

Barriers to access healthcare among the transgender population of Bangalore: A qualitative study

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Abstract

Background

Transgender people are a socially marginalised gender group across the globe and in India. This translates to significant challenges in accessing healthcare. These impede the achievement of Sustainable Development Goal 3 (SDG 3) which calls for universal health coverage and reduction of health inequalities.

Aim

This study explores the barriers and enablers to healthcare access among the transgender population of Bangalore , India.

Materials and Methods

This study included adults who identify as transgender persons, residing in Bangalore city(capital of the state Karnataka). After obtaining ethical clearance from the institutional review board, participants were recruited through non-governmental organisations using snowball sampling. In-depth interviews and focus group discussions were conducted after obtaining informed written consent. Data was collected until saturation. Interviews and focus group discussions were recorded and transcribed in vernacular, translated to English, and analysed thematically.

Results

The barriers identified were discrimination against transgender population, financial unaffordability; distance from healthcare facilities; lack of family support; documentation complexities ; intra-community caste discrimination; poor awareness of government schemes; and resort to harmful alternatives to formal care.

The enablers included respectful treatment by healthcare workers, support systems, inclusive public policies and intake in healthcare centres.

The health demands of the participants were exclusive transgender clinics/hospitals, support for education, free/affordable gender affirming care and community representation in the healthcare workforce.

Conclusion

The barriers faced by members of the transgender community to access healthcare are a direct result of systemic discrimination . Ending discriminatory practices, ensuring community participation and cultural competence are essential steps towards equitable care.

1. Introduction

The transgender population constitutes a socially marginalized gender group. Historically, their representation in public domains, legislative frameworks, academic research, and similar spheres has been minimal. They are seldom visible in public transportation, healthcare facilities, marketplaces, governmental offices, and other communal settings. In India, their visibility is predominantly limited to specific vocational areas, namely traffic intersections, bus terminals, and railway stations. Furthermore, governmental documentation has only recently begun to accommodate an inclusive framework for transgender individuals. The Census of India did not recognize this demographic until the most recent census conducted in 2011, during which they were categorized as "others." A total of 487,803 individuals were classified as "others," of which 20,266 individuals resided in Karnataka.[1]

Transgender individuals have been integral to Indian society for centuries, with historical records acknowledging a "third gender" in ancient Indian texts. Early literary works, including Jain scriptures, explored the complexities of sexuality and gender, with the Ramayana and Mahabharata recognizing the role and significance of transgender individuals. [2]Hijras also played key roles in Islamic religious settings, contributing to state decisions and maintaining high status and financial compensation due to their proximity to royalty.[3]

The British colonial era marked a turning point for the transgender community in India. Initially respected, the Hijras faced increasing marginalization as British authorities sought to criminalize their existence. The Criminal Tribes Act of 1871 specifically targeted Hijras, criminalizing their activities and leading to widespread persecution. [4] Though the Criminal Tribes Act was repealed in 1952, its legacy persisted through various municipal laws. In recent decades, India has made strides toward recognizing the rights of transgender individuals. The Supreme Court's recognition of transgender persons as belonging to a "third gender" has been a significant milestone. [5]However the Transgender Persons (Protection of Rights) Amendment Bill, 2026 has drawn flak from transgender communities across the country for multiple reasons including its stance against the right to self-identification.[6]

The transgender people of India face many social problems including marginalization, harassment in educational system, poor economic conditions and discrimination in the workplace, homelessness, transphobia and psychological distress. [7] Transgender people in India face significant disadvantages when it comes to health. They are often marginalized and stigmatized, which leads to limited access to healthcare services. [8] Discrimination and lack of awareness among healthcare providers contribute to inadequate medical care, leaving many transgender individuals without proper treatment for both physical and mental health conditions. Additionally, the healthcare system has historically neglected the specific needs of the transgender community, resulting in insufficient research and data on their health issues. This lack of attention further exacerbates health disparities, with transgender individuals often experiencing higher rates of non-communicable diseases, mental health disorders, and substance abuse, while also facing barriers to accessing gender-affirming care. Overall, the intersection of social stigma, systemic neglect, and limited healthcare access places transgender people in India in a highly disadvantageous position concerning their health and well-being.[9]

The COVID-19 pandemic has intensified these challenges. Globally ,marginalised communities were disproportionately affected by COVID-19 disrupting access to healthcare, gender affirming care and social support systems. During lockdowns, the transgender individuals in India, dependent on informal economies and community networks faced compounded hardships. These included domestic violence, mental health deterioration and heightened economic precarity.[10]

Health systems frequently fail to provide equitable, culturally competent care for transgender individuals. Doctors and healthcare workers often treat transgender individuals as if they were cisgender, disregarding their gender identity. [11]Gender inequality and low socio-economic status contribute to poorer health outcomes for transgender individuals.[12] Globally, and in India, healthcare systems fail the transgender community, often denying treatment and subjecting them to verbal abuse.[13] The lack of public and private healthcare insurance further marginalizes them. [14] These failures present major obstacles to the achievement of SDG 3, which calls for universal health coverage (Target 3.8) and the reduction of health inequalities (Target 3.4).

Until recently, research involving transgender individuals was largely confined to niche areas like HIV/AIDS and mental health. Additionally, research on sociodemographic characteristics often excluded transgender as a gender category until recent years. In this context, it has become crucial to understand the barriers and enablers to healthcare access among the transgender populations. This study is set in Bangalore, the capital of Karnataka state in India, a city with a significant transgender population and active civil society organisations for transgender welfare.

2. Materials and Methods

2.1 Study Design

This study employed a qualitative phenomenological approach to elicit the experiences of this marginalized population.

2.2 Positionality

The lead researcher (NAJ) is a cis woman who is an MBBS graduate and was a resident in Community Medicine at the time of the study. She had attended multiple workshops inside and outside the affiliated institution and collected data for qualitative research previously. She had also visited the NGOs for an earlier study during which general medical consultation was offered and was thus familiar with the participants. She had resided in Bangalore for eight years and speaks the local tongue, Kannada. She is originally from the state of Kerala which was among the first Indian states to establish a Transgender Welfare Committee.

To address the potential power imbalances and cultural differences between a cisgender researcher and transgender participants, the interview guides were reviewed by transgender NGO officials and

community members. Participant feedback was actively sought during transcript preparation and analysis, and member checking was conducted throughout. These measures were intended to centre the perspectives of participants and minimise researcher-imposed interpretation.

2.3 Participants and Recruitment

The study included 30 participants: 16 trans women and 14 trans men. After obtaining ethical clearance from the institutional review board, a few participants were contacted through NGOs — specifically Samara, Sangama, and Solidarity Foundation — working for transgender welfare in Bangalore. The remaining participants were recruited through snowball sampling. Participants were approached face-to-face and/or telephonically.

Inclusion criteria: Individuals aged 18 years or older who self-identify as transgender, residing in Bangalore during the study period.

Exclusion criteria: Individuals who had resided in Bangalore for fewer than six months at the time of recruitment.

Study period: One year.

2.4 Data Collection

Data were collected through four focus group discussions (FGDs) and six in-depth interviews (IDIs). Two FGDs each were conducted for trans women (FGD 1, 2) and trans men (FGD 3, 4) in separate, private settings within NGO offices. In-depth interviews were held in NGO offices and at participants' residences, at mutually convenient times. No non-participants were present in designated spaces. FGDs lasted approximately 45–50 minutes; IDIs lasted 25–30 minutes.

The FGD guide was designed to facilitate group conversations focused on barriers to healthcare access. The IDI guide explored personal experiences with healthcare in greater depth. Both guides were developed in consultation with experts in qualitative research and transgender health, reviewed by NGO officials and community members, pilot-tested, and iteratively refined. All sessions were video recorded and subsequently transcribed in Kannada and translated into English.

2.5 Data Analysis

Data were coded by NAJ using a combination of inductive and deductive thematic analysis methods. Themes were identified and refined through iterative discussion within the research team (NAJ, KL, GS). Three overarching thematic categories were established: (1) barriers to accessing healthcare, (2) enablers to accessing healthcare, and (3) health demands of the study participants. Differences in interpretation were discussed and resolved through regular team meetings. Saturation was determined

when no new themes or sub-themes emerged across successive transcripts; this was reached after the fourth FGD and fifth IDI, with the sixth IDI confirming saturation.

3. Results

The profile of the participants is presented in Table 1.

Table 1
Demographic profile of transgender population who participated in the qualitative study(n = 30)

Characteristic	Category	Frequency
Gender	Trans women	16
	Trans men	14
Age group(years)	18–25	10
	26–35	7
	36–45	7
	46–55	4
	56–65	2
Religion	Hindu	24
	Muslim	4
	Christian	1
	Others	1
Education	Not literate	2
	Primary school	5
	Middle School	4
	High School	7
	Intermediate/diploma	7
	Graduate	3
	Post-graduate	2

After coding and thematic analysis, a coding tree was formed.(Supplementary Material 1)The themes identified are presented below.

i. Barriers to access healthcare

The following themes were identified as barriers to accessing health care.

1. Discrimination against the transgender community.
2. Financial Constraints.
3. Rural-urban differences.
4. Negative attitude of healthcare workers.
5. Documentation and infrastructural complexities.
6. Higher mental costs
7. Discrimination within the community.
8. Poor awareness about government schemes and the health needs of the community.
9. Harmful alternatives to lack of facilities /avoid visiting hospitals.

Theme 1: Discrimination against the transgender community

Discrimination against the transgender community which exists in all sectors of society finds its way to their homes too. Due to the discrimination that they face at home, most trans people leave their homes. This also means that they would have no caretakers in times of a health crisis.

"It starts at our homes itself. They would say: You are a boy. Why do you act like a girl? Why were you born into our family ?" IDI 3: Trans woman.

They face discrimination in public spaces including schools, buses, shops etc.

"I was put up in an Ashram(residential school run by a religious institution) school from childhood. If you ask me about the gender thing, I felt badly discriminated there." IDI 2: Trans woman

This makes it difficult for them to complete their education, find jobs irrespective of their educational status, and find places to stay.

"When we apply for jobs, the companies respond that you are a third gender, and we can't allow you ...(to work in the company)." IDI 1: Trans man.

"If we happen to be trans, they will not give us room (to stay)." IDI 4: Trans woman.

These discriminatory practices put them in a position where the thought of accessing healthcare itself seems like an extraordinary feat.

Despite all this if and when a trans-person reaches out to a healthcare facility, the same forces of discrimination operate there too. They face discrimination from other members of the society who are accessing the facility. This aspect was described by a participant using the example of binary queues in healthcare facilities.

"If we stand in male queues, they stare at us. If we stand in female queues they stare at us. Even though I look like a male, I am scared to stand in the male queue. They would tease me." FGD 3: P1:Transman.

Theme 2: Financial Constraints

These discriminatory practices leave most transgender people in a position to take up begging or sex work for their income. The money they make out of it is usually a substantially decent amount. However, a large amount of their money pays to overcome the discrimination they face. For example, most members of the community avoid public transport which is the cheapest way of transport in the city. They resort to auto-rikshaws and /or cab rides which are heavy on the pocket but greatly reduce their interaction with the general society.

*"We usually take an auto to go to work. We rarely take a bus."*Field notes, Trans woman, Beggar.

The combined lack of education and government IDs makes it difficult for them to have bank accounts or loans, which provide lower interest rates. They have to depend on private finances which charge hefty interest for their needs.

*"We invariably have to take loans for surgery (GAS-Gender Assignment Surgery) from finances. Or we take support from the community members."*FGD1 :P1, P3,P4: Trans women.

Financial constraints also dictate the type of hospitals they go to. This in turn decides the type of care they receive.

*"If I go to a private hospital, they would ask me to undergo many tests. I don't have enough money at the moment to afford that."*FGD2: P1, Trans woman.

The ones who go to private hospitals sometimes change their hospital to a government one when tests need to be done.

*"We usually go to private clinics. If they ask us to get tests done, we go to government hospitals because they do it for free."*FGD3: P3, Trans man.

Theme 3: Rural-Urban Differences

However, this option to go to government hospitals seems feasible only in urban areas. The infrastructure in government hospitals varies between rural and urban settings with rural ones particularly being known for non-functioning / mal-functioning equipment and other infrastructure.

*"In our area(rural) if we have to get an X-ray or a scan we go to a private hospital. In government hospitals, the machines would not work in most cases. They also give incorrect results. So we go to a private(hospital). But the government hospitals in the city are good. The ones in the villages are not proper."*FGD4: P1, Trans man.

There are other reasons also to choose private hospitals over government hospitals. Participants reported that they were far from their residences.

"Government hospital is too far. I go to a private clinic which is nearby. They treat us well." FGD3: P3, Trans man

Theme 4: Negative attitude of healthcare workers towards them

How healthcare workers treat the patient is a major determinant of which hospital patients prefer to go to, be it the transgender community or any other community. Members of the transgender community often find themselves at the receiving end of the negative attitude and behaviour of healthcare workers (HCWs). It starts with passing looks at the clothes that community members wear and goes up to total refusal of treatment.

"First, they will look at our dress. What kind of dress we wear is our personal choice." IDI 2: Transwoman

"Do you know XXY (private hospital)? They laughed at my dress." IDI 1: Transwoman

"One doctor said that they can't treat transgender patients." IDI 4: Transman

"My friend had an anal fissure. She went to a hospital. The doctor refused to examine her." IDI 3: Transwoman

HCW absenteeism and inconvenient working hours were also problems associated with government hospitals. Participants reported that often doctors would not be available in government hospitals during working hours. Participants found the working hours of primary health centres (PHCs) inconvenient as they close before the usual time when the community members get back from work. Participants also reported unprofessional, disrespectful behaviour in government hospitals. They reported being yelled at, asked to stand in long queues etc.

"In government hospitals, they yell at us. They are annoyed while they treat us. They don't even consider the age of the patients. They ask elderly people to stand in queue and yell at them if they don't." FGD1: P5, Trans woman.

However, the faux untouchability that community members face is universal in government and private hospitals. HCWS refuse to touch and examine them.

"Some people(HCW) don't touch us because we are transgender" FGD2: P3, Transwoman

These attitudes also differ in severity depending on whether the transgender person has undergone gender assignment surgery (GAS) or not. The ones who have not undergone GAS experience more discrimination.

"Whether we have undergone / not undergone surgery is none of your business." IDI 2: Transwoman.

"They (HCW) wouldn't touch my friend because she had not transitioned yet." IDI 1: Transwoman

Participants also shared experiences where they were laughed at by doctors. An instance shared by a transman visiting the gynaecology OPD for PCOS is given below.

"I pass very well as a cis-man if I wear very oversized clothes. So usually they think that I am a man. For them, I am a cis -man. I have to go with another feminine presenting person, like my mother or sister. When they asked for the age(of the patient), it got very confusing because then they would ask who was the patient. Then I replied that it was me. They started laughing then. And the gynaecologist said: "uterus venam". (you should have a uterus first)." IDI 6: Transman

There were also instances where the participants felt their autonomy over the body was disrespected. HCWs tend to look at the community members as being incapable of making the right decisions for themselves. A participant's experience when she was advised emergency surgery for a diagnosis of appendicitis could throw some light.

"I was advised a scan. My reports were normal. If my reports were normal why did she(doctor) send me for surgery? She told me that emergency surgery needed to be done. I had been telling her that I did not have a guardian. But she said that she did not know all that and I had to call somebody for emergency surgery. She said " Kuch bhi karo! Kisi ko leke aao!"(Do anything! Bring anyone!). She could have told me to look for someone and that they would help me if needed. It is my body, my issue, I would suffer for it." IDI 1: Transwoman

There were many instances where the participants felt disrespected and /or formed a negative opinion about the HCW because of improper and unclear communication by the HCW.

"I told them to draw less blood for a test. They told me they were doing their duty(by refusing to draw less blood) and that they needed to take that amount of blood." IDI 2: Transwoman

"I have observed that in government hospitals they give the same medication for toothache and fever. I don't know why it is that way. I don't know why they give the same medications even when the symptoms are different." IDI 5: Transman

Theme 5: Documentation and infrastructural complexities

In some places, the government hospitals do offer good care. For people who have BPL (Below Poverty Line) cards government hospitals are all the more the best option as the cards offer free treatment in most cases and negligible costs in others. But the problem of BPL card bearing the sex assigned at birth becomes the barrier here.

"So I go to Sarkar (government) hospital, the care is good over there. I have a BPL card. In Sarkar hospitals, if you show your card (Below Poverty Line(BPL)) you will get a big discount on your bills. And in that (BPL card) it (sex) will be female. And it would become awkward and they (hospital staff) would be like eh? It is so hard that it will give me a slump for a week." IDI 5: Transman

Another problem is the wrong assignment of wards during hospital admission. Many transwomen reported being admitted to male wards.

"Whenever I was admitted to hospitals, I have always been in male wards. They should put us up in a female ward." IDI 2: Transwoman

Many a time the community members are asked to visit multiple departments on multiple days, especially for gender-affirming care (GAC). In addition to this, the clinicians who provide GAC would be available only on certain days of the week. This requirement delays access to GAC and thus accounts for the gatekeeping of GAC.

"When I went to take hormone therapy they told me to go to a different place. There I was again told to go to another place. So I left it." IDI 4: Transman

Theme 6: Mental health effects of healthcare visits.

These difficult circumstances also translate to higher mental costs to access healthcare for transpeople.

"I can only go when the friendly doctor is available. I have to go to these doctors with whom the consultation would not give me a big breakdown. I have to be very conscious and I have to see when they are available, and only go in then, to actually keep working and be available for the next week." IDI 6 : Transman.

Theme 7: Discrimination within their own peer community.

The transgender community of India is not exempt from the discriminatory practices of casteism and classism. These practices create a divide within the community and make it even more difficult for low-caste and low-class community members to avail of services. Added to internalised transphobia, these practices complicate structures which were originally set up for the community. This becomes even more pronounced when the staff members of NGOs working for the community are of upper castes and hold these beliefs.

"I am a very different transgender. I have not done sex work also. I am not connected to the community." IDI 2: Trans woman, NGO staff.

"My family is very supportive. But they are Tamil Brahmins. So they expect prestige (from me). They told me not to be with the community." IDI 5: Trans man, NGO staff.

Theme 8: Lack of awareness about government schemes among the peers and healthcare providers

Community members are frequently told that the hospital staff are not aware of what kind of care and clinicians can help them. This is often followed by the hospital refusing to treat them.

Some schemes are run by the government for the benefit of the transgender community. Both the community members and the government officials seem to have poor awareness about them. One example is the health insurance scheme i.e., Ayushman Bharat TG Plus. On asking about the scheme most participants said they had not heard about it. The few who had heard about it said that neither they nor the officials they spoke to had an idea about how to avail of it.

"They should give us insurance. We don't know where to go for it. IDI 5: Transman.

Theme 9: Harmful alternatives to lack of facilities /avoid visiting hospitals.

Gender Affirming Surgery (GAS) is not widely available in the government sector yet in Karnataka. In earlier days they were not available in the private sector too. Castration performed by the senior members of the community is an alternative that the community has taken up.

As explained earlier the mental cost of a community member visiting a healthcare facility is high because of the existing discriminatory practices. Many members reported delaying/avoiding a visit to the hospital for the same reason.

"I don't visit the doctor for small complaints. I take hot water and DOLO 650 (over-the-counter paracetamol tablet). Only when I have severe problems, do I go to the hospital." IDI 2: Transwoman.

"It is so hard. Sometimes you have an emergency when you have to go to the hospital then and there. But you can't do that because you have to wait for the friendly doctor to be available. " IDI 6: Transman

ii. Enablers to access healthcare.

Factors which enable community members to have access to healthcare are described under 3 themes:

1. Positive interactions and inclusive practices
2. Support Systems & Policies
3. Education & Competence

Theme 1: Positive interactions and inclusive practices.

Healthcare workers being experienced in treating the community members seem to help in 2 ways according to the participants. One, the HCW would be aware of the needs of the patient. Two, the familiarity of the doctor makes the interaction much more smoother for the patient. Equal and respectful treatment, touching and examining the patients without hesitation were described as examples of good treatment. Many participants reported choosing private hospitals despite higher costs because of this reason.

"Some doctors touch and examine us properly, measure BP, put the stethoscope on our chest even if there are nurses or other staff to do these." FGD 1: P6, Transwoman.

Of particular importance are the seemingly simple but powerful things that were described. An instance of a non-Kannada(local language)-speaking community member's interaction with a nurse while visiting a government hospital is given below.

*"I spoke to her in English. She didn't know English. But she still tried to speak to me. That was very good"*IDI 1: Transwoman.

*"When we walk into these private hospitals, they smile at us."*IDI 3: Transwoman

Theme 2: Support Systems & Policies

At times of health crisis, community members are each other's support systems. The senior community members adopt younger ones as their children. They take care of each other during hospital admission and provide financial support for GAC. They even support each other for education.

*"I called my adopted mom to the hospital. She came "*IDI 1: Transwoman

Including the option of a third gender in government forms was lauded by the participants. They also mentioned going to hospitals that provide healthcare to patients of all genders. Health camps conducted by specialists for the community were also appreciated.

"They (HCWs at a private hospital) don't care about the gender. They take (provide healthcare to) everyone." IDI 6: Transman

"The third gender option has come....(in the government forms).I am very thankful." IDI 1: Transwoman.

Theme 3: Education & Competence

Participants mentioned that HCWs who received specialist-level education treated them better. They thought that the doctors who mistreated them were mostly general practitioners with Bachelor's degrees.

"Some doctors talk behind us. Doctors who have done only MBBS are the ones who treat us like that." IDI 1: Transwoman.

Participants also expressed that their education helps them navigate the system better. They preferred the cheapest options and hospitals often for GAC and other treatments.

*"I am not okay with the finances associated with hormone therapy at the hospital I go to. But they(private hospitals) were the cheapest option."*IDI 4: Transman

Health Demands of the Participants.

The participants felt that the following things should be prioritised to improve access to healthcare for transgender population in Bangalore.

Demands have been presented under the following themes:

1. Separate hospitals/spaces/doctors for the transgender community
2. Support for education
3. Representation in the healthcare workforce
4. Free/ affordable gender-affirming care.

Theme 1: Separate hospitals/spaces/doctors for the transgender community.

Acknowledging the marginalisation that the community faces opens the question of how to distribute healthcare resources equitably. In this context the demand made by the participants to have exclusive spaces/hospitals for the transgender community is significant. They spoke about having a separate room, a separate doctor in general hospitals and a dedicated hospital for their needs.

"It would be helpful if the government opened a hospital specially for us." FGD 2: P1, Transwoman.

"Separate doctors and a separate space for transgender people in the hospital." IDI 6: Transman.

They spoke about being admitted to the right wards. They also called for an end to the practices of discrimination and respectful treatment.

Theme 2: Support for education.

Support for education was another demand. This highlights the need to coordinate with other departments to ensure the provision of education to all members of the community.

My first demand is support for transgender community's education. First, let us get educated so that we can speak for ourselves, we can be our advocates.

FGD 2:P6 Transwoman

Theme 3: Representation in healthcare workforce

The participants of this study also demanded that there should be members of the community in the healthcare workforce. This would help in delivering healthcare with the required sensibilities and also make the interactions of the community with the healthcare system easier by fostering mutual understanding. This would also improve their chances of receiving compassionate treatment.

"There should be a doctor from our community. This is what I wish for. Good doctors who treat us like their family should be there." FGD 2: P1, Transwoman

*"In your(data collector, doctor) place, a transgender person should sit."*IDI 2: Transwoman.

Theme 4: Free/ affordable gender-affirming care.

The participants of this study demanded free/ affordable GAC(gender-affirming care). This is a call for technology that is appropriate and affordable for the community with which they can access GAC which is a top priority for the members of the community.

*"Hormones (therapy) should be made free."*FGD3, P5: Transman

"It would be really helpful if a laser treatment (facial hair removal) facility was made available in government hospitals." FGD 2: P3:Transwoman.

*"Everyone wants to have silicon(breast implants). But they are very expensive. If a facility to get it for free was there, everyone would have done it."*FGD 1: P2: Transwoman.

4. Discussion

In this study, discrimination leading to unemployment, lack of living space, and low financial status emerged as barriers, aligning with findings from Pandya et al. (2020), where these factors were linked to psychosocial issues affecting transgender health.[9] Financial constraints and stigma were recurring themes in both studies, with unqualified practitioners performing surgeries due to the unavailability of Sex Reassignment Surgery (SRS) in both contexts, indicating the systemic nature of these concerns.

The themes of fear and mistrust in healthcare, noted in a United States qualitative study, were mirrored in this study, where participants expressed similar concerns due to past experiences of stigma and discrimination. The specific experience of casteism within the transgender community parallels the role of racism as an intersectional barrier in international contexts. [15] In a study on the impact of COVID-19 on transgender women and hijra in Gujarat, participants favoured private hospitals over government ones due to negative attitudes from healthcare workers, a sentiment echoed by participants in this study. The additional burdens of COVID-19 likely intensified the barriers documented here, although the full scope of COVID-19's impact warrants dedicated investigation.[10]

In Tamil Nadu, the National Health Mission (NHM) and the Tamil Nadu Health Systems Reforms Project have successfully integrated transgender population in service delivery through Gender Guidance Clinics (GCCs).[16] The inclusion of a transwoman as a technical consultant in GCCs was particularly noted, echoing the need for community representation in the healthcare workforce highlighted by participants in this study. A qualitative study from Australia (2021) found that trans and gender-diverse individuals valued respectful treatment, clean and welcoming spaces, and a familiar clinician for healthcare. [17]These factors were also identified as enablers in this study, where participants emphasized the importance of trust and respectful interactions with healthcare providers. In England, positive experiences at gender-affirming healthcare facilities were associated with well-informed general practitioners (GPs), easy referral processes, and the confidence that providers understood and believed the participants. [18]Similarly, this study found that doctors' knowledge, experience, and respectful treatment were crucial enablers for the transgender community.

The demand for free and accessible gender-affirming services in the current study aligns with the achievements of the state-run Gender Guidance Clinics in Tamil Nadu. These clinics, which operate on fixed days with regular timings, have improved healthcare worker (HCW) attitudes and the mental health of their beneficiaries. Additionally, the inclusion of a trans-woman in each clinic meets the participants' demand for community representation in the healthcare workforce. The Tamil Nadu clinics also act as referral centers to the Transgender Welfare Board, providing access to welfare schemes related to education, employment, and housing, which further supports the participants' demands for comprehensive services. The participants in the current study emphasized the need for respectful and professional care in healthcare settings, a theme also echoed in studies from Australia and England. The National AIDS Control Organisation (NACO) of India, in its 2023 white paper, [19] emphasized the need for psychosocial support and improved access to general healthcare for transgender individuals. These needs are consistent with the health demands made by participants in the current study. The NACO's recognition of these needs reflects the broader call for holistic healthcare services that address both the physical and mental well-being of transgender individuals, which aligns with the demands of the study participants for comprehensive and inclusive healthcare.

5. Conclusion

Transgender individuals face barriers such as discrimination, stigma, and lack of specialized services, which contribute to difficulties in managing their health and accessing necessary care. The study findings emphasize that lack of financial resources and employment instability further impede access to healthcare. The study findings advocates for a holistic approach to transgender healthcare guided by community demands and needs that incorporates: culturally competent training for healthcare providers, dedicated clinical services, access to free gender affirming care, community representation in healthcare delivery and community leadership in policy and planning.

Declarations

Data Availability Statement

The data that support the findings of this study are not openly available due to reasons of sensitivity and are available from the corresponding author upon reasonable request.

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perspective at all stages of the study.

Ethics approval and consent to participate

The ethical approval was obtained from the Ethical Committee of Ramaiah Medical College and in accordance with the Declaration of Helsinki. Written informed consent was obtained from all participants prior to their participation in the study. Participants were fully informed about the study purpose, voluntary nature of participation, their right to withdraw at any time without consequence, and how their data would be used and protected. All participants' privacy and confidentiality were carefully maintained throughout the research process.

Author Contribution

Joy and Krishnappa ideated the study , and co-created study tools. All authors contributed to the analysis and reviewed the article. Joy collected data and wrote the main manuscript.

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