The Struggle for Care: Insights into the Barriers to Transgender Healthcare in West Bengal, India[1]*

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1. Introduction

There is considerable diversity in how individuals and groups understand, experience and express gender through the roles they take on, the expectations placed on them, relations with others and the complex ways that gender is institutionalised in society. The 'fuzzy gender' approach recognises the essential continuity between body and mind, where everything is in 'shades of grey' (between the physical and psychological aspects of gender) (Nagoshi et al., 2012; Tauchert, 2002). The transgender population is an umbrella term for people identifying themselves anywhere along the gender fluid scale. There are many non-western equivalents to the term transgender in India e.g., *hijras, kinnars, aravanis, kothis, shiv-shaktis* and many more based on the region and their role in a relationship. These variations existed even before the term 'transgender' came to use. In most areas of the Indian subcontinent, *hijras* are a cultural gender group; born male by birth (or intersex in some cases), wearing female clothing, having feminine mannerisms, and a part of a profession that includes taking alms, showering blessings and sometimes sex work.

Data on gender and sexual minorities are underrepresented and information about them is practically non-existent in Indian health statistics database. Studies on sexual health first began with the AIDS control programmes for 'high-risk' groups for, men who have sex with men (MSM) and Transgender/Hijra (TG). These groups were seen as the reason for transgression and progression of the disease. Health professionals initially conceptualised gender diversity through a lens of pathology. Literature, anecdotes and newspaper reporting reveal that transgender individuals often face discrimination and harassment while seeking primary health care in India.

The global disease and health burden of transgender people remains understudied, particularly concerning the effects of stigma, discrimination, and social and structural factors that affect their health outcomes. The minority status is often a significant predictor of health and social outcomes. 'Injustice in Every Turn' a report of the survey findings of transgender discrimination in the USA finds that 19 per cent were refused care, 28 per cent were harassed in medical spaces, and over 50 per cent had to teach what transgender health care is to their health provider (Grant et al., 2011). Transgender healthcare in particular is a major grey area in the Indian context.

This paper aims to study contextual determinants (barriers/facilitators) associated with access to healthcare, and while doing so, sheds light on the nature of communication between the healthcare provider and the user. A mixed method design was employed where qualitative interviews and quantitative surveys were done simultaneously with 81 participants, answering the research questions within a framework of queer theories. Issues like invisibility, neglect

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* The study uses extensive references which are not cited here due to space constraints. The Institutional Ethical Review Board of Jawaharlal Nehru University, New Delhi, gave ethical clearance to this study and consent form was signed by every participant.

and victimhood are everyday experiences of the transgender population. Around 54 physicians were also interviewed during the study on knowledge and perception of transgender health.
The study reveals that this demographically diverse gender group has specific health needs-issues that are rarely addressed in Indian transgender discourse. Transgender health users have reported that their mistreatment in healthcare surrounds six fundamental issues-poor communication with caregivers, displays of discomfort, gender insensitivity/harassment, poor quality of care, denied and delayed services, and verbal abuse. Multiple levels of stigma and transphobic attitudes of health workers prevent the transgender community from seeking formal health care.
The data from the study represents a powerful resource for demographic research and a better understanding of how gender identity and sexual behaviour (within a diverse section of the population) interact with societal institutions and public utilities that influences studies of fertility, migration, mortality, health, family structure and other subfields. With more research, demographic data, updated clinical and treatment guidelines, providers are likely to be informed about the population's health needs and feel more comfortable while treating them. The paper advocates the need for including sexual/gender minority communities in the planning committees for regional development (intersections of gender, health, education, employment and basic services).

2. Theoretical focus

The term 'heteronormative' refers to the dominant social norms that regulate identities, sexualities and relationships (Narrain & Chandran, 2016). Heteronormativity assumes that a 'family' unit comprises a man, woman, and children. It is also given that they are each heterosexually identified. Hence, 'appropriate' gender and sexual roles are not only expected but also imposed on them. The gender identity of small but notable number of individuals questions the heteronormativity and gender bias. Many transgender individuals are born into circumstances with a greater probability of marginalisation, discrimination and oppression. They are more likely to have the lesser social capital to fight structural inequality. Societies tend to organise in ways that either purposely or unknowingly favour the majority and perpetuate harmful stereotypes and misinformation on the minority groups (Stryker, 2017). The culture and social norms of a region determine the degree of acceptance of diverse gender/sexual identities into the mainstream. Societies in India clutch on to ideas of what is 'normal' and 'natural' based on prejudices and tend to react with scepticism and question those practices that challenge such standards (for some crossdressing and sex change is unnatural).
A significant turn in the queer studies was the AIDS epidemic that necessitated a rethinking of the relationship between identity, sexuality and public health (making sex a public concern) (Stryker & Whittle, 2013). Active sexual politics of various identities countered the homophobic characterisation of AIDS as a 'gay disease'. Health professionals in the West started gradually using terms like *asserted males and females* for transgender youths as 'asserted' would mean than someone else would not approve of their gender status (Meier & Labuski, 2013).
Several literatures reveal that transgender individuals often face discrimination and harassment while seeking primary health care. The judgemental attitude of the providers and their preconceived notion of gender/sexual identities create a discouraging atmosphere for

transgender health users. Studies have also reported increased rates (than cisgender population) of depression, anxiety, substance abuse, heavy consumption of alcohol and tobacco, rape, intimate partner violence, suicidality and self-harm. (Bockting et al., 2005; Cole et al., 1997; Dickey et al., 2017; Garofalo et al., 2006; Xavier et al., 2005). The risk factors escalate with denied health care due to associated stigma. Compared to cisgender counterparts, more transgender people seek out mental health support for matters that might not relate to their gender identity (Meier et al., 2011). It is also found that access to healthcare for transgender community is a problematic area as their previous experiences with health providers limit formal health-seeking.

This paper uses the framework of 'minority stress theory' and 'intersectionality' to understand transgender health. The healthcare system, as a part of the political and cultural system of the society, has constantly perpetuated inequalities based on gender, sexuality, class, caste, ability and region. Theories derived from feminist and queer studies form the basis of the study, which influences health users' needs and behaviours and the healthcare provider's knowledge and perception of transgender health.

Minority stress theory suggests repeated difficult social situations act as stress that contribute to health disparities, for the LGBT people. These stressors are categorised into two types- external and internal. External stressors (also 'distal') deals with experiences of rejection, prejudice, and discrimination from the society. In time, external stressors can become internal (or 'proximal') stressors, which is characterised by self-doubt, internalised homophobia, vigilance, remaining in the closet, chronic anxiety, depression and outright disapproval (Meyer, 2003; Pascoe & Smart Richman, 2009). Together, internal and external stressors accumulate over time, leading to chronically high levels of stress that causes poor health outcomes. Numerous empirical studies support the minority stress theory regarding transgender health status. The paper by Meyer (2007) also explores minority stress processes along a continuum: from distal stressors to proximal personal stressors.

Oppressive structures like patriarchy, misogyny, capitalism, casteism and racism intersect to make transgender individuals more vulnerable (Rudman & Glick, 2008). An intersectional perspective helps to understand interrelated dimensions of inequality and how they operate. This framework also challenges the lines of fractures within the minority groups and the dominant culture group (Gamson & Moon, 2004; Institute of Medicine (U.S.), 2011). The economic and social positioning of groups within society is associated with institutional practices and policies that contribute to unequal treatment. Battle & Crum (2007) talks about the structural and psychosocial challenges of being a racial minority and how that has an economic dimension that affects access to health services. They also talk about how queerness is stigmatised in the black community and how that further complicates matters concerning internalised homophobia and discrimination. The political well-being of gender minorities is also inextricably linked to their health. The health status of transgender individuals cannot be examined in terms of a one-dimensional sexual/gender-minority category but must be seen as shaped by their multiple identities and the simultaneous intersection of many characteristics.

3. Materials and methods

Reflections on the health issues of the transgender population (and their complex regional identities) pose several methodologic challenges. Problems like defining and measuring socially constructed categories and sampling the hidden populations concerning sensitive topics are significant hurdles (Dean et al., 2000; Meier & Labuski, 2013).

Mixed method research is the primary methodology and approach for this study that involves collecting, analysing and integrating qualitative and quantitative research methods. In this study, the qualitative interviews explore the experiences of transgender individuals while accessing the health care system. At the same time, quantitative methods like responses from surveys are used to explain the relationship between the health behaviour of the community and their access to primary health care. The reason for combining both qualitative and quantitative data by converting them into a mixed-method study is to understand the research problems both in the detailed description and by the broad numeric trends (Creswell & Plano Clark, 2018). The interviews generated themes and memos, while the survey generated descriptive statistics. The two forms of outcomes are then integrated through joint displays, data transformation, and meta-inferences. In this study, data sources explore and access the transgender community's experiences, relationships, interactions, accounts, feelings, memories, interpretations, expectations, perceptions, emotions, opinions, thoughts, behaviour and practices, given the time and space. Mixed methods research offers an approach that can provide both width and depth to the study. It helps to obtain a better understanding of the phenomena and, at the same time, increase the evidence base of the survey (Andrew & Halcomb, 2009; McBride et al., 2019). According to Morgan (1998), a mixed method is the best way to capture the complexity of different factors influencing health and health-seeking behaviour.

Since the community itself is very closeted, it is vital to know both their individual experiences and, at the same time, have a substantial number that will reflect the community experiences. A phenomenon could be explained through quantitative data, and rich descriptive could be obtained through the qualitative data collection method. Merging and comparing the results will help to generalise the phenomena. Mixed methods are helpful to integrate in-depth qualitative interview data of the transgender key informants with the cross-sectional survey data from the transfeminine community in West Bengal.

Samples were collected from 19 out of 23 districts in West Bengal from 2019-21. Only trans-feminine spectrum of the population was considered for the study. The inclusion criteria were that the respondents must be a resident of West Bengal and had used health services there, at least once in the past year. Physicians from West Bengal were also interviewed regarding their perception and practices on transgender health. While identifying transgender individuals a two-step approach was employed. First, the respondents were asked about their sex at birth and then they were asked about what they feel their gender is. For interview purposes, only those who manage or are involved with Community Based Organisations were considered. They were also capable of providing further contacts, which were followed up for the survey. Pseudonyms are used throughout the study and data is managed with complete confidentiality. Questions covering socio-demographic characteristics, living arrangements, general health,

lifestyle and nutrition, sexual health, mental health, health-seeking behaviour and barriers or facilitators to healthcare were asked.

Table 3.1: - Sampling details of the study

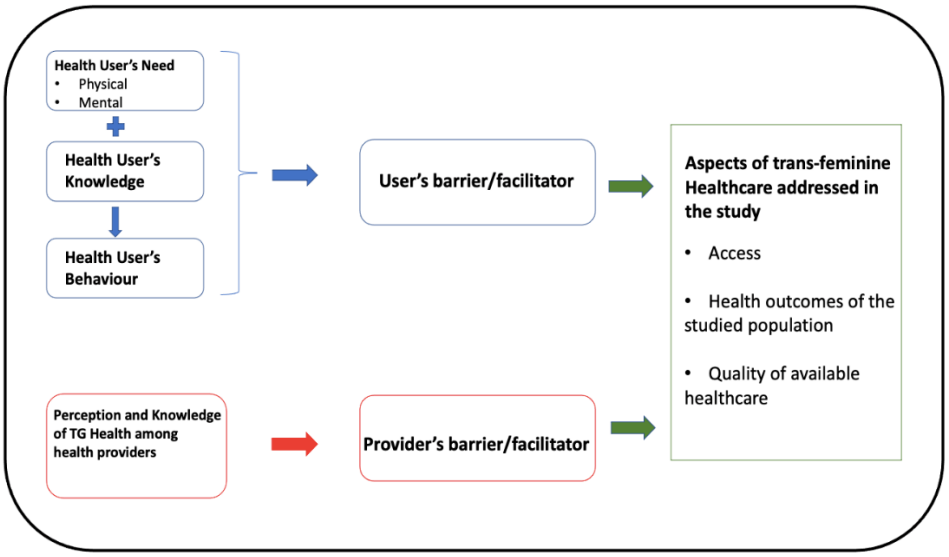
Sampling consideration	**Relevance to the study**
Target population	Transfeminine population in West Bengal; Registered physicians in West Bengal
Sample timing	Synchronous; June 2019 to September 2021
Sampling relationship	Parallel; QUAN and QUAL samples are different
Mixed Method sampling strategies	Snowball sampling for TG population (Total sample=81) QUAN; **N=59** QUAL; **N= 22** Theoretical sampling for physicians (a form of sequential sampling in which the researcher examines a particular phenomenon based on theory leads) **N=54**
Source: - Conceptualised by the author	

Interviewing through purposive sampling is done until theoretical saturation or informational redundancy has been achieved, that is, when no new data or dimension stimulate new theoretical understanding.

3.a. Conceptual framework

The conceptual framework in the form of a diagram guides the research design. It is a system of concepts and ideas that underlie the research and their relationship with each other. Theoretical frameworks as organising structures are a must for mixed methods studies (Evans et al., 2011).

Figure 3.1: - Framework of the study



SOURCE: - Conceptualised by the author

This conceptual framework provides a structure for a complex investigation of health needs, behaviours and communication and patient-centric healthcare. Theories derived from feminist and queer form the basis of the study, which not only affects the outcome indirectly but directly influences health users' needs and behaviours and the healthcare provider's knowledge and perception of transgender health. Health service users' experiences and behaviour could act as a facilitator or barrier to effective health outcomes, improved access and better quality of health services. The opposite is true as well.

On the other hand, health care provider's knowledge also acts as a facilitator or barrier to health outcomes, improved access and better quality of health services. The diagram allows a constant interaction with the theory and data and helps in addressing the related constructs (Evans et al., 2011).

This paper deals with only the 'access' part of the study outcome. In layman's term, 'access' means ability of the health users to avail health services which include, prevention, screening, maintenance of health, management of diseases and treatment. The IOM defines *access* to health care as the "timely use of personal health services to achieve the best possible outcomes" (Institute of Medicine (U.S.), 2011. pp. 61). For the betterment of health, access to qualified practitioners is also important. Access to care varies by state, demographics, and insurance coverage. Good access can improve the quality of life for patients. Five different aspect of health accessibility will be addressed through the study-approachability, acceptability, affordability and appropriateness (Levesque et al. 2013).

4. Results

Transwomen in this study faced more discrimination because of their lowered gendered status (being a woman) and female gender expression (cross-dressing; which is often publicly displayed, like in the case of the *hijras*). Navigation within the 'non-transitioned' space is also greater for asserted males than asserted females as more transwomen opted for surgical interventions to claim their feminine space.

Delay in identifying gender dysphoria (medically), lack of family support (often evicted/displaced), isolation, disruption in vocational education, unemployment, and disenfranchisement; all led to a undervalued gender status. The exclusion of the non-normative gender identities from public life is reinforced by strategies like cultural censorship, criminalisation and civic disenfranchisement through denying civil rights and political representation (Seidman, 2001).

4.a. Lifetime experiences

'Harassment' has been used 133 times to narrate life stories and explain the poor utilisation of formal health care services as per this study. The next most repeated word was 'discrimination', used 86 times while accessing public facilities, including health care. Almost every interviewee used 'harassment' and 'discrimination' at some point during their interview. *"I stay in a red-*

light area, and I am a child of a Dalit[2] *sex worker. So, you see, I face stigma being a transwoman, a Dalit and a child of a sex worker.*"- says Bani. This instance depicts how their lives are pitted with multiple levels of stigma and prejudiced events. More than 90% respondents have reported verbal abuse (in form of calling names, hooting, cat-calling, rude behaviour, and discrediting identity) to be the most common harassment in medical spaces. Many (44%) respondents have said that they visit medical institutions wearing feminine attire. Surprisingly the rest either dress in men's clothing or unisex attires even though they associate with feminine identity and social role. Manu had to leave the doctor's clinic because of an uncomfortable situation, *"I always visit the doctor wearing a saree and sindur*[3]*. That is what I wear in general. Once a doctor asked my relationship status and enquired why I am wearing sindur. Immediately, he started laughing at me. I got up and left."* Ravi is accustomed to the harassment due to cross dressing, *"I have to wait for a long time in the lobby- say for two/three hours. This happens more when I cross dress. But I think this is 'normal'. If you cross-dress in public areas, people will tease you."* The participants have divulged that harassment is more when they cross-dress, and all those who have worn feminine attire have reported being harassed in public hospitals. Somewhere they have also normalised this kind of harassment in the public spaces.

Vishakha faced harassment during admission to a government hospital in Kolkata. *"Once, I had cerebral malaria and was taken to reputed government hospital. I was kept waiting for four hours on an emergency bed as they could not decide where to put me- male or female ward. There was so much confusion! After this delay, my activist friend called the local councillor, and in a few more hours, a private cabin was allotted. The nurses would misbehave, and they did not respond when I called them. Harassment was there at every stage. I had to face all of these because of my gender identity."* In general, trans people feel uncomfortable in public areas when people stare at them because of their gender expression. Incidents like this were shared by 88 per cent of the respondents.

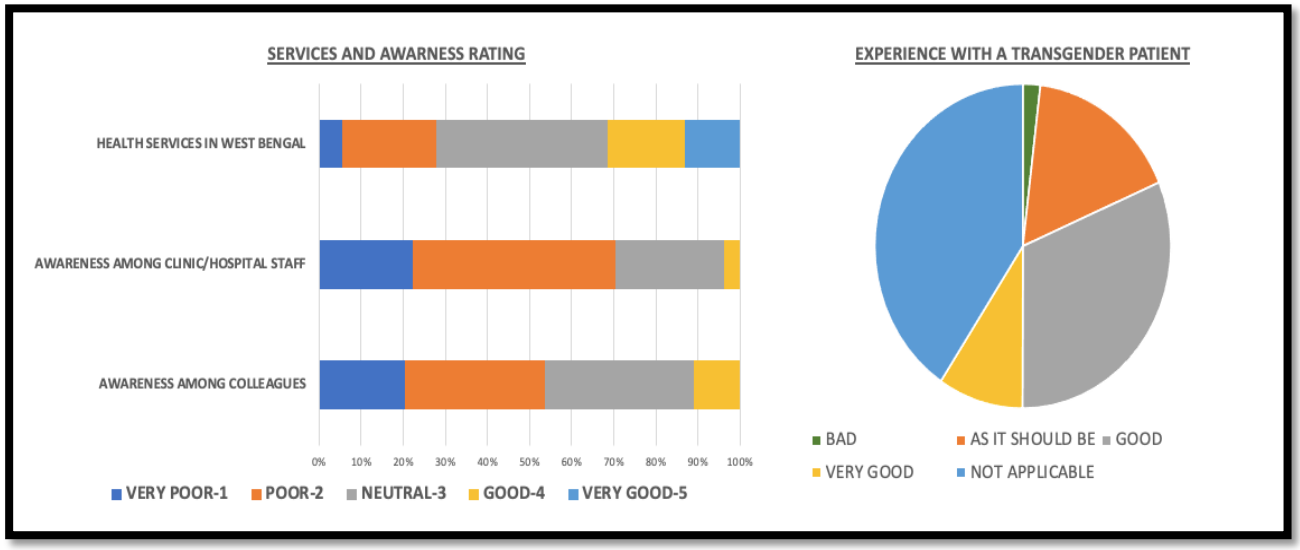
4.b. Health providers' perspectives

The study asked 54 physicians through theoretical sampling about their perception and knowledge of transgender health. This survey was done keeping in mind the overall concept of transgender health, which has two sides of the story: the user's side and two the providers' side. Contrary to the belief that there is lesser visibility of transgender health users, the majority of doctors (57%) have encountered trans-feminine patient at some point in their career. Around 22 per cent have reported having treated a transgender patient in case of an emergency. Some doctors believe being transgender is a mental disorder and more than 70% said that they feel uncomfortable around transgender patients. Over 90% believe that they could not provide proper care as they have never done any course/workshop on gender affirmative care. The

[2] Dalit refers to historically marginalized communities in India, formerly considered 'untouchables' under the India's caste-based hierarchical social structure.
[3] Sindur (also spelled as sindoor) is a traditional red or vermillion powder worn by married Hindu women along the parting of their hair as a symbol of marital status.

transphobic attitude of doctors, ignorance and multiple levels of stigma prevents the trans community from seeking formal health care.

Figure 4.1: - Distribution of doctors by rating for experiences, services and awareness



SOURCE: - Computed by the author from primary data, 2019-2021. N=54

The bar chart evaluates three aspects: healthcare services in West Bengal, awareness among clinic or hospital staff, and awareness among colleagues. Although progress has been made in some areas, significant efforts are still needed to improve healthcare services and awareness. In comparison to this majority (52.3%) of the transgender respondents also think that the existing health services are average with further room for improvements. Around 53 per cent rated their experience with transgender patients as 'good' and none of them reported that their transgender patients misbehaved with them. Even though most doctors identify a communication gap, some quickly blame the trans community for their health behaviour. According to one of the doctors, *"users have to participate in accessing the healthcare actively. Until they claim their needs, nothing will change. I also find a communication gap between transgender and 'normal' people. Some TG community consciously maintains such differences to protect their secrecy. This gap needs to be bridged somehow."*

4.c. Barriers to health services

Research suggests that provider-patient communication is often challenging and complex. Even though 75-90 per cent of people experience clinically significant symptoms, only one third would seek medical help to avoid encounters with physicians (Pennebaker, 1982). If such gaps exist for the cisgender population, the transgender population is likely to face similar issues, compounded by stigma and transphobia. Around 75 per cent of doctors and 78 per cent of transgender health users said that they feel there is a gap in exchanging health information. A health user informed that, "*Doctors get scared when they see a hijra person. They get confused and do not know how to behave with us. Doctors are not willing to understand TG patients. Both the patients and doctors do not have a clear understanding of transgender health care."* However, the trans-feminine population faces more communication barriers because of

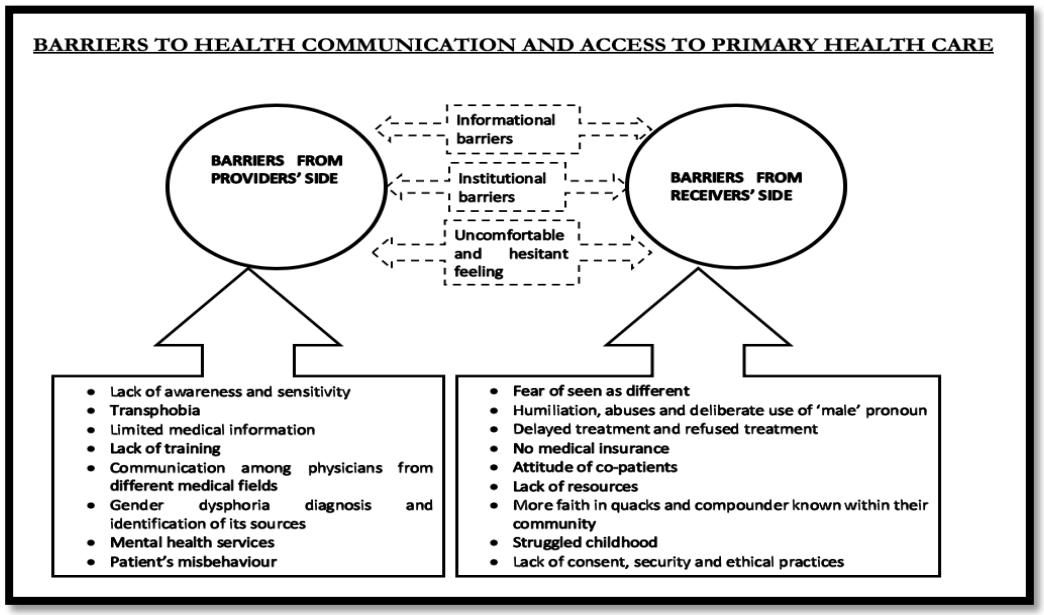
gender expression and transphobia from society (health providers being a part of that society). Many doctors, said that the gap in social capital and education leads to the most significant communication barrier. The general themes of communication gap from analysis of transcripts are lack of doctor's knowledge and understanding among doctors, transphobia, less time per patient along with the users' fear of disclosing and wide gap in social capital. Tapashi says- *"Doctors do not know what the term transgender means and how they should be treated. Transgender persons also feel ashamed to disclose themselves as they fear that the doctor would not understand them and rather judge them".* On the other hand, a doctor says, "*there is a lack of empathy from our side as well. Discrimination prevents TG patients from seeking treatment. But sometimes they would also express loud behaviour, clap and use slangs on the hospital premises*." Riya rightly says, "*the whole medical fraternity has no knowledge about our bodies. This is a patriarchal society full of prejudices, and doctors are not out of that system; hence they do not know about us and do not know how to respect us."* One of the doctors says, *"transgender health is still a mystery to public hospitals".* Indeed, not many doctors knew about trans-specific healthcare. Most doctors agree that there is a misinterpretation of information from both sides. However, it is interesting that most doctors explained the gap as their inability to communicate and for transgender persons, the gaps are directed toward the doctor's failure to provide conducive environment and trans-specific health care. This communication gap also leads to generation of a poor health literacy. The users feel disrespected, lost and lack confidence in the doctors (Poteat et al., 2013; Snelgrove et al., 2012). Finally, the outcomes of the communication gaps are gender bias in the medical community, poor delivery of patient care, poor health organisation and more visible and widened health disparity across gender and socio-economic groups.

Barriers to proper health care are multifactorial and are both ways. Informational and institutional barriers work from both providers' and receivers' sides. Lack of knowledgeable health care providers and medical information regarding trans health care is cited as hurdle for trans patient. Provider side barriers include- lack of training, limited medical knowledge, little access to information, communication among physicians of different medical fields, the role of mental health services and gender dysphoria diagnosis (Bauer et al., 2009; Fikar & Keith, 2004; Gapka & Raj, 2003; Snelgrove et al., 2012). In many cases, the providers' and service users' perspectives and expectations do not align regarding the accessibility of health care and medical treatment outcomes (Gulliford et al., 2002; Mason et al., 2004; Snelgrove et al., 2012).

There are more barriers than facilitators to transgender health. In fact, there are no identifiable facilitators to transgender health. The study identifies 16 types of obstacles to healthcare as perceived by the users. Tapashi was admitted to a government hospital in an emergency after the incident of gang rape. Even in that condition, she had to deal with harassment from the medical providers. *"I was rushed to reputed public hospital after this incident. The doctor on duty said 'do boys get raped!!' The nurse and the staff boys started giggling. One of the staff boys said, 'you open your clothes and show us whether you are raped from the front or from behind'. This is how I was harassed at the emergency. The hospital did not even give me any ART drugs. I had to take it from the CBO where I worked. After three days, I was discharged from the hospital. The doctor said before leaving, 'do not do such 'dirty' things further. Try to*

control your sexual urges.' I was shocked at this behaviour. I do not do anything he was indicating." Another time, she encountered weird questions about a very common fever. *"Post my emasculation surgery, I went to see a doctor because I had a high fever. At first, the doctor gave me a perplexed look. He was confused about whether I was a male or a female. He started to ask me weird questions about my body and how I have sex. Immediately, I got up and left. Before leaving, I told him that I had paid his fees so that he could buy some books on sex and gender and get himself educated."* The excerpts of her encounters in public health system highlights delayed and denied care because of her gender identity.

Figure 4.2:- Barriers to access to health



SOURCE: - Conceptualised by the author from primary data, 2019-2021.

Specific barriers to health communication were identified during the study (both interview and survey) and from the literature. Figure (4.2) shows the nature and directions of the accessing barriers. Barriers are seen from both the receiver's side, that is, the trans patients and also from the provider's side, which is the health care professionals. Informational barriers, structural barriers and interaction barriers affect both ways. There are, however, certain specific factors that act as barriers from each side. The cultural, social and behavioural factors are different for each side and work under various levels of stigma as well as past experiences. A qualitative study by Snelgrove et al. (2012) with thirteen physicians found five primary barriers to health care for transgender persons. They are: - accessing resources, medical knowledge deficits, ethics of gender transition-related medical care, diagnosing or pathologizing trans patients, and health system determinants. A centralising theme of 'not knowing where to go or who to talk to' was also identified. They also found that patients' unrealistic expectation of the outcome, especially in transition-related care, poses a significant challenge. Both the trans community and healthcare providers agree that there are many barriers to healthcare for trans persons that cluster around four main issues: (1) uneasiness to disclose, (2) lack of provider experience,

knowledge and resources, (3) structural barriers, and (4) financial barriers (Institute of Medicine (U.S.), 2011; Roberts & Fantz, 2014; Snelgrove et al., 2012).

Some of the emergent themes of barriers identified by the respondents are- harassment by a doctor, rejection, deliberate use of disrespectful language, inquisitiveness about sexual practices, lack of privacy, misbehaviour by doctor, unethical practices by doctors, no 'other gender' option in medical forms, delayed care, longer wait time than cisgender, harassment by staff, harassment by co-patients. These discrimination processes have been so normalised that most of the respondents casually pass by such events without any objection.

Parama had to face unnecessary questions from the doctor- "*I had a stomach ache, but the doctor asked about my sexual orientation and sexual practices. The doctor also asked me whether I was a hijra. I felt humiliated and left. Tell me what relation you find with a stomach ache and all these irrelevant questions.*" Jeena feels "*there is no privacy in government hospitals. They try to harass every TG person. Once I had a problem with my private parts. The doctor asked me to open my pants in front of everyone. I was embarrassed a lot."* Shiela had to face multiple forms of harassment during medical check-ups and testing. *"I had STI a few years back. I went to see a doctor in a government hospital. He did not even hesitate to say, 'why do you do these things? Until and unless you people rectify these things will happen. Don't you feel ashamed?'. I was so embarrassed that I had to leave." "Another time, I went for a COVID-19 test. I told the receptionist to write 'TG' in the gender column. Now when the report came, I saw that my name was written as 'TG XYZ' and my gender 'not known'. Just tell me what to do? Even if I tell them what to write, they will not use a word that is unknown to them. I feel my gender identity has been violated because of this action."*

Table 4.1: - Challenges in access to health care among the trans-feminine population

BARRIERS FACED WHILE ACCESSING HEALTH	**PERCENTAGE**
Wait longer than cisgender	45.8
Delayed treatment	55.9
Ridiculed by medical professionals	74.6
Mistreated by medical professionals	42.4
Refused treatment by medical professionals	22
Felt uncomfortable during medical tests	18.6
Unethical practice by doctors	52.5
No TG option in medical forms	86.4
SOURCE: - Computed by the author from primary data, 2019-2021. N=81	

There are also multiple levels of barriers to access to health care: personal, community level and structural. It is also seen that in 23 per cent of cases, transgender persons avoided healthcare due to anticipated discrimination (Kcomt et al., 2020).

Table 4.2: - Multi-level barriers faced by the trans-feminine community while accessing health care

Level of barrier	Representative themes and quotations
Personal	• Lack of awareness of service availability • Cannot pay for costly transition-related services in private hospitals *"I do not want to go for SRS. I am happy the way I am because I cannot afford five-six lacs rupees for SRS. Moreover, I heard there are a lot of complications as well. I can be a trans without any surgery as well."*
Community	• Preference for emasculation from unregistered clinics • Acceptance/Rejection in the community based on the gender status *"I think it is better to go to Bihar and get emasculation done. It is cheaper and far less complicated. Anyways I cannot have sex with the neo-vagina. So, it is better to settle for emasculation. Most of the kothis, hijras and launda dancers now prefer this over castration from the elderly hijras."*
Structural	• Lack of trans-friendly units/clinics; No GAT services • No clarity on the legal status of SRS • Shortage of culturally competent doctors • No inclusion in health policy • No coverage in insurance *"Tell me, is there any benefit for us anywhere? We are always marginalised. There are no efforts from the government to mainstream us."*
SOURCE: - Computed by the author from primary data, 2019-2021.	

Stigma and widespread prejudices are the primary reasons for discrimination in health care for transgender people in the United States (White Hughto et al., 2015).The scenario is no different in the case of India.

Table 4.3:- Examples of stigma in healthcare encounters

Forms of stigma	Representative quotations
Blaming	The doctor shouted at me, *"Why did you do all these dirty works. It is obvious you would have an infection. Now you have to come to me. I am treating you this time, but I do not want to see you again."*
Shaming	The doctor giggled at me at first. Then he said to me, *"Your name is that of a female, but you are a male. Do you think you can be female by changing your name?"* I always wear sindoor. Now the doctor asked me, *"Who will marry you that you are wearing sindoor?"*
Othering	*I went for a COVID-19 test a few days back. I told the person to write 'TG' in the gender column. Now when the report came, I saw that my name was written as 'TG XYZ' and my gender 'not known'. Just tell me what to do? Even if I tell them what to write, they will not use a word that is unknown to them.*

Discriminating	I have faced a lot of discrimination while visiting doctors in female clothing. Once a receptionist said, *"Oh! You people again! The doctor is not available now. Come back tomorrow."* I can see that the doctor is there checking his patients.
SOURCE: - Computed by the author from primary data, 2019-2021.	

Transgender persons are not in the social position to challenge the system and hierarchies of knowledge. Many doctors, in fact, agreed that the gap in social capital and education leads to the most significant communication barrier. But in reality, such knowledge gaps only perpetuate stigma driving further disadvantage and vulnerability. This discrimination process has been so normalised that only six respondents said that they were vocal or protested when they were ill-treated in a medical set-up.

5. Discussion

Previous experiences of harassment and discrimination along with gender dysphoria and additive minority stress lead to certain types of health behaviours. Like behaviours in illness, where most respondents sought help from informal health set-ups or simply self-medicated themselves based on the information available from the internet, social media and/or advice from peers. Their recognition comes with legal and medical pre-conditions that often infringe the right to self-determination, privacy and physical integrity (Szydlowski, 2016). Family, educational institutions, workspaces and health policies work as institutions of resistance for transgender persons. It is to be kept in mind that experiences of discrimination in health care are not homogenous and vary with the socio-cultural-economic identity of the person. This study finds that discrimination and social status have an inverse relationship. A similar finding has also been observed by Romanelli & Lindsey (2020) while discussing health care discrimination and intersecting identities.

The experiences by study participants clearly depict that the life of a transgender person is not easy as their minority identity acts as a stumbling block in every aspect. Gender identity and related minority stress play a critical role in the health-seeking behaviour of transgender individuals. There are quite a few proximal and distal stressors that create minority stress on transgender individuals. To balance out, community support and Gender Affirming Therapy (GAT) are two crucial pillars of coping with minority stress. This stress has a damaging impact on the mental and physical health of the transgender persons until and unless remedied with trans-inclusive environment.

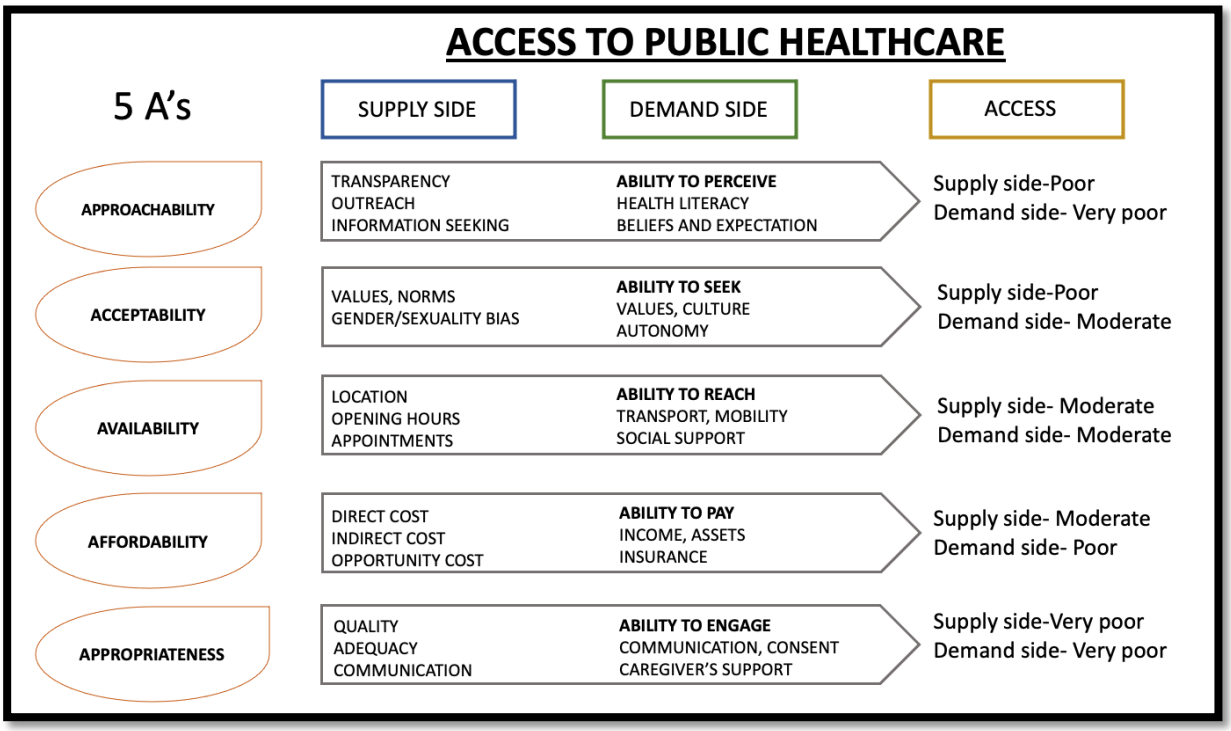
Right from the reception counter to the doctor's chamber, there is a non-acceptance throughout the health system. There are more barriers than identifiable enablers (like treatment guidelines, workshops, availability of specialised services, inclusive environment, comprehensive care models, legal support and advocacy for identity recognition, grievances redressal) for transgender health in West Bengal. It is seen that transgender people are less likely to have access to insurance than the cisgender population due to discrimination in employment and lack of social capital (Stroumsa, 2014). Besides all forms of bias, affordability in accessing health is a crucial issue for transgender persons seeking healthcare.

The prevalence of implicit bias in the healthcare setting is evident in the medical curriculum (Nama et al., 2017). There is no curriculum in the education system for doctors and allied health

providers where they are taught about the specificities of dealing with a transgender patient. Reference categories of medical tests also pose a significant barrier to seeking healthcare that is binary gender-specific. The hormones, creatinine, components of the complete blood count and alanine aminotransferase have reference intervals for males and females (Hembree et al., 2009). A transgender person (MtF or FtM) practically has no reference category. Transgender persons are often on HRT, and the absence of such categories only points out the medical system's reluctance to include diverse medical categories. Furthermore, doctors often violate ethical principles of confidentiality and consent.

Around 85% respondents have multiple mental health problems like depression, anxiety, guilt and trauma. Roughly 53 per cent of respondents from the study said that they have been to a counsellor at least once in their life. Besides these, the high rate of substance abuse and suicidal tendencies among the transgender population needs to be mitigated with guidance and support. In this study, around 46 per cent of respondents have done self-harm, 27 per cent attempted suicide, and 44 per cent had suicidal thoughts. Apart from inadequate mental health support, discrimination, ill-treatment, harassment and negligence further act as stressors to their psychological health.

Figure 5.1: - Levels of access to public healthcare among trans-feminine study population



SOURCE: - Conceptualised by the author from primary data, 2019-2021

Levesque et al. (2013) identify five different aspects of accessibility to health: approachability, acceptability, availability, affordability, and appropriateness. These five A's are conceptualised by the scholar to define the access to public healthcare from the study findings. Please note that the 'access' outcomes are not quantitatively measured. Rather, they are the meta inference drawn from both the approaches (QUAL+quan) together. The outcomes are influenced by the field observations as well. The findings refer to the interviewed and surveyed trans-feminine

community and the health providers in West Bengal. Further studies with larger sample sizes are required to verify these outcomes at national level.

- **Approachability**: - the health care user must be able to reach the service providers and engage in social and cultural factors that shape the service and its structure (such as beliefs associated with a practice or practitioners providing the care). For transgender persons, approachability is low as many practices self-medication, use of over-the-counter drugs and visit to non-medical professionals. Only in the case of GAT, tendencies to contact formal institutions are higher. Navigating through the rigid health care process becomes difficult for most due to a lack of caring and competent health professionals.
- **Acceptability**: - This approach works from both the receiver's and provider's sides. Acceptance of formal medical practices are low among transgender people, and it is further lower for health providers. Various anecdotes and the data from the study suggest that transgender people cannot access the health care system because of the low acceptance rates among the doctor's community.
- **Availability**: - An essential aspect of seeking health care is the timely availability of the services. Needless to say, the most demanding service is the GAT is not available to the trans population in public hospitals. Only a few private clinics perform gender-affirming surgeries without considering the patient's satisfaction. There is also a shortage of information for health users on managing gender dysphoria, endocrine management and sexual health.
- **Affordability**: - Services need to be affordable to increase access. Many users turn to unprofessional medical surgeons to perform emasculation, otherwise not affordable in private hospitals. Most insurance companies do not provide coverage for HRT and surgeries. In most cases, a common person (so do transgender persons) only visits a hospital in illness behaviour and not for preventive check-ups. This is to avoid the continuous investments involved in preventive check-ups.
- **Appropriateness**: - The health users must believe that the service fits their needs. They should feel that a particular treatment is curated explicitly for them. In most cases, the providers fail to take a personal and medical history of trans persons because of transphobia and lack of knowledge on trans health. This leads to incorrect prognosis and poor referral rates. Many users are also not comfortable disclosing their gender/sexual identity to the doctors in fear of anticipated stigma.

The underlying spadework of stress is clearly visible in the health outcomes of the community. In general, physical health, sexual health and mental health of the studied population is mediocre. Their typical health behaviour of avoiding formal medical institutions is the reason of poor health outcomes. The community also shows high risk-taking behaviour and consumption of alcohol and tobacco to deal with their daily hassle of living a life of marginalised gender. These outcomes are poorer than the cisgender counterpart when compared on few parameters from the national health survey.

Generating knowledge regarding transgender health can guide public health discussions and bring important issues to the surface. At the core, an expansive definition of health suggests the centrality of issues of inclusion to the well-being of populations. A positive outcome of

patient-centric behaviours by the health providers (valuing patient opinion, expectations and preferences) showed greater patient satisfaction (Stewart, 1984). Patient-centred communication practices allow providing input from the patient's side as well (Stableford & Mettger, 2007). Choosing appropriate language and pronouns is essential for building trust and fostering a positive relationship with transgender patients.

6. Conclusion

The prevailing transphobic and homophobic attitude among health care professionals and people makes it even more difficult for a transgender person from a low socioeconomic setting to access the services at private health centres. Most of the time, they are refused treatment, and almost every time, they are verbally abused. They are seen as outcasts and hence are cornered in the system. There is also an underestimation of the number of populations for which specific policies could be targeted. This leads to faulty policy frameworks and limited implementation.

A drawback of the study is that it questions access to healthcare only at one level of healthcare workers- the doctors. Attitudes of nurses, administration, technicians and ward boys are only obtained from the health user's experiences. The doctors, however, displayed very minimal knowledge of transgender health and lacked expertise in managing transgender patients.

A healthy population is essential for human development. Transgender health needs to be viewed within the framework of human rights, where knowledge must translate to visible and effective action. The agencies need to engage with issues that present a threat to the population's health. Creating systems and atmosphere that allow transgender people to affirm their lived identities are crucial for their health and well-being.

In the current setting, transgender health users do not get optimal health care (more negative health care) which directly increases the burden of diseases and morbidity rates among the population. Failure to recognise and accommodate transgender health users within sex-segregated healthcare systems leads to exclusionary and deficient health policy.

Reference:

Andrew, S., & Halcomb, E. (Eds.). (2009). *Mixed methods research for nursing and the health sciences*. Wiley-Blackwell Pub.

Battle, J., & Crum, M. (2007). Black LGB Health and Well-Being. In I. H. Meyer & M. E. Northridge (Eds.), *The Health of Sexual Minorities* (pp. 320–352). Springer US. https://doi.org/10.1007/978-0-387-31334-4_13

Bauer, G. R., Hammond, R., Travers, R., Kaay, M., Hohenadel, K. M., & Boyce, M. (2009). "I Don't Think This Is Theoretical; This Is Our Lives": How Erasure Impacts Health Care for Transgender People. *Journal of the Association of Nurses in AIDS Care*, *20*(5), 348–361. https://doi.org/10.1016/j.jana.2009.07.004

Creswell, J. W., & Plano Clark, V. L. (2018). *Designing and conducting mixed methods research* (Third Edition). SAGE.

Dean, L., Meyer, I. H., Robinson, K., Sell, R. L., Sember, R., Silenzio, V. M. B., Bowen, D. J., Bradford, J., Rothblum, E., White, J., Dunn, P., Lawrence, A., Wolfe, D., & Xavier, J. (2000). Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns. *Journal of the Gay and Lesbian Medical Association*, *4*(3), 102–151. https://doi.org/10.1023/A:1009573800168

Evans, B. C., Coon, D. W., & Ume, E. (2011). Use of Theoretical Frameworks as a Pragmatic Guide for Mixed Methods Studies: A Methodological Necessity? *Journal of Mixed Methods Research*, *5*(4), 276–292. https://doi.org/10.1177/1558689811412972

Fikar, C. R., & Keith, L. (2004). Information needs of gay, lesbian, bisexual, and transgendered health care professionals: Results of an Internet survey. *Journal of the Medical Library Association: JMLA*, *92*(1), 56–65.

Gamson, J., & Moon, D. (2004). The Sociology of Sexualities: Queer and Beyond. *Annual Review of Sociology*, *30*(1), 47–64. https://doi.org/10.1146/annurev.soc.30.012703.110522

Gapka, S., & Raj, R. (2003). *Trans Health Project: A position paper and resolution adopted by the Ontario Public Health Association.* OPHA.

Grant, J. M., Mottet, L. A., Tanis, J., Harrison, J., Herman, J. L., & Keisling, M. (2011). *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey.* (pp. 1–220). Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force. https://www.transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf

Gulliford, M., Figueroa-Munoz, J., Morgan, M., Hughes, D., Gibson, B., Beech, R., & Hudson, M. (2002). What does "access to health care" mean? *Journal of Health Services Research & Policy*, *7*(3), 186–188. https://doi.org/10.1258/135581902760082517

Hembree, W. C., Cohen-Kettenis, P., Delemarre-van de Waal, H. A., Gooren, L. J., Meyer, W. J., Spack, N. P., Tangpricha, V., & Montori, V. M. (2009). Endocrine Treatment of Transsexual Persons:An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism*, *94*(9), 3132–3154. https://doi.org/10.1210/jc.2009-0345

Institute of Medicine (U.S.) (Ed.). (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. National Academies Press.

Kcomt, L., Gorey, K. M., Barrett, B. J., & McCabe, S. E. (2020). Healthcare avoidance due to anticipated discrimination among transgender people: A call to create trans-

affirmative environments. *SSM - Population Health*, *11*, 100608. https://doi.org/10.1016/j.ssmph.2020.100608

Levesque, J.-F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*, *12*(1), 18. https://doi.org/10.1186/1475-9276-12-18

Mason, K., Olmos-Gallo, A., Bacon, D., McQuilken, M., Henley, A., & Fisher, S. (2004). Exploring the Consumer's and Provider's Perspective on Service Quality in Community Mental Health Care. *Community Mental Health Journal*, *40*(1), 33–46. https://doi.org/10.1023/B:COMH.0000015216.17812.ed

McBride, K. A., MacMillan, F., George, E. S., & Steiner, G. Z. (2019). The Use of Mixed Methods in Research. In P. Liamputtong (Ed.), *Handbook of Research Methods in Health Social Sciences* (pp. 695–713). Springer Singapore. https://doi.org/10.1007/978-981-10-5251-4_97

Meier, S. C., & Labuski, C. M. (2013). The Demographics of the Transgender Population. In A. K. Baumle (Ed.), *International Handbook on the Demography of Sexuality* (Vol. 5, pp. 289–327). Springer Netherlands. https://doi.org/10.1007/978-94-007-5512-3_16

Meyer, I. H. (2007). Prejudice and Discrimination as Social Stressors. In I. H. Meyer & M. E. Northridge (Eds.), *The Health of Sexual Minorities* (pp. 242–267). Springer US. https://doi.org/10.1007/978-0-387-31334-4_10

Morgan, D. L. (1998). Practical Strategies for Combining Qualitative and Quantitative Methods: Applications to Health Research. *Qualitative Health Research*, *8*(3), 362–376. https://doi.org/10.1177/104973239800800307

Nagoshi, J. L., Brzuzy, S., & Terrell, H. K. (2012). Deconstructing the complex perceptions of gender roles, gender identity, and sexual orientation among transgender individuals. *Feminism & Psychology*, *22*(4), 405–422. https://doi.org/10.1177/0959353512461929

Nama, N., MacPherson, P., Sampson, M., & McMillan, H. J. (2017). Medical students' perception of lesbian, gay, bisexual, and transgender (LGBT) discrimination in their learning environment and their self-reported comfort level for caring for LGBT patients: A survey study. *Medical Education Online*, *22*(1), 1368850. https://doi.org/10.1080/10872981.2017.1368850

Narrain, A., & Chandran, V. (Eds.). (2016). *Nothing to fix: Medicalisation of sexual orientation and gender identity*. SAGE Publications India.

Pennebaker, J. W. (1982). *The Psychology of Physical Symptoms*. https://doi.org/10.1007/978-1-4613-8196-9

Poteat, T., German, D., & Kerrigan, D. (2013). Managing uncertainty: A grounded theory of stigma in transgender health care encounters. *Social Science & Medicine*, *84*, 22–29. https://doi.org/10.1016/j.socscimed.2013.02.019

Roberts, T. K., & Fantz, C. R. (2014). Barriers to quality health care for the transgender population. *Clinical Biochemistry*, *47*(10–11), 983–987. https://doi.org/10.1016/j.clinbiochem.2014.02.009

Romanelli, M., & Lindsey, M. A. (2020). Patterns of Healthcare Discrimination Among Transgender Help-Seekers. *American Journal of Preventive Medicine*, *58*(4), e123–e131. https://doi.org/10.1016/j.amepre.2019.11.002

Rudman, L. A., & Glick, P. (2008). *The social psychology of gender: How power and intimacy shape gender relations.* (pp. xiii, 386). Guilford Press.

Seidman, S. (2001). From Identity to Queer Politics: Shifts in Normative Heterosexuality and the Meaning of Citizenship. *Citizenship Studies*, *5*(3), 321–328. https://doi.org/10.1080/13621020120085270

Snelgrove, J. W., Jasudavisius, A. M., Rowe, B. W., Head, E. M., & Bauer, G. R. (2012). "Completely out-at-sea" with "two-gender medicine": A qualitative analysis of physician-side barriers to providing healthcare for transgender patients. *BMC Health Services Research*, *12*(1), 110. https://doi.org/10.1186/1472-6963-12-110

Stableford, S., & Mettger, W. (2007). Plain Language: A Strategic Response to the Health Literacy Challenge. *Journal of Public Health Policy*, *28*(1), 71–93. https://doi.org/10.1057/palgrave.jphp.3200102

Stewart, M. A. (1984). What is a successful doctor-patient interview? A study of interactions and outcomes. *Social Science & Medicine*, *19*(2), 167–175. https://doi.org/10.1016/0277-9536(84)90284-3

Stroumsa, D. (2014). The State of Transgender Health Care: Policy, Law, and Medical Frameworks. *American Journal of Public Health*, *104*(3), e31–e38. https://doi.org/10.2105/AJPH.2013.301789

Stryker, S. (2017). *Transgender history: The roots of today's revolution* (Second edition). Seal Press.

Stryker, S., & Whittle, S. (Eds.). (2013). *The Transgender Studies Reader* (0 ed.). Routledge. https://doi.org/10.4324/9780203955055

Szydlowski, M. (2016). Gender recognition and the rights to health and health care: Applying the principle of self-determination to transgender people. *International Journal of Transgenderism*, *17*(3–4), 199–211. https://doi.org/10.1080/15532739.2016.1217183

Tauchert, A. (2002). Fuzzy Gender: Between Female-embodiment and intersex. *Journal of Gender Studies*, *11*(1), 29–38. https://doi.org/10.1080/09589230120115149

White Hughto, J. M., Reisner, S. L., & Pachankis, J. E. (2015). Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. *Social Science & Medicine*, *147*, 222–231. https://doi.org/10.1016/j.socscimed.2015.11.010