Gender-Affirmative Healthcare in Kerala

A Preliminary Report*

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[Compiled by Shilpa Menon
For Queerala, an organisation for Malayali LGBTIQA+ Community]

*This report was not sponsored by any institution.

Queerala

Queerala is a registered organisation, for Malayali LGBTIQA+ (Lesbian, Gay, Bisexual,Transgender, Intersex ,Queer, Asexual) people, based in Ernakulam, Kerala. Since 2010, Queerala has been an active platform for the rights of the LGBTIQ+ community in Kerala and India and focuses on various awareness campaigns on Sexual Orientation, Gender Identity/Expression and Sex Characteristics (SOGIESC). Queerala also focuses on sensitisation on SOGIESC inclusive healthcare services, educational curriculum, workplace policies and local self governance, under Project Vistaara, by SAATHII.
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Project VISTAARA

Project Vistara by SAATHII focuses on advocacy in the following areas:

- the Supreme Court of India's verdict on Section 377, which provides opportunities for advocacy in all domains pertinent to LGBTIQ+ communities,
- implementation of the NALSA verdict in full spirit,
- policy advocacy for ending bullying against gender nonconforming children,
- advocacy towards implementation of UGC's anti-ragging regulation,
- advocacy towards LGBTIQ+ inclusive medical curriculum and inclusion of LGBTIQ+ inclusive contents in continuing medical education (CME) of health care providers.

Queerala is the implementation partner for Project Vistaara in the state of Kerala.

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Abbreviations Used

CBO – Community-Based Organization

FTM – Female-to-male

HT– Hormone Therapy

LGBTQIA+ – Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and others

MHPs – Medical Health Professionals

MSM – Men who have sex with men

MTF – Male-to-female

NGO – Non-Governmental Organization

SoC – Standards of Care

SRS – Sex Reassignment Surgery

TGs – transgender(s) [regional usage]

WPATH – World Professional Association for Transgender Health

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Important Terms*

Transgender person

A person whose gender identity does not match with the sex, and associated gender role, assigned to them at birth. It is important to note that transgender is an identity category as well as a medical category. That is, the term transgender must be used for people primarily based on whether they themselves identify as such, and not based on how they look, or what medical procedures they undergo.

Cisgender person

A person whose gender identity matches with the sex, and associated gender role, assigned to them at birth.

Trans women

People who are assigned the sex "male" at birth, as well as the associated gender role, but do not identify with these, and identify as women. They are sometimes referred to as "male-to-female" (MTF) transgender persons.

Trans men

People who are assigned the sex "female" at birth, as well as the associated gender role, but do not identify with these, and identify as men. They are sometimes referred to as "female-to-male" (FTM) transgender persons.

Gender dysphoria

The WPATH's Standards of Care report (2011) defines gender dysphoria as "discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)." (pg. 5). This term is preferable to the older term "Gender Identity Disorder."

Gender nonconforming

A term that may be used by people who do not conform to conventional expectations regarding gender and gender roles. Transgender persons may or may not refer to themselves as such.

* Based on the "GLAAD Media Reference Guide – Transgender" <https://www.glaad.org/reference/transgender>

Gender-affirmative healthcare

Refers to a range of medical procedures that help transgender individuals affirm their gender identity and mitigate gender dysphoria. These can vary from to person, but they include psychiatric counseling, hormone therapy, and surgical and cosmetic procedures to alter primary and secondary sex characteristics (such as laser hair removal, genital reconstruction, chest reconstruction, etc.). Individuals may require one or more of these options to manage their gender dysphoria and live fulfilling lives. There is general consensus in medical literature that gender-affirmative procedures help improve the mental wellbeing and quality of life of transgender individuals. ✳

Sex reassignment surgery (SRS)

Also known as gender confirming/affirmation surgery, this refers to a range of surgical procedures that help a transgender person to affirm their gender identity through body modification. Transgender persons may or may not choose to undergo SRS. It is important to note that a person has the right to identify as transgender irrespective of whether they have undergone SRS.

A note on the popular connotations of terms in Kerala

Although people who are gender queer (those who have a sense of dissonance with the gender assigned at birth but do not identify as belonging exclusively to another gender) often include themselves under the transgender category in Western contexts, in Kerala, the term "transgender" has popularly come to refer specifically to those who identify within the binary, i.e., as feeling a dissonance with their gender assigned at birth (man/woman), and desiring to live and be recognized as the other gender (woman/man). Whereas the implications of this merit greater investigation, this report examines the healthcare needs of trans men and trans women, and does not touch upon gender queer persons' needs. ✙

There is also a tendency for the term "transgender" to be conflated with trans women in popular understandings and even by those in the transgender community, and the implications of this will be explored in a later section (section 5, point 7).

✳ "What does the scholarly research say about the effect of gender transition on transgender well-being?" What We Know: The Public Policy Research Portal. Cornell University, 2019. <https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-well-being-of-transgender-people/>

✙ The lack of conversations around being gender fluid or genderqueer is noted by some transgender activists, but it continues to remain an issue minimally addressed both within the transgender community, and in policy measures.

TG" is an abbreviation used widely by Malayali transgender individuals to refer to themselves and their community. "TG" is used as a noun, as in "I am a TG/transgender", rather than "I am a TG/transgender person." However, using "transgender" as a noun is discouraged in English-speaking contexts as it is considered dehumanizing.

Another term that is popularly used by community members in Kerala is "transsexual," used to describe transgender individuals who have undergone sex reassignment surgery, is a. The term "transsexual," too, is being outphased in Western contexts as it can reinforce discrimination against transgender individuals who do not opt for gender affirmative surgery. In many cases, transgender persons prefer to identify as men or as women, with the term "transsexual" or "transgender" being used to refer to their experience of transitioning rather than their identity itself.

"Community" is another term that is used often by transgender individuals in Kerala. This community does not directly refer to any ritualized institution like the *hijra* or *tirunangai jamaat* system which comprises of formal hierarchies and family structures. "Community", rather, refers to social and support networks among transgender people, and people in the LGBTQIA+ community in general, created through HIV-AIDS activism and NGO intervention, and more recently, through CBOs for transgender persons. In Kerala, communities are also sustained by trans women who follow less formal mentoring relationships modelled on the guru-chela system followed in other states.

In general, the conversation on the best ways to describe and address transgender people is an ongoing one, and health professionals and policy makers need to be attentive to how transgender persons identify themselves rather than relying on outdated usages.

* * *

Introduction

Background

In 2015, Kerala became the first Indian state to implement a comprehensive policy for the welfare of transgender persons according to the directives of the 2014 NALSA Judgement that affirmed the rights of transgender Indians. Despite the clear recommendations of the policy aimed at improving the lives of transgender people, Kerala continues to be an unsafe space for transgender persons because of lack of proper implementation, continued social stigma, and a general lack of awareness about what it means to be transgender, or for that matter, to identify within the LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual and others) spectrum.

In 2017, the case of a trans man whose sex reassignment surgery had been severely botched up by an untrained doctor in the Thiruvananthapuram Medical college gained some attention in the media.[*] Despite initial celebratory reports about a first-of-its-kind medical procedure in Kerala, it was later revealed that the trans man's health was in a dire condition, and that he had been inadequately informed about his options and the risks involved. In 2018, a 22 year-old trans man committed suicide when he was repeatedly denied gender affirmative surgery.[✠] Violating both national and state-level directives that adults need not take parental consent for sex reassignment surgery, he was refused treatment without parental consent. These publicized cases, however, form only the tip of the iceberg. Most transgender individuals continue to suffer because of lack of access to gender affirmative procedures, or because of medical malpractice by doctors.

Scope

Therefore, the aim of the report is to look at the extent to which the healthcare provisions of the Kerala State Transgender Welfare Policy of 2015 has been implemented, and also to explore on-the-ground issues in providing gender-affirmative healthcare to transgender persons in Kerala. It is not meant to be a general practice guide (cf. Sappho for Equality, 2017) or a comprehensive study. As such, by compiling the concerns and opinions of experienced transgender community workers and MHPs, this report points at some specific areas that require attention and concerted dialogue between transgender community representatives, policymakers and MHPs within the specific regional context of Kerala. In addition, this report will also touch upon other aspects of healthcare for transgender individuals, such as general healthcare and HIV-AIDS surveillance and treatment, since they are also important aspects of healthcare for transgender persons.

[*] "Man accuses Thiruvananthapuram hospital of negligence after sex reassignment surgery." Scroll.in, 13 May 2017. <https://scroll.in/pulse/837350/man-who-underwent-sex-change-operation-charges-thiruvananthapuram-hospital-with-negligence>

[✠] "How Transphobia and Ignorance of Doctors Drove a Kerala Trans Man to Suicide." The News Minute, 11 May, 2018. <https://www.thenewsminute.com/article/how-transphobia-and-ignorance-doctors-drove-kerala-trans-man-suicide-81116>

Methodology

This report was compiled through consultations with a small group of transgender persons across Kerala, both trans men and trans women (none who identify as gender fluid), many of whom are activists and transgender community representatives in government bodies for transgender persons' welfare. These individuals shared both their personal experiences of seeking gender-affirmative care as Malayalis, and also their knowledge about general trends within the community in terms of seeking healthcare. Input was also collected from trusted MHPs who provided gender-affirmative care in Kerala, largely in the private sector. For a full list of the contributors, see section 6. Consultations were carried out in two sessions over two years: the first set of people were consulted in 2018, and a second set in 2019, where more trans men were consulted, and follow-ups done with several individuals in the 2018 set to discern changes, if any, over a year.

Overview of Existing Healthcare Directives

Here is a short overview of the healthcare provisions in the Kerala State Transgender Welfare Policy of 2015:

SRS/HRT and other gender affirmative procedures – The Policy is clear that transgender persons in Kerala have the right to choose their identity independent of hormonal or surgical intervention (pg. 4). The Policy mentions the need for a fund for those who wish to have SRS (pg. 12). The survey of 4000 (almost exclusively MTF) trans people in the state conducted before framing the policy yielded the information that whereas 52% of them felt a need to change physical appearance, only 9% have actually done so (pg. 7), indicating severe limitations in accessing gender-affirmative procedures.

General healthcare – The Policy recommends the setup of special health insurance schemes for TG people, as well as non-discriminatory policies in hospitals, and training for staff (pg. 12). HIV serosurveillance - Provision of separate HIV serosurveillance centres for transgender people (pg. 4).

Mental health and counseling – Legal action against medical practitioners who attempt "conversion therapy" (pg. 10); proper counseling about gender-affirmative options and post-operative counseling (pg. 12).

Care for minors and adolescents – The Policy document mentions the need to include gender non-conforming children under the ambit of the Juvenile Justice Act (pg. 11). It also states the need for legal action against parents who desert or abuse their gender nonconforming children (pg. 10). Service providers in Anganwadis and other agencies catering to juveniles and child protection must also be trained to deal with gender nonconforming children (pg. 13).

Overview of Healthcare Schemes Implemented

Some of these policy directives have been implemented through schemes and provisions that can be accessed by anyone with the ID card for transgender persons issued by the Social Justice Department. They are:

- The allotment of up to INR 2 lakhs as reimbursement for transgender persons who have undergone SRS,
- The provision of INR 3000 per month for a year for post-SRS care and recovery,
- The opening up of clinics exclusively for transgender persons in 2 government medical colleges (Kozhikode General Hospital and Kottayam Medical College), long-term plan to open clinics in all government hospitals,
- The approval of 5 short-stay homes across the state that provide care to transgender persons recuperating after SRS, apart from functioning as a safe house in times of crisis.

Facilities in Kerala

Public and Private Sector Providers

Table 1: Gender Affirmative Services in Kerala

Name of Establishment	Status/Services Provided
Public Sector Services	
Kottayam Medical College	Pilot clinic for transgender persons set up in 2017; operates one day a month. General health services, counselling regarding gender affirmative care options, certification for SRS, and preliminary testing before HT available for free. Sensitized staff and doctors. Free top surgery successfully performed for a trans woman in 2019.
Kozhikode General (Beach) Hospital	Clinic for transgender persons, consultation once a week with minimal waiting time. Only general health services offered.
Ernakulam General Hospital	No clinic for transgender persons despite news reports.[*]

[*] "Transgender clinic at Ernakulam government general hospital." Deccan Chronicle, 22 September 2017. <https://www.deccanchronicle.com/nation/in-other-news/220917/transgender-clinic-at-ernakulam-government-general-hospital.html> accessed on 09/09/2018

Trivandrum Medical College	No special services for trans people; one case of SRS in 2017 resulted in severe complications.
Department of Homeopathy, Thiruvananthapuram	A clinic for transgender persons exists, but receives no clients for lack of outreach, which is being planned. General healthcare services are offered once a week. Only known AYUSH[✣] facility for trans people.
Thanal short-stay home for trans men, Thiruvananthapuram	Offers accommodation for up to three months for trans men, also care after SRS.
Mudra short-stay home for trans women, Ernakulam	Offers accommodation for up to three months for trans women, also care after SRS.
Short-stay home for trans women in Thiruvananthapuram	In the process of being set up.
Short-stay home for trans women in Kottayam	In the process of being set up.
Short-stay home for trans women in Kozhikode	Stalled due to conflicts between the district Social Justice department and transgender representatives; resolution ongoing.
Private Sector Services	
Renai Medicity, Ernakulam	Offers "SRS packages" at minimal cost and has a full team of doctors with an established protocol; also handles gender change in documents. Exclusive clinic, "Integrity," to be set up soon.
Sunrise Hospital, Ernakulam	Identity Clinic started in 2018; currently non-functional—no integrated team. Psychiatric support, evaluation and certification for SRS is currently offered, as well as some surgical procedures.
Amrita Hospital, Ernakulam	Hormone therapy, full SRS for trans women, top surgery for trans men and laser hair removal at subsidized rates.
Specialists' Hospital, Ernakulam	Advertises SRS services; not preferred by community members because of cost and quality issues.

✣ Alternative medical systems, namely, ayurveda, yoga and naturopathy, unani, siddha and homeopathy.

State of affairs: Privatization and its implications

Hospitals, like most other public institutions, are unsafe spaces for transgender persons. Many of the transgender persons consulted for this report indicated that transgender persons avoided government hospitals, even for general healthcare needs, because of lack of privacy and discriminatory behaviour by doctors and other staff members, which can be deeply traumatic. Given the stigma around transgender persons and SRS, hospital staff need to be able to handle transgender patients in a sensitive manner. Exclusive clinics in government hospitals are a welcome measure in this context, if accompanied by long-term sensitization within these institutions, but only two such clinics are currently functional, with services being offered as rarely as one day a month.

All those who were consulted for the report emphasized the fact that government facilities for gender-affirmative healthcare were non-existent or rare, a fact that is evident from Table 1. There is no government hospital that provides SRS. Lack of manpower, absence of training and experience are all cited as issues. There were indications that gender-affirmative care is not prioritized in government hospitals, which are already working on minimal resources. There is, as of now, no health insurance scheme tailored for transgender people. Currently, all transgender people who seek SRS within Kerala go to private hospitals.

There is a distinct trend of privatization of gender-affirmative services in Kerala, which has important implications. While private players like Renai Medicity and Amrita are setting the standards for gender affirmative healthcare and offering cost-effective services, there is the danger that this trend would restrict healthcare to those transgender people who can afford it. It can also add to the idea that processes like HRT and SRS are "luxury" cosmetic services rather than essential welfare measures to address the right to live of a certain section of people in society. MHPs emphasized the need to include gender-affirmative healthcare in existing welfare schemes. There is a need for private-public partnerships and public sector intervention in order to make gender affirmative care accessible and affordable.

There were reports of surgeries being performed with inadequate expertise and facilities in smaller clinics both within and outside Kerala. There are several cases of transgender persons suffering lifelong complications and serious health issues (like urinary incontinence, recurring infections, necrosis and chronic pain) because of botched surgeries, with doctors extracting more cash from clients for several corrective surgeries. Trusted private-sector MHPs reported that they regularly have clients who are seeking corrective surgery after undergoing poorly performed procedures

elsewhere. Given that many transgender persons seeking surgery do not have the resources to recognize and combat medical malpractice for profit, there must be stricter government monitoring of such practices in the private sector, or at least a means for transgender persons to lodge complaints with the Transgender Justice Boards, warranting investigations and punitive action.

There is now a move towards enabling the direct transfer of money for SRS to private hospitals by the government. This is a welcome move in that it enables trusted private-sector health providers to be recognized by the government. However, only Renai Medicity is currently involved in the talks for this scheme.

Patterns of treatment-seeking among Malayali transgender individuals

Observations and recommendations

1. Gender affirmative care is rarely sought

Those who were consulted for this report affirmed the findings of the State Policy survey that SRS, HT and psychiatric counselling (to explore options rather than to "cure" the condition) are opted for only by a minority of transgender persons in Kerala. SRS in particular tends to be viewed as being both financially and socially costly. Families tend to disapprove more strongly of SRS and prefer that transgender family members stay closeted or discreet. Lack of proper counselling (both for individuals and for their families), lack of availability of healthcare options near their home, high costs, lack of trust in the medical establishment due to several instances of malpractice all contribute to gender-affirmative processes such as HT and SRS being rare choices for transgender Malayalis. These are not so much choices as structural impositions, and must be urgently addressed.

2. Information barriers and reliance on informal networks

SRS, for both trans men and trans women, involve multiple surgeries, some of them complex. For HT and SRS, there are several options available, and it is crucial for MHPs to make these decisions in consultation with their clients, seeking fully informed consent. Many trans people are inadequately informed about the options available to them, resulting in problems ranging from dissatisfaction owing to misinformed expectations, to severe health complications.

As of now, access to gender-affirmative care relies almost exclusively on community networks–transsexual people who have already undergone the procedure advise others on trusted doctors and hospitals. MHPs mentioned that bystanders who come with SRS-seeking clients are largely transgender friends or mentors from the community, rather than natal family members. There is high incidence of self- medication reported both by MHPs and community members, where transgender individuals take hormone medication upon their friends' advice rather than relying on MHPs. This can lead to overdose and a number of serious side effects like depression, mood swings, weight gain or loss, organ damage, etc. HT needs to be supervised by an endocrinologist and accompanied by psychiatric support to manage side effects.

MHPs and representatives also mentioned that many transgender people who have undergone SRS do not speak to their peers about complications and exploitation by hospitals out of a sense of shame. There is an absence of proper discussion on how improper surgery can affect one's sex life and mental and physical health. This reliance on informal networks indicates that there are no accessible, formal and fully reliable support networks for transgender people seeking information on healthcare options. Such information barriers make transgender clients easy targets for exploitative medical institutions, and there were several reported instances of health issues owing to self-medication and/or improper healthcare. While there is ample research and documentation on best practices in gender-affirmative care, these rarely percolate to the community.

3. Reliance on out-of-state institutions

In general, there are very few facilities for gender affirmative care in Kerala compared to neighboring states like Karnataka and Tamil Nadu. Given the minimal presence of long-existent traditional communities like Hijras or Tirunangais in Kerala, transgender people have only recently obtained visibility in Kerala's public sphere.
Community representatives from Kerala were unanimous in saying that facilities in places like Mumbai, Delhi, Coimbatore, Mysore, and Bangalore enjoyed greater trust within the community because they have catered to the needs of transgender persons, particularly trans women, for a long time. Coimbatore (Vela Hospital in specific) was most commonly mentioned as a place where people travelled to for surgery, since it is closer to Kerala and has a history of transgender care. Some community representatives were unaware of SRS facilities within Kerala. Both MHPs and representatives mentioned that many of these out-of-state services bypassed proper documentation, informed consent and WPATH guidelines in order to give quick, cheap services to transgender people. MHPs in Kerala are often approached for corrective surgery after such experiences result in complications.

4. Time period

The WPATH SoC recommends a 12-month period of hormone therapy and of living in the desired gender role (Pg. 60). This allows the individual to gradually adjust to bodily changes and explore options carefully. Some MHPs agreed with this opinion, whereas others were of the opinion that SRS can be carried out with minimal preparation, given that the client was willing and cleared through psychiatric evaluation.

Within the community too, opinions varied. Some were of the opinion that SRS needs to be a well-thought decision taken over a longer term to minimize the toll on health, and that some medical institutions exploited less informed clients by doing quick surgeries for money. Others felt that year-long preparation often discouraged trans people and made the process too expensive, uncertain and difficult, and went against the idea of self-determination. Additionally, some private hospitals extended this period to several years, leading to financial exploitation of the client. They also indicated that there was a tendency for transgender persons seeking gender- affirmative processes to value risky but quick results over gradual transition, leading them to prefer unethical providers or less effective procedures. This could have adverse impacts on their hormonal balance and sex lives.

MHPs reported that there was a tendency for clients to stop consultation when they realize that it will be a slow process. It also becomes difficult to later perform effective reconstructive surgery in case the client wishes it. In general, the mixed opinions around the time period for intervention indicate that there is a need for concerted dialogue around the issue. While the timing and procedures involved in gender affirmative care vary from person to person depending on their health and their choices, there need to be established standards that are known both to MHPs and transgender clients.

5. Travelling and consultation–the need for a treatment protocol

Providing healthcare for transgender individuals requires an interdisciplinary team of doctors who are working together–usually comprising an endocrinologist, psychiatrist, and for SRS, a plastic surgeon, urologist and (for trans men) a gynaecologist as well. A treatment protocol also needs to be developed to systematize the working of such a team, as has been demonstrated in the Mahatma Gandhi Medical College and Research Institute, Puducherry , the erstwhile Identity

* An interdisciplinary team led by Dr. Sameera Jahagirdar, an anaesthetist who is a trans woman, has developed a protocol for providing healthcare for transgender individuals in the Mahatma Gandhi Medical College and Research Institute. See "The making of a standard protocol in gender care," Hindustan Times, 20 April 2018. <https://www.hindustantimes.com/india-news/the-making-of-a-standard-protocol-in-gendercare/story-bbncDzdQX3CIZD76doHS0L.html>

Clinic of Sunrise Hospital in Ernakulam, and with the team of doctors at Renai Medicity. Given the absence of such systematized care in most districts in Kerala, it was found that many transgender individuals consulted MHPs in separate hospitals for different processes such as psychiatric evaluation, counseling, general healthcare, hormone therapy and SRS. This presents many challenges in terms of logistics, both for the MHPs and the client. If the MHPs are not in communication with one another, the quality of care provided suffers as well. Lack of a protocol can also result in non-transparent and ad hoc procedures.

6. Mental health, Counseling and "Minority Stress"

Psychiatric evaluation is often used to either try to "cure" transgender identity or determine the authenticity of transgender individuals' claims. It is more rarely used to help transgender people explore their options and arrive at informed choices and to diagnose existing mental health issues like depression and anxiety that can be exacerbated by hormone therapy and/or SRS. According to the MHPs consulted, many transgender individuals in Kerala come to mental health professionals, either of their own volition or because of compulsion by their families, and in most cases, the visit is prompted by a crisis situation, such as attempted suicide, forceful marriage, substance abuse, behaviours seen as "abnormal" by the patients' families, etc.

One MHP commented that the psychiatrist is the main link in the SRS process, and (s)he should mentally prepare and support the patient throughout the process. However, there were several reports of malpractice by psychiatrists and psychologists, and most transgender people harbour deep distrust towards mental health professionals. There are indications that many mental health professionals are unaware of gender variance and the correct protocol to be followed in treating a transgender person. Psychiatrists were reported as having discouraged transgender clients from surgery (because their dysphoria might just be a "feeling"), as not following proper assessment procedures for transgender clients who wished to have SRS and as not even knowing how to address their transgender clients. Although an MHP consulted for this report was of the opinion that it is mental health professionals with spurious qualifications who provide such services, community members reported such behaviour from well-qualified mental health professionals as well, indicating that there are serious gaps in the training given to qualified MHPs.

In most of the cases covered within the ambit of this report, psychiatric intervention and support stopped at the assessment stage before HT or SRS, whereas sustained and lifelong counseling and psychiatric support is recommended by the WPATH SoC. It also recommends that counseling also needs to be extended to families and the broader communities of the clients (pg. 30). It was observed that this practice was informally followed in most cases where care was sought within Kerala, with one or more of the medical health professionals in the SRS team serving as ad hoc counsellors for the client, and if needed, their family. While this is a good practice, it needs to be standardized and formalized.

An important term emerging from academic literature on gender and sexual minorities is "minority stress"–heightened psychological stress experienced by minority groups because of systemic social stigma. MHPs and representatives indicated high levels of depression, substance abuse and suicide in the community as a result of lack of social acceptance, giving preliminary indication that the usual patterns of severe minority stress among gender-variant groups are present in Kerala among transgender individuals.

7. Invisibility of trans men

Because most measures are community-driven, and the community (as well as district transgender Justice Boards) is dominated in visibility by trans women*, the needs of trans men are not adequately met. Even the survey of 4000 transgender individuals on the basis of which the state policy was drafted comprised 99% trans women (pg. 5). Having healthcare options close to home is particularly important for trans men, who might face severe restrictions in mobility as female-assigned persons who are confined to domestic spaces in Kerala's conservative culture. Trans men lack the kind of long-standing platforms for mobilization that trans women have had owing to HIV- AIDS intervention programmes.

Healthcare policies need to acknowledge the different needs of trans men and trans women. Although HT is cheaper for trans men (they require only testosterone shots, as opposed to a combination of androgen suppressors and female hormones for trans women), surgical intervention is much more complex and involves 5 surgeries. SRS also tends to cost more, which means that the 2 lakhs allowed by the government is often insufficient for trans men. All MHPs consulted indicated that their clients largely comprised trans women. All the private sector hospitals offering full SRS (including genital reconstruction) in Kerala have only performed it on trans women thus far. There is, so far, no reported successful case of bottom surgery (i.e. genital reconstruction) for trans men in Kerala, indicating that there is a lack of facilities and/or expertise in this regard.

Therefore, trans men may benefit even more from formalized and targeted medical healthcare in Kerala given that they may face difficulties in reaching out for advice and support from within the community. Indeed, after the set-up of comprehensive gender affirmative services in some hospitals in Kerala, the number of trans men availing gender affirmative care has steadily increased, according to MHPs.

* This was evident given the absence or scarcity of trans men as community workers in districts apart from Thiruvananthapuram and Kochi, with (trans women) representatives saying that they are hard to locate and contact, and when found, difficult to retain within committees and Justice Boards. Some representatives seemed to conflate "TG" with being trans female, with the understanding that the Transgender Welfare Policy is mainly meant for trans women, and not trans men. This reflects the popular misunderstanding that "transgender" refers only to trans women, and plays an important role in the unintentional exclusion of trans men from support networks and policies.

8. The case of minors and adolescents

Puberty can be a particularly traumatic experience for gender variant persons, and many of them are brought in for psychiatric care at a very young age. Many parents whose children exhibit gender non-conforming behaviour first take them to paediatricians–therefore, gender sensitization needs to cover a range of medical health professionals. Currently, MHPs in Kerala follow the practice of treating them with parental consent, or of referring adolescents to institutes in other states that offer gender affirmative care to minors. Since there is no follow up done after referrals, it is difficult to know whether these children actually get the help they need. There are clear protocols for adolescent trans healthcare within international medical societies and in the WPATH SoC, and there is a need for these to be made legally possible in Kerala.

In general, issues relating to non-conforming children and adolescents present a legal and policy loophole, with the result that trans people only become eligible for rights and benefits once they are adults. The absence of laws to deal with HIV-AIDS surveillance, prevention and treatment and gender-affirmative healthcare needs of juveniles can create a gap that will leave many minors more vulnerable than their adult counterparts. One community worker remarked that many minors engage in sex work, but interventions are made difficult because existing schemes and programmes do not cover minors.

9. Cost of care

Given the exclusion of transgender individuals from educational and employment opportunities, and widespread poverty among them, financial constraints play a predominant role in determining the healthcare choices that they make. SRS costs a minimum of one lakh in Kerala and can cost up to 3 lakhs in general. Hormone therapy can be more expensive for trans women (Estrogen tablets and Androgen replacement, around Rs. 1200 per month) than for trans men (Testosterone injections worth around Rs. 200 per month). Laser hair removal is also a very expensive procedure, especially since there are very few public sector providers, compelling trans women to seek services in the private sector that offers it as a cosmetic service.

Given that SRS is costly, there is a chance that the dominance of private providers can turn SRS into a profit-oriented venture. Given that a majority of transgender people continue to be economically deprived, this could add to their problems, often pushing them to engage in risky ventures or sex work to earn enough money for SRS. There are indications that a large number of transgender people who seek surgical procedures have to undergo another round of corrective surgery when the first process is either poorly performed, causing severe complications, or not to their satisfaction. Therefore, substandard services add to the cost of healthcare. The recent declaration of Rs. 2 lakhs for transgender individuals seeking SRS has been welcomed by those in the community.

Conclusion

First and foremost is the recognition that healthcare is by no means isolable from wellbeing in general–the healthcare aspects of transgender persons cannot be addressed independently of their status as social beings and citizens–a matter emphasized upon by those who were consulted for this report, and in the WPATH SoC. The WPATH SoC also makes clear that it is not being transgender, but the social stigma forced upon those who consider themselves transgender, that leads to a majority of the problems faced by transgender persons. Although gender affirmative procedures have been shown to mitigate dysphoria, there is evidence that SRS alone cannot address health and morbidity issues specific to transgender individuals,[*] which may arise from prolonged social stigma and mistreatment. Gender-affirmative healthcare, therefore, is not just about surgical and biomedical procedures, but about social acceptance and long-term support. This view was agreed upon by all those who were consulted by the author.

Secondly, the need for state-based, public sector-driven healthcare is also clear: healthcare services within Kerala can help reduce costs for transgender individuals, and allow better bystander care, better communication between MHPs, etc. In particular, care closer to home can be especially beneficial to trans men, who suffer from severe restrictions on travelling as female-assigned persons. In general, the difficulty and lack of due process with regard to changing gender and name in ID documents makes long- distance travel a difficult and even dangerous venture for all transgender people. Facilities within the state will allow better regulation and some mitigation of exploitation of transgender people. It will also make transgender individuals less likely to prefer "quick SRS" outside the state–a risky practice. This report finds that those seeking care within the state are more likely to develop long-term relationships with their MHPs, allowing long-term care and support for transition and/or counselling. Facilities closer to the clients' homes can also help MHPs to engage their families and broader communities (schools, neighbourhoods, etc.) in mitigating gender dysphoria.

All of this reflects the need for greater dialogue among MHPs and community representatives, as well as greater regulation and standardization of healthcare services for transgender individuals, informed not just by the WPATH SoC, but also by the regional and cultural context of Kerala. To deal with the general distrust of MHPs among the transgender community, it is imperative to have gender/sexuality inclusive

[*] Dhejne, Cecilia, Paul Lichtenstein, Marcus Boman, Anna LV Johansson, Niklas Långström, and Mikael Landén. "Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden." *PloS one* 6, no. 2 (2011). <https://doi.org/10.1371/journal.pone.0016885>

Summary of Findings

- Lack of services within the state,
- Insufficient implementation of the Kerala State Transgender Welfare Policy,
- Privatization of gender affirmative healthcare,
- Excessive reliance on informal networks of information,
- Lack of consideration of the different needs of trans men and trans women,
- Managing costs of care,
- The need for an interdisciplinary healthcare team and a standardized treatment protocol based on the WPATH SoC,
- Better mental health systems for transgender individuals,
- Special provisions for early interventions in the case of minors and adolescents.

Social stigma is also a major health concern for trans people.

In-state facilities enable long-term and holistic healthcare.

training for health practitioners (doctors as well as supporting staff) in fields ranging from psychiatry, endocrinology and general health to pediatrics. It is also equally important for transgender persons to have easy, confidential and free or inexpensive ways to access personalized information about their healthcare options, and government- funded transgender clinics play an important role in addressing this aspect. Transgender Justice Boards at the state and district levels can play a major role in bringing together MHPs from private and public institutions, along with community members, to chalk out practice guides and recognize specific challenges and solutions.

Clinics for transgender persons, both public and private, must also take up training and research as they expand their facilities beyond general healthcare. The recent setup of an Indian subsidiary of the WPATH, called the IPATH (Indian Professionals' Association for Transgender Health), with MHPs in Kerala being part of it, presents great potential for collaborative research and development in the area of gender-affirmative healthcare. Such associations must consult transgender community representatives to ensure that research is accessible to, and inclusive of, transgender persons.

Contributors

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