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PRECARIOUS AGING: TRANSGENDER LIVES, HEALTH SYSTEMS, AND SOCIAL EXCLUSION

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Abstract

Pakistani transgender people experience lifelong exclusion due to family rejection, institutional abandonment, and social protection. Forced from their families at a young age and initiated into collective households through the guru-chela system, they are socialized outside the main social structures. This enforced separation generates cycles of migration and compounds marginalization across the life course. As they reach old age, the burden of exclusion from family and labor markets, health care, and the law leaves older transgender people in a dire situation. This paper explores how gendered discrimination, migration, and age shape access to health and social welfare, and how it draws on sexual politics to understand discrimination. It draws on Butler's theories of gender as performativity (1990) and precarity (2004), and Bourdieu's theories of social suffering and symbolic power (1991). The present study conducted three focus group discussions and 14 in-depth interviews with people who identify as transgender and are 50 years and older, using interpretative Verstehen. A sample of 35 participants was recruited. We explored the experiences of aging, family abandonment, and discrimination in health. Participants described severe mental illness, depression, loneliness, and gender dysphoria. Family abandonments in early life and subsequent migration were reported as continually undermining a sense of connection and identity, and participants' self-esteem was low. Participants lacked health insurance and reported being denied medical care, even during a crisis. Joint pain, due to hormonal imbalances, was widely reported, as was the use of black-market hormones by some, leading to severe health complications. Despite the risk of sexually transmitted diseases, knowledge and access to prevention strategies were low. In line with the transgender training program of Punjab Skills Development Fund, the present research identifies its best practices and its gaps. It advises non-discriminatory health care, education, and social security reforms to eliminate prejudice, as well as community care and counseling centers that offer health care and support for registration.

Keywords

trans community, aging, seclusion, gender dysphoria, psychological traumas, lack of access to health care

Introduction

Transgender people in Pakistan are in a very vulnerable position across social, cultural, and political contexts. They have been both recognized and marginalized historically and in the present. During the Mughal period, *khwaja siras* held prestigious positions in royal courts as advisors, tutors, or tax collectors, and were frequently granted lands or stipends, forms of institutional recognition. This public life changed during the British colonial period. The Criminal Tribes Act of 1871, among other legislation, placed *hijras* and *khwaja siras* in the category of criminal tribes. Registered, regulated, and prohibited from public performances or appearances, such measures institutionalized stigma and cultural constraints. By redefining *khwaja siras* and *hijras* as criminals and deviants, and thus breaking away from their pre-colonial status, the colonial redescription set the stage for legal and social repression of

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transgender people in Pakistan today (Hinchy, 2022). In the 2000s, the Pakistani courts, in a few subsequent decisions, began to recognize the rights of *khwaja siras* for the first time at a formal level, although the state did not enforce these rights fully (Rehman & Roomi, 2012). Transgender people are ostracized by their families in childhood and raised outside conventional forms of kinship, creating lifelong conditions of precarious relationships and social networks. As the community ages, members are at risk of becoming even more vulnerable as cultural means of survival (or livelihood), such as performing rituals, begging, and prostitution, decline. Housing precarity also compounds these problems, as intra-household power dynamics and intergenerational tensions within transgender families can result in the expulsion of older members of the community. Without employment opportunities, pensions, or social insurance, older transgender people live in states of extreme vulnerability.

Transgender aging also coincides with systemic exclusion from health care. Pakistani health care is not usually responsive to the needs of transgender people, much less to the needs of older people, which means that older transgender people cannot access health care or long-term care (Fredriksen-Goldsen et al., 2014). Although the 2018 Transgender Persons (Protection of Rights) Act intends to, it remains unimplemented, and health care facilities lack gender-sensitive and inclusive services. The policy silence in this matter contributes to precarity at large and perpetuates a cycle of marginalization. The progressive nature of the constitutional and legal framework has proven to have no actual impact in practice for transgender individuals (Rashid & Rashid, 2022).

In this article, Pakistan's trans aged population is included in Butler's precariat. This article argues that exclusionary regimes in health care, the absence of social security, and family abandonment exacerbate precarity. In this context of institutional abandonment, this paper seeks to understand the production of precarity among the older trans population in Pakistan.

Theoretical Framework

This research triangulates and draws on three theoretical approaches to understand the conditions of life for aging transgender people in Pakistan. Butler's work theorizes precarity as a social, political, and economic process that produces some forms of life as more vulnerable to harm and less deserving of protection. In the case of aging transgender individuals in Pakistan, this means that vulnerability is not an arbitrary function of age, but a function of institutional and legal neglect and social stigma. The results of this study, particularly participants' experiences of being refused hospital care, lacking access to health insurance, and having to source hormones from the black market, are clear manifestations of the structural precarity described by Butler. Butler's earlier theorizations of gender performativity are also relevant. Gender is not a natural biological category but is constructed through social practices and regulatory norms. For Pakistani transgender persons, not meeting the regulatory gender norms of binary gender identity results in social punishment that is initiated in childhood and extends across the lifespan. In this study, participants recounted being expelled from schools, forced marriages, forced surgeries, and excluded from family events and gatherings, which reflect the regulatory violence of gender norms on those who do not abide by them. Bourdieu’s notion of symbolic power adds to this picture. Symbolic power is achieved through the naturalization of social orders, making exclusion seem normal or natural. When doctors, nurses, and therapists refuse to treat transgender patients, when families ostracize their transgender children, and when state institutions do not uphold the rights promised in the 2018 Act, they are engaging in the exercise of symbolic power, transforming discrimination into a social norm. These three frameworks together explain how older transgender people in Pakistan experience cumulative precarity: Butler’s precarity explains why they are vulnerable to institutional

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violence; performativity theory clarifies how they are socially punished; and Bourdieu's symbolic power clarifies why exclusion is so difficult to resist and recognize.

Despite the long history of transgender communities in South Asia, Pakistan has received scant attention in terms of literature on identity, rights, and activism among the young (Najmabadi, 2014). Far less has been devoted to the problem of aging, but their lack of connection with families and social networks, and their precarious employment, compounds vulnerability in later life. This limited literature focuses on how the absence of medical services, gender dysphoria, and social stigma play a role in the marginalization of older trans people (Shah, 2016). It is imperative to note that the topic remains inadequately discussed in policy or academic literature (Fredriksen-Goldsen et al., 2014).

Gender Dysphoria and Health Awareness

Pakistan does not currently have national psychiatric guidelines for the care of transgender individuals. Psychiatric practitioners in clinical practice refer to external models such as the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), and the guidelines of the Royal College of Psychiatrists, reflecting the absence of locally formulated psychiatric standards (Habib, 2024). Gender dysphoria is characterized in the DSM-5 as a prominent incongruence between the experienced and the assigned sex that results in clinically significant distress (Association, 2013). The International Classification of Diseases, Eleventh Revision (ICD-11) is different from this construction in the advent of the condition of "gender incongruence" and the removal of the same from the classification of the field of mental disorders, a purposeful action that is intended to reduce the impact of stigma (WHO, 2019).

This foreignization of mass realities points towards bigger institutional gaps. Western models of diagnosis that are imposed from the outside, and not translated at a cultural level, risk overlooking religious, cultural, and family realities of Pakistan's transgenders. Foreign models increase medical expertise at the expense of sociocultural references of gender variation in Pakistan. Experts are thus doubly bound when national mandates are absent, and they are not well prepared to address the intersections between psychiatry and sociocultural referents. Denial at an institutional level goes deeper than at the level of therapeutic terminology. Trans health is not known in the Pakistani medical curriculum and therefore not at all known in the repertoires of most professionals, with the result that affirming treatment is not available. Dissonant training results in disparate diagnoses, and in some cases, pathologization. This is a clinical and structural problem. Care for trans people is absent at a national level and fragmented and reliant upon personal convictions (under foreign guidelines).

This is also reflected in academic work in higher education. An open letter to Pakistan was published in the Archives of Sexual Behavior to move towards larger changes and bring about transformative change in transition-related care in terms of capacity building and institutionalizing practices (Mumtaz, 2021). The critique points to a greater oversight of the rise of transgender health in public health agenda-setting, insurance coverage, and medical ethics.

What's missing with the research and other than the diagnostic model from abroad is a health policy that matches the Pakistani sociocultural understanding of transgender health. Absence of national guidelines means a transgender life outside the state's health policy, and that calls for therapeutic reform, which adds cultural sensitivities to medical expertise.

Hormonal Therapy and Lapses in Medical Consciousness

This lack of standardized hormone therapy protocols in Pakistan is a sign of neglect of transgender health in Pakistan's health system. Despite the Transgender Rights Act of 2018 specifically guaranteeing access to gender-affirming healthcare, the promise has been more of a symbol of intent rather than substance. There is no publicly accessible study in Pakistan that

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has evaluated the clinical effectiveness, health outcomes, and psychosocial outcomes of hormone therapy in transgender individuals (Saqib & Saqib, 2023). The lack of data indicates not only a lack of knowledge but also institutional failure, because policymakers cannot formulate informed interventions without a body of evidence to draw on. The vacuum causes transgender individuals to turn to harmful alternatives without medical supervision in most situations, and therefore at considerable peril to their lives.

Regional examples present the implications of such inadequate policies. In Nepal, for example, the lack of gender-affirming care has caused many transgender women to buy hormones from unlicensed cross-border markets in India (Regmi et al., 2019). Such a practice has led to untoward health consequences involving abnormal uterine bleeding, cardiovascular disease, and thyroid disease. Such a result illustrates how the state's lack of action engenders patterns of danger, as the excluded turn to unlicensed and harmful alternatives due to institutional inadequacy. The situation in Pakistan is sure to replicate these tendencies because medical infrastructure, supervisory mechanisms, and public education are similarly lacking.

Conversely, world standards offer established and precise plans for safely delivered hormone treatment. Endocrine Society guidelines suggest the active participation of multidisciplinary teams of endocrinologists, psychiatrists, or other mental health professionals, and primary care doctors. These also emphasize the need for standardized dosing protocols and blood monitoring so that risks such as venous thromboembolism can be actively managed (Hembree et al., 2017). These standards demonstrate the capacity of systems to manage health risks and ensure equity. The lack of such standards globally and Pakistan's current inaction provide evidence of neglect. By failing institutionally to establish avenues for safe hormonal care, Pakistan invisibly transgender people in health circles, and denies them their promised legal rights.

Invisibility stems from a lack of clinical studies. Advocacy for transgender health care is nebulous without empirical data on transgender people's health experiences and outcomes. Policy makers and health educators lack the evidence that would allow them to insert information about transgender health into their teaching or hospital policies. Thus, the cycle of neglect continues: the lack of awareness among providers leads to a reluctance among transgender people to seek care, which affects the gathering of data and, therefore, reinforces the marginalized status of transgender groups in the health care system and in studies.

Healthcare Access and Structural Bias

Along with inadequate health infrastructure, habitual bias and discrimination play an important role in defining transgender access to health care in Pakistan. Ahmad et al.'s (2024) qualitative evidence from the experimental audit study establishes the pattern of discrimination in health care and demonstrates its systematic nature. Their research revealed that compared to cisgender patients, transgender patients in low-cost private health care settings were given shorter physical checkups, rushed consultation times, and fewer questions to aid diagnosis. The pattern of findings across multiple sites indicates that bias is embedded in clinical encounters rather than due to clashes of individual biases. Similarly, Younus et al. (2022) talk about how transgender people in Karachi continue to encounter discrimination at hospitals, limited access to services, and ingrained social stigma. These patterns echo the existing literature that has highlighted the wider health challenges faced by transgender populations in Pakistan, such as poverty-related, provider-related, and lack of trans-inclusive health services (Khan, 2020).

These findings are complemented by qualitative findings that outline the experience of transgender patients in abusive health care. In Pakistan, ethnic minorities were shown to be constantly subjected to abusive language and contemptuous attitudes of health care providers (Lay, 2025). These stories confirm the widely prevalent culture of fear in hospitals and health

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care centers, where not only are patients treated with suspicion and stigma, but even the elementary practice of medical treatment is denied to them. These narratives present how health facilities, far from being spaces in therapeutic encounters with the people in health crises to whom they offer services, become spaces of violence and exclusion.

Investigative journalism also offers additional evidence of structural neglect. Journalism in Rawalpindi has reported several instances where trans patients with sexually transmitted diseases and tuberculosis have had to wait longer than other patients or have been refused care. This is evidence of structural exclusion, in which patients are denied treatment at various stages of their journey, from reception to consultation with a specialist. The upshot is a health-care system that undertreats trans people and discourages them from coming forward in the first place. These exclusions cannot be excused as mistakes. They are symptomatic of broader systemic injustices that intersect with other social inequalities (Lay, 2025). No-win situations are pervasive at every level of health care: from waiting times to wards to the duration of consultations to even care. Such conditions also have a detrimental effect on the relationship between transgender patients and health care professionals. They delay care-seeking behaviors, allowing diseases to progress. This can be devastating for the individual and the community in early treatment of diseases like HIV and tuberculosis. Exclusion from health care institutions also has symbolic implications. In excluding transgender patients from the health institution, healthcare systems continue the social trend of exclusion and sends a message to society that the lives of transgender people are not worthy of being protected and preserved. In doing so, exclusions in healthcare is not an isolated incident but one of the continuums of violence that transgender people experience in public, work, accommodation and policing spaces. Beyond building medical facilities, to end the healthcare exclusion, a battle against the structural dimension of prejudice that is embedded in the medical school curriculum, institutional environment, and policy is essential.

Discrimination and Exclusion in Hospitals

The most obvious and incapacitating exclusion is, perhaps, the one that lies behind the walls of hospital environments, whereby transgender people are faced with institutionally erected obstacles to treatment. Time after time, it is a question of ward assignment. The doctors are either inconsistent or uncertain about where to put the transgender patients, either on the male or the female ward, and the patient is in liminality. This uncertainty is not only time-wasting but also humiliating, and in most cases, it downright refuses admission. Reports by activists and community-based organizations reveal that in many cases, staff turn transgender patients away out of the door, so much so that they are left to the mercy of expensive private care, or in the worst-case scenario, they are left to do without treatment. These practices in question show how institutional rigidity, considering a binary view of gender, is directly linked to health disparities (Khan & Abbas, 2024).

It is not just an administrative failure to exclude on these grounds; it is also very profound in its symbolic significance. Such examples convey a very strong message to the transgender patients that they are not a part of the healthcare system and that their existence is not legal. This is the complete antithesis of the national legislation’s promise of inclusiveness. The Pakistani hospitals have failed to even make such basic structural measures as building inclusive wards or even giving gender sensitive care training to the staff. This failure to address the loopholes makes the health system entrench distrust between the transgender community and health facilities and perpetuates the patterns of abandonment and avoidance of the government medical services. The resulting situation also contravenes the goals of public health and the state's human rights obligations (Saeed, 2024).

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Silence in Doctor-Patient and Policy Discussion

Even though discriminatory healthcare practices are well-documented, transgender health is nearly absent from medical education and policymaking circles. Gender diversity is not specifically addressed in the classroom, so little preparation is provided for new doctors and nurses to deliver competent and respectful care. This neglect at the education level ensures that prejudices, stereotypes, and practices are perpetuated in health facilities. This is the case with the report from The Express Tribune in 2018 that the first national study on transgender health found a wide gap in sensitivity and awareness among health-care professionals that included widespread misgendering and condescension (Wasif, 2018).

Policy debates are similarly void of such omissions. There has been condemnation by Amnesty International (2023) in response to the proposed amendments to the Transgender Persons (Protection of Rights) Act 2018 that would deny or even criminalize access to gender-affirming health care. The consequences are reminiscent of the limits on legal progress in the aftermath of political backlash and moral panic. The Act of 2018 legislated the rights of transgender individuals in relation to health care, but hasn't backed the declaration of rights with either enforcement or provision. There is no real evidence of efforts to mass-educate health practitioners.

Omission of transgender issues from medical education and policy shows a cultural reluctance to acquaint non-binary groups with the state's schema. The institution reinforces social hierarchy to the advantage of cisgender groups by relegating transgender health to the margins of the mainstream agenda. Such silence ensures invisibility and perpetuates discrimination, staving off transformation. This creates a contradictory situation in which the rights of transgender people are institutionalized in law but denied in hospitals and clinics.

Family Abandonment and Social Exclusion

Reclusion also occurs very early in the lives of most transgender people, before hospitals and the state. Systems of support that in Pakistani culture primarily revolve around the family become violent and rejecting. Subsequent studies then show that a large share of the transgender population in the province of Punjab face abuse, violence, or rejection by their families in childhood or adolescence (Rizvi et al., 2023a). In this way, rejection prevents them from receiving protection in terms of emotional, economic, and security protection and leads transgender individuals towards unsafe coping strategies.

This family rejection has trickle-down effects. Without these protective frameworks of most of the population, transgender individuals are "misappropriately" forced into forms of work, such as begging and prostitution, in which they are subjected to further violence and exploitation. So financial inequality is associated with family rejection, which creates a structural inequality that may not be overcome in adulthood. Moreover, the psychological trauma of rejection confirms feelings of isolation, shame, and distrust that are, in turn, the basis for weakened resilience and psychological well-being. When micro-exclusion within the family interacts with macro-exclusion in health care and policy, a cycle of disadvantage occurs. Transgender people excluded from their families are further excluded from health care and from the law. This is a pattern of exclusion that shows the duplication of discrimination across life domains from the family to the hospital to the state. The confluence of the different factors suggests that ameliorative measures in isolation will be ineffective. If change does not disrupt the continuum of exclusion that runs from the private to the public, transgender persons will remain ensnared in a pattern of exclusion that denies their rights and inflicts harm.

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Research Gap

The literature surveyed here suggests a pattern: that transgender people in Pakistan experience exclusion that is systematic rather than arbitrary, has its origins in the colonial legal system, is perpetuated within the family and community, and is reproduced in health care and education. Yet, much remains to be done. In other countries, work on the lives of transgender older adults has emerged in the last decade, with studies from the United States and Europe detailing the effects of minority stress and age (Fredriksen-Goldsen et al., 2014; Witten, 2014). This research has shaped clinical and policy responses in these countries, but has not been incorporated into research in South Asia, where the social, legal, and cultural conditions for transgender experiences are very different.

In Pakistan, most of the research is either on younger transgender people or on issues of identity and rights, not aging. There is little about health, mostly about HIV and STIs. There is no published qualitative research that focuses on the lived experiences of older transgender people and links these to health and to theoretical conceptualizations of precarity and symbolic power. This research seeks to redress this by collecting empirical data from transgender people aged 50 and over and analyzing it through a Butler-Bourdieu framework attentive to both the systemic creation and social reproduction of vulnerability.

Research Questions

This study is informed by the following research question:

• How does the theory of precarity by Butler resolve the everyday life in later years for transgender people in Pakistan?

• How much are health systems and social protection policies reproducing structural exclusion towards aging transgenders?

• How do family desertion, livelihood precariousness, and health care exclusion cross over and impact everyday survival in aging trans populations?

• What are the wider implications of such exclusions for policy-making and social justice in Pakistan?

Aims

The main objective of this paper is to bring into sharp relief the lives of transgender elders in Pakistan through the prism of precarity. The paper, in the course, attempts to:

• Describe in detail how social, political, and institutional systems dish out vulnerability in unequal measures to the transgender population.

• Reflect on how health systems and social protection systems actively exclude transgender needs.

• Emphasize the visibility of transgender elders in policy debates as well as in scholarly articles.

• Contribute to social justice commentary in calling for health and welfare policy responsive to the needs of the reality of aging transgender populations.

Research Method

One research methodology utilized was qualitative research to see how social exclusion and marginalization affect older individuals in the transgender population. Two qualitative research instruments were utilized:

1. Focus Group Discussion (FDGs)
2. In-depth Interviews

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This approach enabled a focus on lived experience to understand the complexities of exclusion and marginalization within mainstream communities, health-care systems, and policies. A qualitative approach was deemed appropriate because the study seeks to illuminate the precarity of age, sexuality, and inequality as experienced and described by the participants. These experiences cannot be adequately captured through statistical methods; they can only be understood through the perspectives of those who live them. The transgender community lives in their communes and prefers to meet in group settings. Due to social seclusion, they don't open easily; focus group discussions helped in understanding the respondents' shared experiences. However, a few of the transgender people requested a separate interview, as they wanted to share their experiences, narrate their life story, and be heard, but at the same time wanted a private setting.

Three focus group discussions were conducted, each lasting 90-120 minutes. Each group had between 10 and 15 participants. A researcher and a moderator were both present throughout. Sessions were audio-recorded, and detailed field notes were taken. Participant language, body language, and colloquialisms were noted and used in supplementing the transcribed data.

The pattern that was followed was:

- Ice-breaking questions
- Contextual questions
- Open-ended/thematic questions
- Closing questions.

The aim was to keep each session interactive and minimize groupthink by actively engaging all participants. These FGDs were well-suited to sensitive subject matter because hearing shared stories often encouraged participants to articulate realities, they might otherwise keep private.

Fourteen in-depth interviews were conducted, each lasting between 60 and 90 minutes. The in-depth interview participants were recruited separately from the focus group participants, bringing the total sample to 35 individuals across both data collection methods. Data collection continued until thematic saturation was reached, meaning that no substantially new themes emerged from additional interviews. The interviews followed this sequence:

- Rapport Building
- Explanatory questions
- Probing questions
- Deep, insightful questions
- Reflective questions
- Closing questions

A purposive sampling technique was used. The inclusion criteria were age 50 and above, transgender identity, and working-class background. Purposive sampling was chosen because the study sought participants with a specific lived experience of aging as a transgender person in Pakistan, a population that is socially hidden and difficult to reach through standard sampling frames.

Thematic analysis following Braun and Clarke (2006) was used to analyze the data. Codes were generated inductively from the transcripts and field notes, then organized into broader themes and sub-themes through iterative review and discussion between the research team members. Saturation was assessed independently by two researchers before data collection closed. Access to the research population was very challenging. The Punjab Skills Development Fund, a government of Punjab public sector skill training institution offering vocational training to marginalised communities including the transgender community, was approached to facilitate the process, as it is currently providing skill training programs for the

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transgender community. PSDF acted as the gatekeeper and provided a safe venue for focus group discussions and in-depth interviews. Participants ranged in age from 50 to 65 years. All were based in Punjab, primarily in Lahore and surrounding urban areas. All identified as transgender (*khwaja sira* or *hijra*) and came from working-class backgrounds, relying on livelihood sources such as informal labor, begging, dancing at ceremonies, and sex work.

Results and discussion

This section presents findings from three focus group discussions and 14 in-depth interviews conducted with 35 transgender individuals aged 50 and above. Analysis is based on the six stages of thematic analysis identified by Braun and Clarke (2006). An inductive process was used to code the transcripts and field notesT. the codes were grouped into themes and interpreted against the backdrop of the study's theoretical framework. Health-related accounts are considered participant-reported subjective accounts; no medical diagnoses or causal biomedical accounts are made. We present the discussion in terms of five broad themes, illustrated with participant quotations and interpreted through Butler's (2004) theory of precarity, her concept of gender performativity (1990) and Bourdieu's (1991) concept of symbolic power.

Theme 1: Cumulative Abandonment and the Making of Precarious Lives

The most common theme we found across all FGDs, and interviews was that these participants experienced precarity as not beginning in old age. It began in childhood and was compounded by each subsequent loss. Being rejected by family was cited as the starting point of this precarity. Exclusion from the household resulted in a loss of emotional, financial, and social legitimacy in Pakistani society through kinship. This in turn led to a series of events: early withdrawal from school, forced displacement, involvement in informal and often hazardous work, and increasing social exclusion in adulthood.

This was clearly articulated by Interview Respondent 4 (age 60): "*By the time I was 11 or 12, the neighborhood had made life miserable for my family and me. From then on, I have been in constant migration. There is no place that I can call home because I had to leave my family behind as well at a young age. I live alone and work as a laborer in the sabzi mandi market of Lahore*". This story not only reveals the way a single rejection in childhood led to a lifetime of mobility and economic precarity. Respondent 4's migration is not an option but what Butler (2004) calls "forced exposure" to conditions of vulnerability that other social groups are not exposed to.

FGD 1, Respondent 9 (age 54) crystallized the dynamic of family rejection in this way: "*People are willing to accept their sons if they are drug addicts or criminals, but if you are a trans child, then you don't belong anywhere. Trans children are thrown out like they are nothing. People don't understand that trans children are their children, and they deserve the same love and care. We are shunned for turning to sex work, but no one cares enough to prevent us from turning to sex work as a means of earning*". This statement speaks to Bourdieu's (1991) notion of symbolic power. The institution of family has the power to confer or withhold social recognition. And when it is denied in the context of gender non-conformity, it is judged as a normative expression of whose life is worth living. Not only is the transgender child expelled, but they are also symbolically defined as a source of dishonor, a definition that then becomes a part of every social interaction.

The social classification resulting from family rejection is also reproduced elsewhere. FGD 2, Respondent 3, (age 57) was one of the participants who explained how society labels all transgender people as sex workers: "*As a transgender, I am always seen as a sex worker, even if I am not. Society and our family members come up with a self-fulfilling prophecy that,*

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as trans, we can only bring dishonor and shame to the family name. Wherever I go, I feel people whispering about me behind my back, even schoolchildren. I had to change my school, my house, and leave behind my ancestral community because of constant humiliation." This story highlights how symbolic classification, first enacted by the family, is then replicated by the community, peers, and institutions, thereby requiring further relocation to escape stigma.

Marriage also became a specific strategy of families to overcome transgender identity by reverting to normative gender. Interview Respondent 6 (age 58) recalled being married at 25: "*My family married me off and thought this might fix me, but this is who I am at the core. It cannot be changed. My wife did not like my dancing and participating in trans rituals. She always asked me for a divorce, but my father always kept me from divorcing her. It is a weird way to live because even though I have children, I never felt like a husband or a father".* The arranged marriage did not resolve the family's rejection of the respondent's identity; it increased the stress and oppression. The forced enactment of heterosexual gender roles highlights the regulatory nature of gender that Butler (1990) describes, and the social and domestic punishments for non-conformity.

The impact of this exclusion is a lifetime accumulation. FGD 1, Respondent 1(age 52) disclosed the psychological burden of being socially excluded over the years, she said: "I *have two names, one is the ID card, and the other one is in my community. Though I am used to it, I am also mentally tired. I was not permitted to attend family get-togethers since I was young, but now I am accustomed to it. I have no health card, no insurance. I hardly have the strength*". The normativity of exclusion in making it its own mode of harm is what is analytically important here. After living her life behind a ban, the respondent is not outraged but weary, a resigned adjustment to being deprived of something, an internalization of precarity that represents how deeply it has entered identity.

The theme of dysfunctional socialization, established in the coded data, illustrates how the early commune's existence within the *khwaja sira* system became both a shelter and an additional site of deprivation. Having been excluded from family and formal institutions, participants were inducted into *guru/chela* households that provided community and identity but also reinforced separation from mainstream social life. Several participants described being forbidden from attending family weddings, meeting visiting relatives, or participating in any family ceremony. As FGD 2, Respondent 4 (age 61) shared: "*We are not allowed to meet any family members visiting or take part in any family ceremonies. When our siblings are getting married, we are not allowed to come in front of their in-laws or attend the ceremony*". By old age, this decades-long exclusion from kinship networks left participants without the intergenerational care networks that most aging Pakistanis rely on. As Interview Respondent 11 (age 60) described it: "*My mother loved me a lot, but after her death, I was not allowed to visit home anymore, especially after the marriage of my siblings. The communal or familial care is not for a transgender person in our culture; we are seen as a curse. Eventually, aged and old transgender individuals either end up dying in misery or at some place like Fountain House. We are secluded from society like an amputated, infectious part*".

Theme 2: Institutional Exclusion from Healthcare and the Reproduction of Harm

All the respondents in this study said that they were refused medical care or simply avoided hospitals because they were afraid of being abused. Such a close resemblance does not imply that there are individual cases of personal prejudice at work, but rather a structural trend in which health institutions replicate the exclusion that families and communities perpetuate. This corresponds to Bourdieu's (1991) analysis of the functioning of symbolic power in terms of institutional fields: the hospital, similar to the family, becomes the space in which the social hierarchy is practiced, and the transgender body is defined as out of place.

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Both FGDs and interviews repeatedly identified ward assignment as a key obstacle to care. Participants described being shuffled between male and female wards, refused admission while staff debated where to place them, and ultimately turned away from treatment: "*Doctors, paramedics, and other hospital staff don't cater to us. We keep getting shuffled between male and female hospital wards.*" FGD 2, Respondent 8 (age 65) described the experience of hospitals with a vivid expression of terror rather than care: "*I spend most of my days quite depressed and in physical pain. My body has developed aches all over, but no one can tell me why. There is no one to educate us, even about our own bodies. If anyone goes to the Fountain House when they are in a serious condition, they never make it back. If you are on a bed there, it is your deathbed. I once went there for medication for a headache, and they put me on psychiatric medication, which made me drowsy all the time. I later found out they were anti-depressants. They will prescribe anything to us without telling us the side effects. No one talks to our community about our health seriously*". This account reveals two overlapping failures. The first is the immediate harm of wrong medication given without consent or explanation. The second is the more profound institutional failure of a health system that has no competence in treating transgender patients, and uses psychiatric medication instead of primary care, effectively pathologizing the identity of the patient instead of addressing the complaint presented.

This exclusion was aggravated by the lack of health documentation. None of the study participants had a health insurance card. Some had never been taken to see a doctor. The answer of FGD 1, Respondent 1 (age 52) was simple: "*I have neither a health card nor insurance. The last check-up was 8 years ago.*" Interview Respondent 2 (age 55) had accepted the impossibility of seeking care so much that self-treatment was the new norm: "*After the death of my parents, my siblings isolated me and I am not to see family, and in-laws, either, even when I have some medical problems, I know that no doctor would take care of me, I just use over-the-the-counter medicine or desi totkas (remedies).*" This self-governing avoidance is an outcome of health. When people give up seeking help due to the belief that they will be rejected, manageable disorders advance to severe levels.

The respondents also said they use the NGO-operated health camps as their sole source of basic medical check-ups. Although such camps offered some relief, they operated on the fringes of the formal health system and could not replace ongoing, comprehensive care. According to one participant: "*There are camps, as Fountain House set up by non-governmental organizations, where we can only receive our basic check-ups*". This was most lucidly put by Interview Respondent 10 (age 57): "*Most of us will fight alone because there is no safe system that we can go to. We will use our savings to buy quacks or black-market hormones, and we know that it will hurt us, but we have no other choice. We will keep on suffering silently as our health starts to break down with our age because of the fear of being judged or rejected. The saying that we know it will hurt us is important."* Neither were the participants unaware of the dangers of using unmonitored hormones or being treated by non-licensed professionals; they were making limited decisions where there were no safe options available. This is precarity in the sense Butler (2004) means it: the lack of institutional support that would allow one to make safer choices.

Institutional exclusion was further exacerbated by the elimination of previously available safety nets. As one of the FGD 3 participants observed: "*It has no support program to serve us. Years ago, we could use a health card, but even that is no longer true. We have no safety net.*" This pulling back of even bare minimum provisions describes how policy retrenchment can be an active practice of institutional harm, denuding the residual provisions that had cushioned transgender people to some degree against the impact of healthcare exclusion.

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Theme 3: Physical and Psychological Health Under Conditions of Structural Neglect

Students reported a variety of both physical and psychological health issues that were interrelated and reinforcing. The psychological implications were ubiquitous: depression, loneliness, emotional numbness, a sense of despair that pervaded most of them, and what some of the participants called an existential crisis of the meaning and value of their lives. These did not reflect discrete clinical events but rather the cumulative psychological burden of a lifetime of rejection and exclusion. The results align with the previous studies that identified high rates of depression and anxiety among transgender individuals in Pakistan, as well as the lack of formal mental health services or support strategies for them (Gul & Mohsin, 2023). The sub-theme codes that were formed because of the data were: deep depression, isolation, social withdrawal, hypersomnia, emotional numbness, loneliness, and rejection sensitivity. A few of them described this in rather graphic terms: "*I just want to stay in a lock and not communicate with anybody, and I feel as though I am empty, and my whole life was a waste*".

Interview Respondent 12 (age 56) explained this build-up: "*Since early childhood, I had to experience the trauma of harassment and abuse, and rape. The woe never ceased. Later, I discovered that I have not a single affection, care, or protection. I shall constantly be accused of assaulting myself. The loss of location, migration, and the absence of care have now come back to haunt my health. Sometimes I am so frustrated and annoyed at the tiniest of things".* The content of the trauma is not analytically significant here; rather, the respondent's conclusion is that it is their entitlement to blame rather than to protection. This is internalization of symbolic violence (Bourdieu, 1991) at its worst. The subject has internalized the societal belief that they are causing their own misery rather than that institutional failure is to blame.

The texture of aging as expressed by FGD 2, Respondent 14 (age 58): "I *am frustrated, hopeless, and tired of aging under such circumstances; our aging is not like mainstream members of society. We age without care systems, without financial cover, and with the obligation to perform odd jobs throughout our lives. No one was ever willing to hire me for a proper job. Running from one job to another, migrating constantly for housing and meals, has left me empty and deeply depressed. If this is life, then I wonder what death is like*". The comparative framing- 'our aging is not the same' -is a sociologically important observation. The participant is not describing a personal deficiency but a structural difference in the conditions under which aging occurs. Butler's (2004) theory of precarity holds that vulnerability is unequally distributed across populations. This respondent is articulating precisely that inequality from the inside.

Physical health concerns were equally pervasive. FGD 2. Respondent 5 (age 56) described the co-occurrence of chronic pain and structural impossibility of addressing it: "*I have immense leg pain, and back pain often, but I hate going to the doctor. My last check-up was 3 years ago, and it was not a pleasant experience. I get up every day and must work hard just to afford a meal. Between this struggle and the constant anxiety that comes with living as a trans person, I cannot afford to worry about my health as well*". The expression "I cannot afford to worry about my health" is a simplification of the rationality of structural neglect: where subsistence alone takes up all the resources at its disposal, then the responsibility of health maintenance is not a decision that can be made.

Physically, the respondents complained of extreme joint pains, pains in the body with no medical justification provided to them, and the physical effects of the unregulated use of hormones in the long term. The coded information found a sub-theme of lack of any health education: "*No one has ever informed us about the hormones in our body, or what makes us the way we are. There is no awareness of hormonal treatments. This is the first time we are hearing about the specific hormones, our unusual health problems, and we have never been informed about this by any medical doctor.*" Interview Respondent 13 (age 55) spoke about a

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case that was especially horrible: "*My family made me undergo a series of surgeries and painful hormone treatments, just so that I could be socially accepted and mask my identity. It is because of hormonal treatments that my mental and physical health have been put in a very bad place. I am only able to stay in my house because I must look, act, dress, and behave.*" This narrative cuts across two lines: of the forceful imposition of gender norms and through the body and of the health outcomes of a system that offers no safe, regulated avenue of care relating to gender.

The coded data also revealed a sub-theme of forced surgical procedures, where participants talked about how they were forced into surgery not due to their wellbeing but to please family or social pressure: "*I was born as an intersex person, and I had undergone several critical surgeries which had been imposed by my family, which left me with a lot of medical and psychological complications. Few of our community members had ever died during the procedure."* These stories show that the health system is dysfunctional with transgender individuals on various fronts at once: it will not offer inclusive care, but it will continue to be the gatekeeper to the surgery procedures that social conformity requires.

Both FGDs and interviews indicated gender dysphoria to be one of the sources of continuous psychological discomfort. The participants explained what it is like to be in a body that does not reflect their identity, and especially the pressure of the outside world to act in a gender manner that is not congruent with their identity. One participant remarked: "*I can only dress in a particular manner to be socially accepted, sometimes I take heavy hormones to develop facial hair, the reflection in the mirror has to be a man, but deep inside I am trans and I was born this way. It is not acceptable of who I am*". This internal identity and exterior performance is the very tension that Butler (1990) describes as the punitive labor of gender norms: having to play a gender that the regulatory society recognizes, at the expense of psychological coherence.

Theme 4: Documentation, Legal Identity, and the Paradox of Recognition

One of the most startling observations from the FGDs was that the Gender X label on the Computerized National Identity Card (CNIC) was now perceived as a source of harm rather than security. The interviewees described the X marker as a precipitant of discrimination in hospitals, government offices, and workplaces. One FGD 1 respondent said: "*Our ID card identifies us as citizens of this nation, yet since our gender X is engraved on it, we are considered worse than a trash bin in most areas and offices*". This observation cites a paradox in the core of the Transgender Persons (Protection of Rights) Act of 2018. Nisar (2018) has demonstrated that the legal consciousness of the transgender population in Pakistan is complex, as it simultaneously acknowledges and discriminates against them and the CNIC data indicates that this legal consciousness is now dictated by a document that makes the transgender community visible to discrimination, not protected from it. The Act acknowledged the right of transgender individuals to self-identify their gender on official documents, which was to protect their rights. Practically, though, the visible transgender identity on a piece of paper that must be shown at hospitals, government offices, and workplaces has become the tool of discrimination, rather than protection against it. If the institutions are not trained in the practice of inclusiveness, legal recognition may only serve to increase the visibility of transgender individuals to discrimination rather than reduce it. Some of the participants stated that they had to offer this document to access the health card, which had been offered, but they were refused service.

Some FGD and interview participants said they were not covered by social protection due to not having a CNIC. It is impossible to register a cash transfer program, open a bank account or access government services formally without a valid identity document. The insecurity of being undocumented was so severe to some of the participants that they would

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rather not be registered than face the stigma of being identified. This dynamic demonstrates how legal reform, without concomitant institutional change and staff training, can lead to unintended outcomes.

Theme 5: Economic Marginalization, Precarious Livelihoods, and Survival

All FGDs and interviews reported economic lives that were marked by chronic insecurity, an informal and stigmatized livelihood, and a lack of any savings, pension, or financial cushioning upon entry into old age. The most frequently reported livelihoods were begging, attending ceremonies, sex work, daily-wage labor, and infrequent domestic work. A few participants had tried formal jobs and reported being harassed out of factory or service industry jobs. FGD 1, Respondent 7 (age 53) narrated: "*When I was 15, my family left Karachi and went to Lahore because the community was constantly mocking us, and I was not allowed to attend family gatherings anymore, and I even had to leave my home because my family felt humiliated and ashamed. I had to work at a factory, but the employees used to catcall and harass me all day, and I had to leave*". This story eventually explains how workplace harassment is a structural constraint, rather than an interpersonal inconvenience, which is pushing trans people out of formal jobs and into informal survival economies.

Livelihood precarity directly and self-reinforcingly correlates with health. FGD 2, Respondent 5, (age 56) explained the calculation that makes health nonexistent at all: "*Every day I get up and must work hard to go eat something. Between the struggle and the anxiety that is always with me as a trans person, I cannot afford to even think about my health as well. Long-term health management is not possible when the daily survival takes all available resources and energy*". It is not a failure of personal prioritization but the foreseeable result of structural exclusion from stable jobs and social protection.

The material aspect of this precarity is reflected in the compromised living situation theme identified in the data. The participants talked of staying in crowded shared accommodation within the urban slums since the landlords elsewhere were not permitted to rent to transgender people: "*We cannot find anyone to accommodate us on rent within the city, we always have to live in slums and share a room with other trans community members to afford the rent*". Some of them defined sex work as an option that was not satisfactory, but the option that remained when every other alternative was shut down. FGD 2, Respondent 12 (age 56) explained the lack of options at the same time: "*When I look at my life, there is no hope, and my aging is terrifying me since there is no security or medical coverage. I go to people's houses to do minor domestic tasks and to eat one or two meals a day. This fear of aging is not abstract. It is the logical acknowledgment that aging bodies need more attention when revenue-generating potential is diminished and that in the case of lack of savings or coverage, there is no cushion to that move*".

The structural conditions pushing transgender individuals into the world of sex work were expressed especially eloquently by Interview Respondent 9 (age 54): "*We are made to be shunned because of our turning to sex work, but no one cares enough to make sure that we do not turn to sex work as a way of earning*". This statement perfectly encapsulates the double bind, where society blames transgender people because of the means of livelihood that its own exclusion has ghettoized them, but never takes responsibility for the circumstances that have rendered such means of livelihood the only viable choice. This dynamic is also present in the coded data on vulnerability to sexually transmissible diseases, with participants indicating that the circumstances of sex work do not allow them to negotiate with clients: "*Our clients tend to have too many underlying health issues, but we cannot ask them, nor can they tell us*".

The low self-worth theme cuts across all five of the overall themes and represents the psychological endpoint of chronic social exclusion. When respondents were asked about their

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future or how they see themselves, some used the trash bin image. When asked where they saw themselves during the FGD, one participant pointed at a bin in the room and said: "*If you ask me where I see myself, I feel like a trash bin. I feel as though my life has gone to waste, and this is my value*". Being outside society, like an amputated, infectious part, was another way it was described. These pictures are not merely metaphors of despair; they are accounts of how the symbolic power (Bourdieu, 1991) has been absorbed. By identifying with waste, the person is replicating the social judgment that institutions, families, and communities impose on them. Intervention, in turn, is not only a structural but also a restorative task: restoring the feeling of value that has been deprived by systematic exclusion.

Conclusion and Recommendations

This paper attempted to explore how family desertion, health exclusion, and structural precarity intersect to affect aging transgender people in Pakistan. The results affirm that exclusion is not an isolated occurrence but an accruing process that starts during childhood and escalates with age. The participants reported being displaced out of schools, families, and even labor markets at a very tender age, abandoned to survive by using risky methods of making a living, and then subject to the same form of exclusion when they were later in life seeking healthcare. Respondent 11 -FGD made this turn quite evident as he explained that aging transgender people would end up dying miserable, ostracized by society as a severed limb. This is what structural precarity means in the sense Butler (2004) uses it: it is not an individual failure that renders life unlivable but the institutional refusal to support it systematically. The notion of symbolic power (Bourdieu, 1991) can be used to understand why this exclusion is difficult to change: the discrimination is practiced by hospital staff, school teachers, family members, and state officials in a manner that cannot be called even unusual; it is extremely hard to make transgender people challenge or even call the harm they are being subjected to. The conclusions also shed light on the shortcomings of legal reform. The Transgender Persons (Protection of Rights) Act 2018 officially secured the right to healthcare and identity certificates, but all respondents in this study did not have health coverage, and most had alleged that they were not provided with treatment during emergencies. An absence of enforcement infrastructure, training of healthcare practitioners, and legal recognition creates, as Butler predicts, a distance between what is on the books and real life. This discrepancy between legislative promise and lived reality has been termed as a fundamental denial of rights; the 2018 Act's protection is mostly symbolic given the lack of implementation mechanisms (Rizvi et al., 2023b).

The Punjab Skills Development Fund's Pehchan program is a free skill training program, with a stipend for trainee transgender individuals. This program not only works to provide opportunities for a dignified source of income for this community but also to promote social inclusion and communal learning by enrolling them in mainstream educational institutions. The instructors at these institutions were trained in gender sensitization and in engaging transgender community leaders, i.e., their gurus. This helped in making the program a change agent rather than just a funding roll-out. This study fully assessed and served as a tangible example of what structured support can look like in practice. The program will mitigate some mechanisms of precarity identified in this paper: it offers an alternative to begging and sex work, alleviates the isolation of commune life, and develops skills that can make them more economically independent. Some participants were initially exposed to formal skills training through PSDF, and their testimonies indicate that the program has tangible effects on self-esteem and social engagement in addition to economic impacts. The recommendations below are based on the trends in this paper and are categorized according to the area or sector that is best suited to implement them.

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1. Schools (enforced by provincial education departments): Multiple respondents talked about sexual harassment, bullying, and expulsion from school due to their gender identity, which compelled them to start their migration early and terminate their educational path. The provincial education departments of Punjab, Sindh, KPK, and Baluchistan are required to implement anti-bullying policies, specifically to include transgender students as a vulnerable group, educate school personnel on gender-sensitive behavior, and establish a system of reporting harassment. This recommendation targets where most transgender people enter structural precarity.
2. Vocational and livelihood schemes (implemented by PSDF and provincial skills authorities): The participants of this research who had been part of the PSDF Pehchan program claimed that it was a turning point that provided them with an alternative to begging and sex work. The program model, incorporating skills training, registration support, and a safe venue, needs to be extended to other cities in Punjab and adopted by skills authorities in other provinces. The focus of expansion must be on participants aged 45 and older who are experiencing the most pronounced loss of informal livelihood opportunities and are most likely to have the hardest time re-joining training programs. The elements of financial literacy must be incorporated so that participants can manage their income, open bank accounts, and save small amounts.
3. Employment inclusion (enabled by the Ministry of Human Resources and federal and provincial labor departments): Respondents reported being denied factory work, domestic jobs, and formal sector jobs, simply due to their identity. The government would be advised to implement an open employment quota for transgender people in public-sector institutions and to offer incentives to employers in the private sector who hire transgender people and adhere to the inclusion criteria. The quotas are to be tracked and publicly reported every year, so that compliance is a fact, not a dream.
4. Healthcare system reform (enacted by the Ministry of National Health Services, provincial health departments, and medical colleges): All the respondents in this study either did not get healthcare or did not want to visit a hospital because of fear of discrimination and abuse. Themes of confusion during the ward assignment, unfriendly staff, and lack of any transgender-specific care pathway were common. To address the ward assignment issue, a standard operating procedure to admit transgender patients that would resolve the ward assignment problem should be established, one day of gender-sensitivity training should be required of all public hospital workers once a year, and a liaison officer should be assigned to each major public hospital, to whom transgender patients can report mistreatment. The curricula of medical and nursing colleges ought to have a course about transgender health requirements and about the impact of unregulated hormone use, which the participants noted as a severe and widespread risk to health.
5. National clinical guidelines (enacted by the Ministry of National Health Services, in collaboration with medical professional bodies): There is no national standard of gender-affirming hormone therapy in Pakistan. The participants reported purchasing hormones via quacks and black-market dealers due to the lack of a supervised alternative, and with severe physical effects. The working group with endocrinologists, psychiatrists, representatives of the transgender community, and the public health specialists commissioned by the Ministry of National Health Services should develop the country-adapted clinical guidelines on hormone therapy and gender-affirming care. These recommendations must be based on the global experience of organizations like the Endocrine Society, but also on the Pakistani healthcare environment, where access, cost, and capacity of healthcare providers vary significantly from those in high-income nations.
6. Social protection and documentation (enforced by NADRA, BISP, provincial social welfare departments): The participants reported that they have been discriminated against in public

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offices, hospitals, and workplaces based on the Gender X marker on their CNIC. Some of them had no valid CNIC, which disqualified them from any official social protection. NADRA is advised to consider the practical implications of the X designation and seek advice from the transgender community organizations on whether alternative methods of documentation would lead to less discrimination while maintaining legal status. BISP and provincial social welfare departments must clearly state that aging transgender people are eligible as a group to the cash transfer programs and eliminate the hurdle of documentation that prevents this group of people from enrolling in the cash transfer programs. To resolve these documentation issues, "structural legal gaps" associated with transgender individuals' entitlement to welfare systems must be addressed (Sohail, 2024).

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