized), and less supportive societal resources [12, 39]. In addition to state-sanctioned criminalization towards transgender people currently occurring from Tennessee to Indonesia, transgender people can face issues being misgendered and mistreated in everyday life, both in public and at home [40]. Underscoring the importance of "passing," people may experience discrimination and mistreatment for behaviors or gender expressions that differ from dominant gender norms [39, 41]. Binary gender norms, albeit largely studied in a US context, are steeped in cultural hierarchies and ideals that then shape mental and physical health outcomes for cisgender and transgender people. Such binary gender norms manifest as structural discrimination, internalized ideals, and in everyday social interactions.

Research on how stigma processes impact health for people across the gender spectrum has raised questions about the international application and methodological challenges of such research [40]. Since different contexts of public stigma can cause a range of health outcomes [42], research has sought to measure levels of internalized stigma by creating and adapting scales to fit diverse cultural contexts [43]. For instance, research on transgender people in the Philippines [44] has adapted and applied scales to measure internalized transphobia, self-stigma, and self-concept [45, 46]. Research on internalized transphobia in South Korea has also recommended that scales be created in local contexts, rather than only translated [47]. International research incorporating minority stress theory has shown how diverse cultural considerations manifest in health outcomes for sexual minority men in China [21] and Nigeria [48], as well as transgender people in Sweden [49] and China [50]. This scholarship demonstrates that cultural values are dynamic, both within and outside of the USA, and can differentially impact experiences with stigma and health for transgender people globally. For sexually- and gender-diverse people worldwide, this research has underscored the importance of crafting culturally specific measures versus taking a one-size-fits-all, universalized approach to stigma and discrimination.

While minority stress theory highlights the specific stressors associated with intersecting marginalized or minority social identities, such as gender identity and presentation, ecosocial theory explicitly centers on the concurrent interactions between social contexts and embodiment. Demonstrating the interplay (and indeed collapse) of distal and proximal factors, ecosocial theory illuminates how macro-level cultural beliefs and structural arrangements influence micro-level social interactions, which then shape power relations and the distribution of resources across societal institutions [51–53], see also [54]:2. Ecosocial theory focuses on pathways of embodiment (how societal arrangements are incorporated biologically), highlighting individual, neighborhood, regional, national, inter- or supranational levels, as well as the role of accountability and agency [55]. In turn, the ecosocial framework has "delet[ed]" the categories of distal and proximal to enable a "multifactorial account" of health and disease outcomes [51]:227, 223).

By highlighting "who and what drives current and changing patterns of social inequalities in health" [55]:672), ecosocial theory simultaneously analyzes structural laws, interpersonal dynamics, and internalized beliefs. For example, scholarship has underscored how macro-level cultural hierarchies and systemic inequalities (e.g., fatphobia) influence individual-level eating behaviors, especially for transgender people who may face additional stressors to comply with dominant gender norms [36]. Passing and conforming to societal standards of femininity can also provide safety and survival for some transgender women in the USA [56]. In these ways, cultural ideals about sex, gender, and sexuality—which differ across time, place, and culture—can impact mental health, stress, eating behaviors, and health outcomes. While the ecosocial theory has examined binary gender ideals and health in the USA [14, 36], how do gender norms and hierarchies impact health outcomes and behaviors for people in different cultural and country contexts?

Previous research has merged ecosocial and minority stress theories to demonstrate the exacerbated stressors for people across marginalized identities, and how such stressors intersect with structural/cultural contexts to create disparate mental *and* physical health outcomes [9, 15]. This article also bridges these theories to analyze how Thai transgender women experience multiple types of discrimination across different societal levels, settings, and interactions; such discrimination serves as a pathway to health, embodiment, and psychological outcomes. By simultaneously attending to the structural "rules of the game," such as laws and policies [53]:98), meso-level institutional contexts, cultural norms, the commodification of health/medical technologies, and the broader social environment, this article underscores the social elements of stress [29] as well as the embodied health outcomes for Thai transgender women. It analyzes the deep connections between societal hierarchies, physical/mental health outcomes, and the lived, everyday experiences of people made marginalized. By attending to the contexts, experiences, and decision-making strategies of Thai transgender women, the article underscores the manifestations, effects of, and strategies to resist various forms of discrimination.

Background: Gender in Thailand

Third-gender feminine people in Thailand were written about in Buddhist texts thousands of years ago, referred to as "*kathoey*" [57]. While some now consider that label derogatory, Thai transgender women are an increasingly visible group, performing in internationally renowned cabarets and nationally broadcast beauty pageants, with images of hyperfeminine appearances circulating across national borders [58]. Amid the abundant cultural representations of Thai transgender women, research has shown that "[d]espite the global perception that Thailand is tolerant towards LGBT individuals," it is common for them to experience various forms of discrimination [13]:665). For instance, using the minority stress theory to measure Thai transgender women's suicidality, research has shown how discrimination across more social situations corresponded with a greater likelihood for participants to report a history of lifetime suicidal ideation [13]:662). Suicidality was also exacerbated by poverty, demonstrating the intersections of mental health and one's class status and social/locational access to resources.

As this article will discuss, legal identification cards that cannot be changed to reflect transgender people's gender is a form of structural discrimination that creates barriers for transgender people across different settings (including health care), and in a variety of interpersonal dynamics. In addition, there are no standardized trainings for medical personnel related to clinical and cultural transgender health competence, including hormone monitoring and neovaginal care [59]. However, Thai transgender women are agential in community-based health care settings [3] and exert resilience and resistance in everyday life. Recent scholarship has underscored the importance of social connections in protecting people across gender and sexual identifications from the health effects of stigma [60], and Thai transgender women have developed strong networks through which they share material resources, advice, and medical insights, helping to alleviate the social effects of stigma [3]. Their sharing of health and medical insights—both virtually and in person—is a form of "collective work," rewriting the paradigm that medical treatment is solely between a provider and the person seeking care [61]:91).

More broadly, ideals of gendered embodiment for cisgender and transgender people in Thailand are linked to governmental regimes that have asserted norms, codes, and regulations amidst broader global relations. Although Thailand was never colonized, appeals to Western tourists and desires to be read as "*siwilai*," or civilized, impacted gendered norms of embodiment [58]. Long hair was mandated for women by King Rama VI (1910–1925) to differentiate men and women in accordance with western norms of civilization ([62]:98). Dress codes emerged in a royal decree in 1941, emphasizing that Thais should dress "in accordance with civilization" [63]:73), adopting gendered styles to appease Western tastes. For example, [58]:424 found:

> The Thai state proffered and enforced sexual differentiation as a means to show its civilizational status and to resist colonial encroachment. In particular, the androgyny of Thai women in Western eyes compelled the state to require their feminization in dress, hair, and behavior.

In addition, state media control and censorship have shaped representations of gender minorities [58, 64]. Thai transgender women have previously appeared in the media as "comic, criminal, or tragic," but with a governmental shift in 2006, "there has been an explosion of more balanced and humane representations" [58]:425, [65]:480).

The urban capital of Bangkok also provides access "to the consumer products that allow for greater gender differentiation" [58]:422), as Thai cisgender and transgender people incorporate a variety of tools—including clothing, hormones, Botox fillers, or surgeries—to embody their ideals of sex, gender, and beauty. According to the *Bangkok Post* [66], over half of Thai cisgender women access services in local beauty clinics, while "six pack" surgeries on men became popular to etch the appearance of abdominal muscles [67]. Health behaviors and embodied health outcomes are thus steeped in specific markets for "technologies of embodiment"—or tools that modify the body, including makeup or a scalpel [68]. In turn, ecosocial theory's focus on consumer products lends insight into how commodified health

and medical technologies can also be used strategically amid discrimination [55]:673).

By illuminating Thai transgender women's experiences with discrimination in multiple settings and across societal levels, this article pinpoints interlocking issues related to stigma, discrimination, and stereotypes across the gender spectrum and institutional/cultural contexts. By bridging minority stress and ecosocial theory, it spotlights how cultural ideals of gendered embodiment impact health decision-making, and how structural and everyday discrimination intersect to create unique stressors and embodied health outcomes for Thai transgender women.

Methods and Epistemological Orientation

Global ethnographic methods attend to political, economic, and macro social structures and everyday lived experiences [69]:20). Ethnographic research unveils details of social life and "subterranean processes" that are not initially obvious [70]:60). This aligns with feminist standpoint theory, which draws on ethnographic methods to create an "alternate to objectified subject of knowledge of established social scientific discourse" [71]:328). The aim is to privilege the voices of people often excluded from mainstream research and discourses through interviews [72]:259). Furthermore, the ecosocial theory asserts that "methods must address the lived realities of discrimination as an exploitative and oppressive societal phenomenon operating at multiple levels and involving myriad pathways across both the life course and historical generations" [73]:936). While quantitative surveys or scales, such as those on discrimination and transphobia, can elucidate transgender people's experiences with self-stigma and rights, qualitative interviews allow participants to expand on their experiences in ways that quantitative measures might not allow, nuancing our empirical understandings of discrimination for marginalized people.

The article draws on in-depth interviews with 62 participants conducted from 2016 to 2021, and 14 months of fieldwork in Thailand, conducted in 2016 and 2017–2018. The fieldwork took place in the Bangkok metropolitan area, Nonthaburi, Phuket, and Pattaya, which are places where many Thai transgender women live and work. As part of a larger project about medical tourism in Thailand, the interviews included 36 Thai transgender women, six health care professionals, six officials from the Ministry of Public Health, four civil society members, three owners involved in the transgender entertainment industry, two medical tourism stakeholders, two private hospital CEOs, one official from Tourism Authority of Thailand, one medical tourist, and one representative from a United Nations–related agency.

All participants provided informed consent, and the research was approved by Institutional Review Boards in both the USA and Thailand. Participants agreed to be recorded as part of the consent process. Table 1 describes Thai transgender women's demographics.

I gained basic proficiency in Thai and was assisted by Thai translators in 33 interviews with Thai-speaking transgender women. Translators were extensively familiar with the specificities of sex, gender, and sexuality in Thailand, and they transcribed the interviews conducted in Thai. They also translated written materials from websites, social media, and news stories. Interviews typically lasted between 1 and 2 h. I recruited Thai transgender women through a health clinic that specialized in transgender health care, and snowball sampling, with participants referring me to other potential interviewees to diversify the sample. All Thai transgender women interviewed were provided monetary compensation (1000 *baht*, or US $33) for each interview, based on the guidelines of the transgender health clinic from which participants were recruited. Interviews were recorded for accuracy and edited slightly for grammar and coherence.

I developed the interview guide for transgender women in consultation with Thai transgender women and a Thai health practitioner who had years of experience working with and advocating for transgender people. Interview topic areas with Thai transgender women included the following: experiences in childhood, family background, gender identity formation, thoughts on identity categories, daily routines, experiences with health care, use of hormones, experience with and desires for gender-affirming surgeries, meanings and ideals of women and femininity, experiences with employment, ideal jobs, experiences with discrimination, their solutions to discrimination, legal identification cards, and broader life goals. I incorporated multiple probes to ask participants to expand on gendered cultural norms

Table 1 Thirty-six Thai transgender participant demographics

Age	Between 19 and 44 years old, average age of 27
Education	
Master's degrees	3
Bachelor's degrees	10
University students	7
High school graduate	10
Middle school graduate	2
Did not report	4
Employment	
Worked full-time	24
Worked part-time/freelancer	4
Full-time students	7
Unemployed	1
Average income for full-time workers	17,430 baht/month ($550 USD)

and their own experiences with discrimination across societal settings. The interview guide also included questions about demographic characteristics, including age, income, educational background, religion, and place of birth. The interviews addressed through open-ended questions how discrimination and treatment occur in everyday settings, allowing participants to describe how they made meaning of such experiences. Several participants expressed gratitude after interviews for the opportunity to reflect on and share their life experiences.

I used NVivo to code Thai transgender women's interview transcripts based on preliminary themes related to discrimination, gender and beauty ideals, general health care settings and encounters, medical services (e.g., hormones and surgeries), legal rights, family acceptance, and the media. Using minority stress and ecosocial frameworks, I then parsed out the different levels of discrimination occurring structurally (i.e., legally), institutionally (i.e., in different meso-level sites), interpersonally (in close relationships and in public/everyday settings), and internally. Figure 1 summarizes the levels of discrimination and aspects of resistance analyzed in this article.

During fieldwork, I visited public hospitals serving mostly Thais, a clinic specializing in transgender health care, and private clinics geared more towards medical tourists. I attended several LGBT+ activism events in Bangkok and participated in three regional meetings related to transgender health and social rights, which were sponsored by local, regional, and international organizations. I spent time with Thai transgender women at their workplaces. I triangulate the observations and interview data with analyses of state policies and tourism discourses, publications about Thai economic growth, and media reports.

My own experiences interfacing with norms of sex, gender, beauty, and embodiment in Thailand also shed light on the institutional and cultural pressures that Thai transgender women spoke about in interviews. During my fieldwork, for example, I was often handed flyers for lip fillers and other aesthetic services as I walked by multiple beauty clinics on the way to buy groceries. My everyday entanglement with gendered cultural norms, institutional settings (e.g., beauty clinics), and technologies of embodiment intersected with themes about gender and embodiment expressed by Thai transgender women.

Macro Structural Discrimination
- Lack of legal identification
- Employment access

Meso Institutional Sites
- Airports
- Health care settings (e.g. binary wards)
- Clubs (denied access)

Gendered Norms and Technologies
- Norms and ideals of femininity and beauty
- Stigma towards fatness and larger bodies
- Commodification of gendered health/medical technologies (e.g. Botox, surgeries)

Micro/Interpersonal
- Embarrassment, confusion, indignity with legal authorities (e.g. immigration officials, police)
- Treated as men or refused treatment by health care providers
- Name-calling
- Mockery
- Dehumanization
- Stereotypes of dishonesty

Micro/Internalized and Psychological Pressures
- Internalization of gender norms
- Pressures to pass as beautiful women
- "Tough" experiences complying with norms of femininity

Resistance/Agency
- Social networks (in-person and virtual)
- Decisions to access health/medical technologies
- Community health centers specializing in transgender health care

Fig. 1 Discriminatory pathways and resistances for Thai transgender women

I assigned participants pseudonymous nicknames to stay consistent with Thai cultural norms and ensure anonymity. Participants had a range of identifications: some preferred "*sao praphet song*," which translates to "second kind of woman." Others said this word denoted they were second-class citizens. Some said they were "women from the heart," while others said no matter which label they chose, they would still be stereotyped. Since some participants found some terminology offensive, I refer to participants as Thai transgender women as a whole, despite the imperfections of this categorization [74]. When quoting individual participants who self-identified, I refer to them using the terminology they used for themselves.

Findings

In the findings below, I first analyze how structural discrimination manifests for Thai transgender women through their lack of legal recognition, presenting issues across a range of meso-level sites and in a variety of interpersonal settings. Next, I focus on Thai transgender women's specific experiences in meso-level health care settings, raising questions about self-reported discrimination and unfair treatment. The article then analyzes how Thai transgender women encounter and resist discrimination associated with cultural norms of gender and femininity, as some decisions to use various technologies of embodiment are structured within this context. Using minority stress theory, the article underscores the unique stressors, pressures, stereotypes, and stigmas for Thai transgender women—while ecosocial theory helps illuminate the simultaneous micro, meso, and macro dimensions of Thai transgender women's experiences with, and resistances to, discrimination.

Structural Discrimination and Legal Identification Cards

This section pinpoints Thai transgender women's lack of legal identification as one of the "explicit laws and rules" ([14]:48) that directly impacts experiences with discrimination and minority stress across a range of meso-level sites and micro-level interactions. In addition to encounters with legal authorities (e.g., immigration officials and police), aspects of daily life for Thai transgender women—even for those who do pass as beautiful women—can be stressful, hurtful, and marginalizing as a result of their legal identification cards displaying a male gender marker.

Due to her legal identification card not matching her gender identity and presentation, Sim, a *sao praphet song* who is a cabaret performer, reflected on the confusion and additional time she spent with immigration authorities while traveling across borders. Sim said, "When I go to some countries by myself or with my boyfriend, like in Japan, I've got to talk with immigration officers. It takes me more time to explain to them. My passport is the problem… Here in Thailand, they still [indicate the name title on the passport] so the immigration officer will be confused when I go to their country, [asking] like, 'Which sex are you really?'" Sim spoke about her experiences with the extra considerations and emotional labor that may arise for transgender people when traveling [75].

Structural discrimination also manifested in Sim's encounters with police authorities, as she said she was treated "disgracefully" when she was pulled over. Sim recalled, "Police officers did not provide me any room or partition for protecting me to urinate on a test stick. I fully agreed to their request – but the way I was disgracefully treated is very disgusting. They did not even care about my human dignity. They just cared about the test result." She continued, "We [transgender women] were not allowed to use a toilet. Perhaps, they might have thought that I had not yet had [genital surgery]. I felt so embarrassed. We are supposed to be treated as a woman, but they didn't." Sim felt undignified without basic considerations of privacy due to her gender. Sim implied that her surgical status (what she referred to as "sexual reassignment") should have afforded her treatment as a woman, but instead she was made to feel embarrassed.

While it is beyond the scope of this article to analyze Thai transgender women's experiences with employment discrimination, Chip, who identifies as transgender, believed her legal identification card specifically hindered her from occupational opportunities. She said, "When I applied for a part-time job during my university years, my applications were sent to a lot of places, but my facial and body appearance did not match with my name title shown on my identity card as 'Mister.' My applications were denied without any supporting reasons several times. Perhaps, [they thought] *sao praphet song* deserved not to be [hired for] any conventional jobs. Sometimes, we are limited in access to job opportunities …" Chip pinpointed how the legal identification card might have impacted her employment options, while speculating whether employers deny work to transgender people, who she says are "limited" in access to work.

Legal identification cards can not only structure discriminatory encounters with authorities such as police, immigration officers, and employers, but also impact Thai transgender women's access to meso-level spaces, as stereotypes persist about transgender women. For instance, Jin, a beauty pageant winner, reflected that she was not allowed into bars because her legal identification shows she is transgender. She recalled a time when she visited Bangkok from her hometown Northeastern province of Sakon Nakhon, stating:

> When I go out or go to the bars, they check my ID and as soon as they realize that I am *sao praphet song*, they don't let me in… There are many places [that do this] around Bangkok. You can absolutely check it out. I wish I could stand up for the *sao praphet song* to obtain equal rights. We also want to go out and be able to have fun just like other people. There are many places [that discriminate] like *Sukhumvit* and *Khao San* Road. I was just in *Khao San* the other day. I was just an ordinary tourist who wanted to go out, but because I'm *sao praphet song* I was not allowed in the club… I was told that *sao praphet song* cause problems, quarrels, and fighting. That's what they said.

This facet of discrimination involves stereotyping and stigma, while Jin emphasized the structural elements of this discrimination: her legal ID card. Even though Jin herself was a tourist visiting Bangkok from an outside province, her experience demonstrates how transgender acceptance is not always afforded to Thais. With societal stereotypes baked into her denial to access a club, Jin said, "They shouldn't judge me right away just because my ID shows that I am a man but my body is like this… I should be able to go to the club…. Obviously this is discrimination. It's not okay." Using ecosocial theory, we see clearly how the macro-level element of legal identification impacted Jin's access to meso-level settings and manifested in these micro-level discriminatory encounters. With minority stress theory, we see how such experiences and encounters impact Jin's psychological experiences—as she is not allowed to "go out and be able to have fun" like cisgender people or foreign tourists. In this example, Jin is clear about what is "obviously" discrimination, pinpointing her desire to "stand up for… equal rights." This example serves as a contrast to how others described their treatment in health care settings, analyzed in the next section.

Integrating ecosocial theory with minority stress theory elucidates how multiple societal levels (micro interactions, meso settings, and macro laws) converge in the discriminatory experiences faced by Thai transgender women. As they attempt to move through different spaces and settings with legal identification cards they are unable to change, Thai transgender women can experience indignity, embarrassment, and confusion. Participants recalled how negative stereotypes impacted their access to spaces such as clubs, as well as employment opportunities, as their legal identification cards were mechanisms through which such decisions were made. Legal identification cards are thus a structural pathway through which discrimination and differential treatment manifest in a variety of settings and encounters.

I now discuss the meso-level setting of health care and how participants perceived their treatment.

Health Care Settings and Encounters: Contradicting Categorizations

Health care interactions are a "microcosm of the intergroup dynamics," manifested through the behaviors and attitudes of providers, and dynamics between people seeking care [76]:519). Here, too, the structural element of legal identification cards undergirds Thai transgender women's experiences and encounters, illuminating how macro-level policies manifest in meso-level situations and micro-level encounters. Although some participants encountered structural barriers and stereotypes in health care settings, they did not always view such occurrences as problematic or discriminatory. The contradictions in the categorization of discrimination demonstrate the multiplicity of experiences within heterogenous and dynamic social groups [77], as well as "concerns about self-report measures" [14]:51) regarding discrimination.

Sunny, who was hospitalized for a severe car accident, said that she was "not that satisfied" with the medical checkup procedure, as doctors were "treating [her] as a male patient rather than female." Sunny recalled:

> When I had to be washed up, for instance, they were slightly reluctant whether a male or female nurse needed to handle the task to look after me. Then they decided to ask my parents to be responsible for this task instead of themselves. Another example occurred when I got my upper abdomen x-rayed, the male nurse told me that I had to be strong and masculine, as my physical body still looked like a straight guy.

While Sunny encountered nurses who refused to bathe her, the task was left to her parents instead. She also interacted with health care providers who did not validate her gender identity, as she said she was also treated as a male when receiving an x-ray, with a male nurse stating her body still looked male.

While Sunny was clear about not being that satisfied with health care services, other Thai transgender women did not classify their health care experiences as problematic or discriminatory. Sometimes, they made light of the situation or accepted their treatment as a fact of the system. Bee, whose parents had to bathe her after a car accident when nurses refused, did not distinctly classify her experiences as problematic. Instead, she said it was "difficult to say whether I was treated equally or not." Her difficulty categorizing this refusal of care as equal or not might be an instance of internalized stigma or self-stigma, wherein marginalized people have absorbed negative societal beliefs about their rights [78]. How would a quantitative survey capture such an experience if respondents themselves are conflicted about whether to count it as discriminatory?

Gan, who identifies as a woman from the heart, laughed gently when she stated she stayed in a male patient room, saying it was "fine" and "not a problem." She added that she did not want to stay in the female ward: "The [wards] are separated like this. Even *kathoey* who already transitioned will be put in the male room." Gan accepted the binary divisions in hospitals as the structural order, not believing it is necessary to be treated with other women. Similar to Sim's explication of surgical status warranting different treatment, mentioned in the previous section, Gan explicated how those who have had surgery are not afforded a female room, emphasizing how the binary order does not change "even" for them.

Other participants acknowledged that awkwardness in health care interactions is normal when their legal identification cards do not match their gender presentation. Kitti said that when she was admitted to the hospital, "staff just felt awkward that my face didn't match with my male name and my short-haired identification card [photo]. But there's nothing bad about it. But when the doctor had to come, he couldn't find me, because of my male name." Kitti accepted confusion and awkwardness about her gender in health care settings, as ecosocial theory illuminates how the structural discrimination of legal identification cards filters into meso-level health care settings and micro-level interactions between providers and people seeking care.

As Kitti did not express any negative psychological outcomes of such binary rules, Mon said she appreciated the ways that hospital staff have accommodated transgender women, even in binary spaces, stating, "If we don't have money to pay for a special hospital room, we need to be sent to a male ward because our title is 'mister.' But [in this case] the hospital tries to help us, for example, [they] move male patients a bit further, or let us sleep outside the room in front of the elevator. But we can never stay in women's ward." While Mon speculated that policy changes could allow transgender women to stay in women's wards, she viewed sleeping in front of the elevator as helpful.

Yet in an interview with Patcharin, a founding member of the Thai LGBT+ activist movement, her eyes welled up with tears when she described occurrences of transgender people being denied a proper hospital room. Patcharin said, "There are stories of transgender women [in hospitals] who were refused to join female wards and refused to join in men's, and put in the corridor because there is no ward to go to." Patcharin looked out the window at the motorcycles buzzing past on the street outside, and then looked back at me, stating, "When these things happen, they are out of sight by their communities and [happen] when you're most vulnerable – so people can't defend themselves or get services." According to Patcharin, the binary setup of hospital wards, and interpersonal relations that take place between health care providers and transgender people, are key forms of inequality. Although some participants accepted, or viewed it as helpful, that hospital staff allow transgender people to sleep outside of the wards in front of an elevator, this was a structural inequality that made activists such as Patcharin visibly upset.

The differences in the categorization of treatment and discrimination in health care settings raise questions about how group members, activists, practitioners, and researchers describe or categorize the experiences of marginalized people with health and heath care worldwide. There can be "controversies abound over which behaviors, enacted by whom, against whom, should count [as discrimination], and how best to counter fears and internalized blame that contribute to underreporting" ([14]:5). What strikes one person as discriminatory might be seen as a helpful strategy or a fact of life for another. The variances in categorization demonstrate that there is no clear or universal narrative of "rights," and that even within groups, there are major differences in how people experience, and report, their realities and social worlds. Cultural norms about sex and gendered embodiment directly impacted health care interactions for Thai transgender women, as legal identification cards structure their encounters. In addition to creating health clinics that specialize in transgender care, Thai transgender health practitioners and activists have more recently mobilized to train health care providers in cultural and clinical competency, creating The Thai Handbook of Transgender Healthcare Services [59] to fill gaps in medical education.

I now discuss how everyday discrimination manifests based on hierarchical norms of gender and beauty, impacting Thai transgender women's decisions to use various health and medical technologies amid pressures to pass as beautiful women.

Gender Norms as Discriminatory Pathways, and Embodied Resistances

Many Thai transgender women expressed how societal acceptance and humane treatment are dependent on one's adherence to cultural norms of gender and beauty. If and when they do not conform to embodied ideals of gender and beauty, they encounter stigma, which "punish[es] those who step outside normative boundaries" [79]:661), and can harm health [80]. In this case, stigma towards those who do not comply with gendered ideals of beauty results in everyday discrimination, such as receiving less courtesy or encountering name-calling. Some Thai transgender women's decisions to access surgeries or control their food intake occurred amid everyday discrimination and cultural pressures to pass as beautiful women, illuminating how gender-based discrimination is a pathway to health in this context.

LGBT+ activist Patcharin expressed that complying with a rigid gender binary affords more opportunities for

cisgender and transgender people. Patcharin said, "Society is pushing people one way or the other – you have to be either a man or woman – and be a man this way, woman that way. There are a few types of man and woman, but still you have to fit those things… [F]eminine women have been encouraged to be so, and have managed and have succeeded social expectations, so they have much more space in society and confidence." Patcharin describes the "limited" binary options for gendered embodiment, and how "more space" exists for women who appear feminine. Such binary gender norms impact Thai transgender women's health behaviors, decision-making, and daily life.

According to Fai, a transgender woman, being a woman is a "tough experience" in daily life. She said, "It's not [just] about having to transform your body to fit with the feminine standard. You also need to shape your manner to fit the standard as well: the way you dress, the way you sit, the way you talk, the way you eat right, the way you speak, the way you release your voice – everything." Fai speaks to the gendered bodily pressures of maintaining social status in Thailand as a woman. The unique "tough[ness]" of everyday activities—from dressing, sitting, eating, and speaking—indicates the stressors and pressures Thai transgender women can face in everyday life.

Thai transgender women spoke to what they perceived were explicit differences in societal treatment for those who passed as beautiful women versus those who do not. For instance, Mon said, "If you want to be accepted by society, you have to look great. And trans women [are] always pressured, so they need to come up farther than others... If you are an ugly transgender, you are a clown. People can [treat you badly], they can dehumanize us as they want. But if you are beautiful, people will talk to you very softly... I experienced [this] myself, because I'm not beautiful…" Pinpointing the pressure and stakes of looking beautiful, Mon spoke to differential treatment and "dehumaniz[ation]" for those who are not beautiful, who she said are considered a "clown." Mon's emphasis on the unique pressures faced by transgender women demonstrates levels of stress they face to "come up farther than," or prove themselves, to others. While in the previous section, Mon did not classify her health care experiences as discriminatory, here she explicates how dehumanization, name-calling, and poor treatment manifest in everyday life based on looks.

Other participants also shared how they receive differential treatment and acceptance based on their beauty. Pim, a *sao praphet song*, said, "Based on the fact that people tend to [judge] others according to their appearance… I [could] be widely accepted if I could be a beautiful and attractive woman." With social acceptance linked to beauty, Goldie echoed, "If I am considered beautiful, people will talk to me very nicely. If I am ugly, I will get another style of talking." As Goldie emphasized courtesy being hinged on one's appearance, Kitti agreed that beauty is a social "value," mentioning the pejorative labeling of people who are not beautiful, stating, "In my hometown, which is a rural community, men always praise beautiful girls… If I am beautiful, boys will treat me like a princess, but if I am ugly, they will see me as a clown or terrifying person." Kitti echoed the labeling of "clown," while noting the difference of treatment in her rural hometown location, as different community environments impact discriminatory treatment.

Pinpointing the role of consumption as a pathway to embodiment [51], Jaya delineated what she interpreted as ubiquitous Thai gender norms, including white skin and being small, while underscoring how surgical technologies can help achieve these norms. Jaya said, "For me, I think beauty in Thailand has a rigid pattern. It is up to marketing in advertising, such as having a small face, long hair, small body, white skin. I think every transitioned transgender person wants to become like those patterns… So, surgery is popular among us to help us achieve social norms about beauty." The emphasis on whiteness is not about appearing white or Western, but instead reveals the embodiment of cosmopolitan norms [68]. While one other participant explicitly mentioned light skin, accessing tools such as surgery allowed many participants to embody this "pattern" of femininity.

Alongside tools such as makeup, clothing, hair styles, and hormones, Thai transgender women's decisions to undergo surgeries took place amid cultural pressures to pass and be read as beautiful, and the consequential everyday discrimination for those who did not. For instance, Bee said, "When I decided to transform myself into a woman, I wish[ed] I could be a beautiful, appealing, and attractive lady. That is simply why being as close to a woman is my highest goal." Similarly, Kitti mentioned how surgeries can allow transgender women pass, or be read as women, stating, "Surgery can help transgender people look like a woman. For example, if your nose is not smooth, you can fix it by surgery. Or even your cheeks and your eyes." Thai transgender participants spoke about how they accessed health and medical technologies to pass as beautiful women, which may in turn allow some to avoid name-calling and discrimination.

Thai transgender women also spoke about negative associations with being larger, reflecting cultural norms of embodiment regarding body size. For instance, Mon said, "If you are big, you will be called "*kathoey-kwai*" (buffalo transgender). Like, 'You are this big, why do you still dress like a woman?'" Echoing societal stigma and identifying the names given for larger bodies, Oom, a *sao praphet song*, shared these beliefs, stating, "Somebody who took hormones but is still not soft like a woman can choose outfits to help their looks. Sometimes their bodies are very big, but they still buy small clothes. When they wear that, it doesn't seem okay for me." Emphasizing and internalizing the

norms that women should not appear big, Oom underscores that being soft and small are key traits for gendered embodiment and social acceptance.

Gendered ideals that women should be smaller impacted not just clothing choices, but also access to surgeries and Botox. Bee remarked, "For the body parts that still look like a man, we can do surgery to make them smaller. Like for the face, I can do Botox to make my face smaller, to look more like a woman." In the context of name-calling and mistreatment, Bee spoke about how societal norms of beauty positioning women as smaller altered her health behaviors, as the technology of Botox enabled her to look more like a woman.

In response to negative associations with larger bodies, some Thai transgender women also changed their dieting behaviors. Chip, a transgender woman, spoke about her experiences taking diet pills after gaining weight from hormones. Gan remarked that her dream of joining a beauty pageant would require her to go on a diet, stating, "I want to join Miss Tiffany [Pageant] as well, but I have to lose weight first. Most contestants are skinny; there is not a single fat person." With the entertainment industry a dominant site through which norms of gendered embodiment circulate, Gan sought to modify her diet to cohere with such ideals.

To avoid stigma, mistreatment, and being called names, Thai transgender women often sought to adhere to beauty standards and cultural norms of gendered embodiment, with some participants deeming it a "pressured" and "tough experience." Thai transgender women's decisions to modify their bodies with surgeries, aesthetic services, or diets took place amid discrimination towards those who do not conform to such cultural norms. This demonstrates how gender socialization processes and ideals of femininity are a distinct pathway to accessing surgeries/medical technologies, as well as eating and weight/shape control, particularly as global, regional, and local cultural frames prize thinness [36, 81, 82, 83]). Stress and embodiment are structured by power, as everyday discrimination and pressures to adhere to dominant norms of gender and beauty impact Thai transgender women's health behaviors. The context of commodified health and medical technologies allows them to resist mistreatment and gain social acceptance—with drawbacks of this strategy discussed next in the "Conclusion and Implications" section.

Conclusion and Implications

This article has integrated minority stress and ecosocial theories to analyze how Thai transgender women's experiences with structural and everyday discrimination impact health outcomes, disparities, and health decision-making. The inability to change gender markers on legal identification cards is a discriminatory structural mechanism that impacts mistreatment and indignity for Thai transgender women across a variety of meso-level settings and micro-level interactions. Cultural ideals of feminine beauty—and stigma/stereotypes towards those who do not comply with such norms—can also create pressure to pass, serving as a pathway to health decision-making and gendered embodiment. Thai transgender women's exposure to discrimination, disrespect, and dehumanization can potentiate stress-related health problems throughout their lives [60]:1). Policies, cultural norms/hierarchies, and institutional contexts intersect with micro-level interactions and individual experiences, as proximal and distal stressors are not distinct (temporally or spatially), but are interwoven and interacting simultaneously [51, 73].

In the meso-level settings of health care, Thai transgender women encountered services in which they were misgendered, not treated, or treated as men. Yet, not all participants reported their experiences in health care settings as problematic or exclusionary, in contrast to the framing by an LGBT+ activist. This illuminates how perceived discrimination varies within groups and across cultural contexts and meso-level settings. In this case, there are differences in "what constitutes dignified treatment versus the denial of dignity" [73]:939), as there is no "unified doctrine" of knowledge [84]:262), nor a universal approach related to minority stress and discrimination. These findings raise questions about the hierarchies of knowledge production and universalized human rights discourses, issues which require a researcher's continued self-reflexivity and awareness of institutionalized power dynamics.

Amid the growth of commodified health and medical technologies, hierarchies of gender and beauty impact micro-level mental and physical health outcomes [36, 82, 83, 85, 86], while resistance can involve using "technologies of embodiment" [68]—such as surgeries, clothing, or Botox—to gain social acceptance. Although Thailand is framed in dominant discourses as an LGBT+ paradise [58, 87], some Thai transgender women reported name-calling and mistreatment if they were not perceived as beautiful women. The "tough experience" of embodying gendered ideals intersects with the structural and interpersonal discrimination they also face across settings, as using health or medical technologies allowed Thai transgender women to pass as women and receive greater courtesy. While this strategy of resistance allows some Thai transgender women to avoid mistreatment, such rigid cultural norms continue to punish those who cannot afford, or do not want to, modify their bodies. The strategy of attempting to avoid discrimination by using health/medical technologies places the responsibility on Thai transgender women, versus broader social policy and societal shifts.

Research, policy, and advocacy can continue to illuminate interlocking issues related to stereotypes, stigma, and resistance by focusing on transgender people's experiences

with, and perceptions of, discrimination throughout the world. Qualitative interviews allow participants to expand on their experiences in the health care setting in ways that quantitative surveys might obscure, providing narrative accounts rather than just a numerical or yes/no answer. There are also regional blueprints that consider cultural specificities and differences to address transgender people's specific needs [88]. Rather than using a one-size-fits-all approach to measure discrimination and self-stigma across diverse groups, existent models such as the Everyday Discrimination Scale [33] may be further crafted to reflect linguistic nuances and the lived realities of marginalized groups across time and place. Using unique scales to account for self-stigma might allow research on health disparities and gender to better capture the context that undergirds how one frames their experiences with rights and/or oppression.

In the Thai context, future research can seek to diversify participant samples by including people from more regions in which Thai transgender women live, such as in Northern areas, as well as seeking greater diversity in socioeconomic status. Research on transgender health more broadly can diversify the age of participants to shed light on interlocking issues over the life course [89]. Scholarship has also sought to alleviate the "joy deficit" in sociological research about transgender people [4]. Aligning with Krieger's [73] call for a focus on resilience, resistance, and agency, future research can include interview and survey questions about how transgender and gender-diverse people cultivate joy worldwide. What is the meaning of joy for transgender people in different settings, and how do people feel joy across cultural and structural contexts? Qualitative data can provide rich insights into transgender joy across time, place, and culture by using interviews, focus groups, arts-based methods, or community-based participatory research. Quantitative scales could also be devised to understand joy across different social and cultural contexts.

Global transgender equity involves the removal of discriminatory laws, policies, and practices, as well as access to culturally-competent health care [90]. Given the specific health issues for transgender people throughout the world—including access to social rights and gender-affirming health care—it is critical that research continue to focus on their experiences worldwide. Research can apply both minority stress and ecosocial theories to global transgender health, analyzing how embodied and mental health disparities emerge across multiple levels of society, and attending to power, hierarchies, and injustices. By demonstrating the interaction between micro, meso, and macro societal levels, we gain a deeper understanding of how mental and embodied health disparities are constructed, which can enable more tailored interventions to alleviate such disparities.

Acknowledgements Thank you to Elyas Bakhtiari, Fernando Galeana Rodriguez, and Meaghan Stiman for their constructive feedback on this manuscript. Thank you to Cati Connell and Joseph Harris for their support and feedback on earlier iterations. I am indebted to the research assistance of Gabriel Seubboon Chaiyasit, Suphakrit Jitrarat, and Kevin Laddapong. Most sincere thanks to the participants, who shared their time, thoughts, and trust.

Author Contribution Reya Farber: conceptualization, methodology, validation, formal analysis, investigation, resources, data curation, writing—original draft, writing—review & editing, visualization, Funding acquisition.

Funding This material is based upon the work supported by a National Science Foundation Graduate Research Fellowship under Grant No. DGE-1247312, Boston University Graduate School, and Boston University Sociology Department Morris Funds.

Data Availability This data is not available publicly.

Declarations

Ethics Approval This study was approved by International Review Boards in the USA and Thailand.

Consent to Participate The author affirms that all research participants provided informed consent.

Competing Interests The author declares no competing interests.

References

1. Reisner SL, Poteat T, Keatley J, Cabral M, Mothopeng T, Dunham E, Holland CE, Max R, Baral SD. Global health burden and needs of transgender populations: a review. The Lancet. 2016;388(10042):412–36.
2. Hanssmann C. Epidemiological rage: population, biography, and state responsibility in trans-health activism. Soc Sci Med. 2020;247: 112808.
3. Lynne A, Enteen JB. Thai trans women's agency and the destigmatisation of HIV-related care. Cult Health Sex. 2022;24(9):1153–67.
4. Shuster SM, Westbrook L. Reducing the joy deficit in sociology: A study of transgender joy. Social Problems. 2022.
5. Meyer IH. Minority stress and mental health in gay men. J Health Soc Behav. 1995:38–56.
6. Hendricks ML, Testa RJ. A conceptual framework for clinical work with transgender and gender nonconforming clients: an adaptation of the minority stress model. Prof Psychol Res Pract. 2012;43(5):460.
7. Hughto JM, Reisner SL, Pachankis JE. Transgender stigma and health: a critical review of stigma determinants, mechanisms, and interventions. Soc Sci Med. 2015;147:222–31.
8. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. Psychol Bull. 2003;129(5):674.
9. Olmos B, Nava A, Jones EJ. Theory integration for examining health care discrimination among minoritized older adults with chronic illness. West J Nurs Res. 2022;17:01939459221128123.
10. Valentine SE, Shipherd JC. A systematic review of social stress and mental health among transgender and gender nonconforming people in the United States. Clin Psychol Rev. 2018;66:24–38.

11. Chodzen G, Hidalgo MA, Chen D, Garofalo R. Minority stress factors associated with depression and anxiety among transgender and gender-nonconforming youth. J Adolesc Health. 2019;64(4):467–71.
12. Testa RJ, Habarth J, Peta J, Balsam K, Bockting W. Development of the gender minority stress and resilience measure. Psychol Sex Orientat Gend Divers. 2015;2(1):65.
13. Kittiteerasack P, Matthews AK, Steffen A, Corte C, McCreary LL, Bostwick W, Park C, Johnson TP. The influence of minority stress on indicators of suicidality among lesbian, gay, bisexual and transgender adults in Thailand. J Psychiatr Ment Health Nurs. 2021;28(4):656–69.
14. Krieger N. Measures of racism, sexism, heterosexism, and gender binarism for health equity research: from structural injustice to embodied harm-an ecosocial analysis. Annual review of public health. 2020;41:37–62.
15. Stanhope KK, Comeau DL, Ulloa M, Leon JS, Suglia SF, Hogue CJ, Kramer MR. Perceptions of stress and resilience among Latina women enrolled in prenatal care in Metro Atlanta through an ecosocial lens. Health Soc Care Community. 2021;29(6):e348–58.
16. Tourism Authority of Thailand. Go Thai, Be Free. 2023. https://www.gothaibefree.com. Accessed 1 Dec 2022.
17. Laphon C, Chuemchit M. Social stigmatization access to services and service satisfaction among transgender persons at Thai red cross AIDS research center-tangerine project: a qualitative study. Journal of Health Research. 2017;31(Suppl. 2):S195-201.
18. Farber R. Gender, health, and labor in Thailand's medical hub. Soc Sci Med. 2022a;301:114950.
19. Farber R. 'Don't think that we die from AIDS': invisibilised uncertainty and global transgender health. Sociol Health Ill. 2022b.
20. UNDP and APTN. "Legal Gender Recognition: A Multi-Country Legal and Policy Review in Asia." 2017. https://weareaptn.org/resource/legal-gender-recognition-amulti-country-legal-and-policy-review-in-asia/.
21. Sun S, Budge S, Shen W, Xu G, Liu M, Feng S. Minority stress and health: a grounded theory exploration among men who have sex with men in China and implications for health research and interventions. Soc Sci Med. 2020;1(252): 112917.
22. De Maio FG. Understanding chronic non-communicable diseases in Latin America: towards an equity-based research agenda. Glob Health. 2011;7(1):1–8.
23. Gustafsson PE, Linander I, Mosquera PA. Embodying pervasive discrimination: a decomposition of sexual orientation inequalities in health in a population-based cross-sectional study in Northern Sweden. International Journal for Equity in Health. 2017;16(1):1.
24. Figert AE, Bell SE. Big Pharma and Big Medicine in the global environment. In Routledge handbook of science, technology, and society 2014 (pp. 456–470). Routledge.
25. Farber R, Harris J. American medical sociology and health problems in the global south. Sociol Perspect. 2022.
26. Bakhtiari E. The missing mortality advantage for European immigrants to the United States in the early twentieth century. Demography. 2022;59(4):1517–39.
27. Dürrbaum T, Sattler FA. Minority stress and mental health in lesbian, gay male, and bisexual youths: a meta-analysis. J LGBT Youth. 2020;17(3):298–314.
28. Link BG, Phelan JC. Conceptualizing stigma. Annu Rev Sociol. 2001:363–85.
29. Pearlin LI. The sociological study of stress. J. Health Soc Behav. 1989:241–56.
30. Thoits PA. On merging identity theory and stress research. Soc Psychol Q 1991:101–12.
31. Hatzenbuehler ML, Phelan JC, Link BG. Stigma as a fundamental cause of population health inequalities. Am J Public Health. 2013;103(5):813–21.
32. Hatzenbuehler ML. Structural stigma: Research evidence and implications for psychological science. Am Psychologist. 2016;71(8):742.
33. Williams DR, Yu Y, Jackson JS, Anderson NB. Racial differences in physical and mental health: socioeconomic status, stress, and discrimination. J Health Psychol. 1997;2(3):335–51.
34. Brewer G, Hanson L, Caswell N. Body image and eating behavior in transgender men and women: the importance of stage of gender affirmation. Bulletin of Applied Transgender Studies. 2022;1(1–2):71–95.
35. Cusack CE, Cooper M, Libbey N, Galupo MP. Rumination & eating psychopathology among trans and nonbinary individuals: a path analysis integrating minority stress. Eat Behav. 2021;1(42): 101544.
36. Gordon AR, Austin SB, Krieger N, Hughto JM, Reisner SL. "I have to constantly prove to myself, to people, that I fit the bill": perspectives on weight and shape control behaviors among low-income, ethnically diverse young transgender women. Soc Sci Med. 2016;165:141–9.
37. Karrington B. The experiences of transmasculine people with contraception and menstruation: a literature review of qualitative and mixed method studies. Transgender Health. 2021;6(6):303–14.
38. Sotto-Santiago S. Time to reconsider the word minority in academic medicine. Journal of Best Practices in Health Professions Diversity. 2019;12(1):72–8.
39. Bockting WO, Miner MH, Swinburne Romine RE, Hamilton A, Coleman E. Stigma, mental health, and resilience in an online sample of the US transgender population. Am J Public Health. 2013;103(5):943–51.
40. Williams SL, Mann AK. Sexual and gender minority health disparities as a social issue: how stigma and intergroup relations can explain and reduce health disparities. J Soc Issues. 2017;73(3):450–61.
41. Nadal KL, Rivera DP, Corpus MJH. Sexual orientation and transgender microaggressions: implications for mental health and counseling. In DW Sue (Ed.), Microaggressions and marginality: Manifestation, dynamics, and impact (pp. 217–240). John Wiley & Sons, Inc; 2010.
42. Corrigan PW, Watson AC. The paradox of self-stigma and mental illness. Clin Psychol Sci Pract. 2002;9(1):35.
43. Boyd JE, Otilingam PG, DeForge BR. Brief version of the internalized stigma of mental illness (ISMI) scale: psychometric properties and relationship to depression, self esteem, recovery orientation, empowerment, and perceived devaluation and discrimination. Psychiatr Rehabil J. 2014;37(1):17.
44. Reyes ME, Alcantara AR, Reyes AC, Yulo PA, Santos CI. Exploring the link between internalized stigma and self-concept clarity among Filipino transgenders. N Am J Psychol 2016;18(2).
45. Mak WW, Cheung RY. Self-stigma among concealable minorities in Hong Kong: conceptualization and unified measurement. Am J Orthopsychiatry. 2010;80(2):267.
46. Wagner GJ. Internalized homophobia scale. Handbook of sexuality-related measures. 1998;371–2.
47. Lee H, Tomita KK, Habarth JM, Operario D, Yi H, Choo S, Kim SS. Internalized transphobia and mental health among transgender adults: a nationwide cross-sectional survey in South Korea. International Journal of Transgender Health. 2020;21(2):182–93.
48. Ogunbajo A, Iwuagwu S, Williams R, Biello KB, Kahler CW, Sandfort TG, Mimiaga MJ. Experiences of minority stress among gay, bisexual, and other men who have sex with men (GBMSM) in Nigeria, Africa: the intersection of mental

health, substance use, and HIV sexual risk behavior. Glob Public Health. 2021;16(11):1696–710.
49. Jäggi T, Jellestad L, Corbisiero S, Schaefer DJ, Jenewein J, Schneeberger A, Kuhn A, Garcia ND. Gender minority stress and depressive symptoms in transitioned Swiss transpersons. Biomed Res Int. 2018;19:2018.
50. Sha Y, Dong W, Tang W, Zheng L, Huang X, Muessig KE, Tucker JD. Gender minority stress and access to health care services among transgender women and transfeminine people: results from a cross-sectional study in China. BMC Infect Dis. 2021;21(1):1–9.
51. Krieger N. Proximal, distal, and the politics of causation: what's level got to do with it? Am J Public Health. 2008;98(2):221–30.
52. Krieger N. Epidemiology and the people's health: theory and context. Oxford University Press; 2011.
53. Krieger N. Ecosocial theory, embodied truths, and the people's health. Oxford University Press; 2021.
54. Ridgeway CL. Why status matters for inequality. Am Sociol Rev. 2014;79(1):1–16.
55. Krieger N. Theories for social epidemiology in the 21st century: an ecosocial perspective. Int J Epidemiol. 2001;30(4):668–77.
56. Miller LR, Grollman EA. The social costs of gender nonconformity for transgender adults: implications for discrimination and health. In Sociological Forum. 2015;30(3):809–31.
57. Jackson PA. Male homosexuality and transgenderism in the Thai Buddhist tradition. Queer dharma: voices of gay Buddhists. 1998;1:55–89.
58. Käng DB. Conceptualizing Thai genderscapes: transformation and continuity in the Thai sex/gender system. In Contemporary socio-cultural and political perspectives in Thailand 2014 (pp. 409–429). Springer, Dordrecht.
59. The Thai Handbook of Transgender Healthcare Services. Center of Excellence in Transgender Health, Chulalongkorn University. 2021. https://ihri.org/wp-content/uploads/2021/09/The-Thai-Handbook-of-Transgender-Heatlhcare-Services.pdf. Accessed 1 Dec 2022.
60. Diamond LM, Alley J. Rethinking minority stress: a social safety perspective on the health effects of stigma in sexually-diverse and gender-diverse population. Neurosci Biobehav Rev. 2022.
61. Connell R. Transgender health: on a world scale. Health Sociol Rev. 2021;30(1):87–94.
62. Pravattiyagul J. Street and state discrimination: Thai transgender women in Europe (Doctoral dissertation, Utrecht University). 2018.
63. Peleggi M. Refashioning civilization: dress and bodily practice in Thai nation-building. The politics of dress in Asia and the Americas. 2007:65–80.
64. Fuhrmann A. Ghostly desires: queer sexuality and vernacular Buddhism in contemporary Thai cinema. Duke University Press; 2016.
65. Käng DB. Kathoey "In trend": emergent genderscapes, national anxieties and the re-signification of male-bodied effeminacy in Thailand. Asian Stud Rev. 2012;36(4):475–94.
66. Thepbamrung, N, Ruffles, M. Bangkok Post. Dangerous beauty industry operates beneath the surface. 24 November 2013. https://www.bangkokpost.com/thailand/special-reports/381424/dangerous-beauty-industry-operates-beneath-the-surface. Accessed 1 December 2022.
67. Kamolvattanavith, T. Coconuts Bangkok. Gym-weary Thais going under knife for instant 6-packs. 26 April 2019. https://coconuts.co/bangkok/news/gym-weary-thais-going-under-knife-for-instant-6-packs-photos/. Accessed 1 December 2022.
68. Hoang KK. Competing technologies of embodiment: Pan-Asian modernity and third world dependency in Vietnam's contemporary sex industry. Gend Soc. 2014;28(4):513–36.
69. Boellstorff T. The gay archipelago: Sexuality and nation in Indonesia. Princeton University Press; 2006.
70. Burawoy M. The extended case method: Four countries, four decades, four great transformations, and one theoretical tradition. Univ of California Press; 2009.
71. Smith DE. Institutional ethnography: a sociology for people. Rowman Altamira; 2005.
72. Collins PH. Gender, black feminism, and black political economy. Ann Am Acad Pol Soc Sci. 2000;568(1):41–53.
73. Krieger N. Methods for the scientific study of discrimination and health: an ecosocial approach. Am J Public Health. 2012;102(5):936–44.
74. Aizura AZ. Mobile subjects: transnational imaginaries of gender reassignment. Duke University Press; 2018.
75. Olson ED, Reddy-Best K. "Pre-topsurgery, the body scanning machine would most likely error:" Transgender and gender nonconforming travel and tourism experiences. Tour Manage. 2019;70:250–61.
76. Major B, Mendes WB, Dovidio JF. Intergroup relations and health disparities: a social psychological perspective. Health Psychol. 2013;32(5):514.
77. Krieger N. Embodying inequality: a review of concepts, measures, and methods for studying health consequences of discrimination. Int J Health Serv. 1999;29(2):295–352.
78. Samakkeekarom R, Taesombat J. Give me more: vulnerabilities of Thai transgender sex workers. In Culture Health & Sexuality. 2013;31(15):S248–S248.
79. Link BG. Commentary on: Sexual and gender minority health disparities as a social issue: How stigma and intergroup relations can explain and reduce health disparities. J Soc Issues. 2017;73(3):658–66.
80. Burgess DJ, Ding Y, Hargreaves M, Van Ryn M, Phelan S. The association between perceived discrimination and underutilization of needed medical and mental health care in a multiethnic community sample. J Health Care Poor Underserved. 2008;19(3):894–911.
81. Bordo S. Unbearable weight: feminism, Western culture, and the body. Univ of California Press; 2004.
82. Kwan S. Framing the fat body: contested meanings between government, activists, and industry. Sociol Inq. 2009;79(1):25–50.
83. Reddy SD, Crowther JH. Teasing, acculturation, and cultural conflict: psychosocial correlates of body image and eating attitudes among South Asian women. Cultur Divers Ethnic Minor Psychol. 2007;13(1):45.
84. Connell R. Northern theory: the political geography of general social theory. Theory Soc. 2006;2:237–64.
85. Gomes SM, Jacob MC, Rocha C, Medeiros MF, Lyra CO, Noro LR. Expanding the limits of sex: a systematic review concerning food and nutrition in transgender populations. Public Health Nutr. 2021;24(18):6436–49.
86. Mojola SA. Love, money, and HIV: becoming a modern African woman in the age of AIDS. Univ of California Press; 2014.
87. Aizura AZ. The romance of the amazing scalpel: "race", labour, and affect in Thai gender reassignment clinics. InQueer Bangkok: 21st century markets, media, and rights 2011 (pp. 143–162). Hong Kong University Press, HKU.
88. Wolf RC, Adams D, Dayton R, Verster A, Wong J, Romero M, Mazin R, Settle E, Sladden T, Keatley J. Putting the t in tools: a roadmap for implementation of new global and regional transgender guidance. J Int AIDS Soc. 2016;19:20801.
89. Lampe NM. Liminal lives in uncertain times: health management during the COVID-19 pandemic among transgender and non-binary older adults. Gerontology and Geriatric Medicine. 2022;8:1–8.
90. Winter S, Settle E, Wylie K, Reisner S, Cabral M, Knudson G, Baral S. Synergies in health and human rights: a

call to action to improve transgender health. The Lancet. 2016;388(10042):318–21.
91. Farber R, Wedell E, Herchenroeder L, Dickter CL, Pearson MR, Bravo AJ. Microaggressions and psychological health among college students: a moderated mediation model of rumination and social structure beliefs. J Racial Ethn Health Disparities. 2021;8(1):245–55.
92. Flentje A, Clark KD, Cicero E, Capriotti MR, Lubensky ME, Sauceda J, Neilands TB, Lunn MR, Obedin-Maliver J. Minority stress, structural stigma, and physical health among sexual and gender minority individuals: examining the relative strength of the relationships. Ann Behav Med. 2022;56(6):573–91.
93. Harnois CE, Bastos JL, Campbell ME, Keith VM. Measuring perceived mistreatment across diverse social groups: an evaluation of the Everyday Discrimination Scale. Soc Sci Med. 2019;232:298–306.
94. James S, Herman J, Rankin S, Keisling M, Mottet L, Anafi MA. The report of the 2015 US transgender survey.
95. Lo S, Horton R. Transgender health: an opportunity for global health equity. The Lancet. 2016;388(10042):316–8.
96. Meyer IH. Resilience in the study of minority stress and health of sexual and gender minorities. Psychol Sex Orientat Gend Divers. 2015;2(3):209.
97. Miani C, Wandschneider L, Niemann J, Batram-Zantvoort S, Razum O. Measurement of gender as a social determinant of health in epidemiology—a scoping review. PLoS ONE. 2021;16(11): e0259223.
98. Nicholson HL. Associations between major and everyday discrimination and self-rated health among US Asians and Asian Americans. J Racial Ethn Health Disparities. 2020;7(2):262–8.
99. Scandurra C, Amodeo AL, Valerio P, Bochicchio V, Frost DM. Minority stress, resilience, and mental health: a study of Italian transgender people. J Soc Issues. 2017;73(3):563–85.
100. Suriyasarn B. Discrimination and marginalization of LGBT workers in Thailand. Sexual orientation and transgender issues in organizations: global perspectives on LGBT workforce diversity. 2016:197–215.
101. Testa RJ, Michaels MS, Bliss W, Rogers ML, Balsam KF, Joiner T. Suicidal ideation in transgender people: gender minority stress and interpersonal theory factors. J Abnorm Psychol. 2017;126(1):125.