“They Treat You Like Some Alien:” Barriers to General Healthcare Access for Trans-Masculine Mumbai Residents

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ABSTRACT: In moving towards liberatory healing for the trans-masculine community, it is imperative to understand their healthcare obstacles and the impact they have on the relationship between trans patients and the medical systems with which they interact. While there is little research on Indian transgender healthcare in general, scholarship about trans masculine experiences in routine, non-gender related healthcare is virtually non-existent. This study begins to fill this research gap with the central objective of understanding trans men and trans masculine people’s experiences in medicine and the barriers they face to general healthcare access in urban and suburban Mumbai. Through in-depth interviews with eight trans-masculine people and three healthcare providers in the Mumbai area, data showed that trans-masculine healthcare barriers presented much more in the public sector than the private. Several key health risks and barriers to care were found. Added health risks for trans-masculine participants include side effects of transition care, mental health challenges arising from stigma and dysphoria, and physical health demotivation and inaccessibility. Barriers to care include ignorance, (double) stigma, the risks of disclosure, and unaffordability. Participants discuss the individual and communal ways they navigate these spaces and propose solutions such as sensitization, more respectful care, and more awareness of trans people.

KEYWORDS: trans-masculine, transgender rights, healthcare access, public health, urban health, Mumbai

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Introduction

The landscape of transgender rights and access to healthcare in India is complex, paradoxical, and diverse. Despite global narratives about trans health that center surgery and hormones, this paper understands trans healthcare in terms of accessibility to broader healthcare systems; from routine check-ups to unrelated illness to mental healthcare, trans people go to the doctor, too. On paper, the highly visible trans community in India would appear to enjoy most of the same rights and opportunities as the general population, as well as community-specific government reservations and scholarships.[1] For example, in 2018, the Indian Psychiatric Society (IPS) removed transness as a pathologization in accordance with India's long history of gender variance.[2] Most recently, the Transgender Persons Act of 2019 grants legal recognition for trans people, including a section dedicated to healthcare access.[3] It requires a trans person to undergo gender reassignment surgery and obtain a certificate from regional legal and medical powers to be recognized as their gender, an arduous process[4] placing them under the labeling power of the medical system. While the act purports to grant sweeping public healthcare rights to Indian trans people, many still face difficulties accessing routine care.[5] However, in the larger scope of Indian trans public health, these barriers to general healthcare remain understudied and underprioritized in favor of transition- and HIV-related research.

Given the diversity of subcommunities and identities encompassed under the term "transgender," trans healthcare research in India has not nearly captured every avenue of need and access. The

literature that does exist focuses mostly on gender-affirming treatment needs. Singh et al. (2014) showcase economic and social barriers to gender-related care for trans-feminine communities in India, including lack of public access, provider unwillingness, and risky alternative methods.[6] Additionally, financial disparities and discrimination have been linked to trans women's access to HIV.[7] These studies highlight the larger trend within Indian trans health research to focus almost entirely on gender/sexual minorities assigned male at birth (AMAB) and specialized care. Those studies which expand their focus to generalized healthcare needs also heavily favor trans-feminine experiences: for example, Bhattacharya et al. (2024) conduct a thorough study of trans individuals' access to nonspecialized healthcare in which they focus on hijra, kothi, and trans-feminine research participants, who cannot be assumed to exemplify the distinctive experiences of trans men.[8]

For the purposes of this study, the researcher defines "trans-masculine" as an umbrella category for those who were assigned female at birth (AFAB) and identify as trans or nonbinary. The prevalence of Indigenous trans-feminine communities such as *hijras* has caused Indian trans public policy, law, and science to center trans women.[9] As such, academic research focusing on trans-masculine (TM) experiences in healthcare remains almost nonexistent in Indian contexts.[10] In a groundbreaking study, Chakrapani et al. (2021) demonstrate the mental health consequences of social, systemic, and familial discrimination against TM communities in India.[11] *Our Health Matters* has conducted several community research studies on TM experiences in India, but while they discuss healthcare discrimination and maltreatment, their analysis focuses heavily on gender-affirming surgery and hormone replacement.[12] Zooming out, Scheim et al. (2020) conduct a scoping review of TM health in low- and middle-income countries, including in South Asia, which highlights the prevalence of transition-related research and discusses the negative social determinants of TM health based on stigma, avoidance, and abuse.[13]

Overall, there is little research on healthcare for TM communities in India, but also an overall lack of research done about

the non-specialized, day-to-day interactions between trans people and systems of medicine. It becomes abundantly clear that economic inaccessibility and systemic societal discrimination are huge obstacles to trans public health,[14] but the more personal barriers to healthcare remain neglected—how do Indian doctors see trans patients, and how does that make them feel? What pressures do gender-nonconforming people assigned female at birth (AFAB) face surrounding their bodies and health in Mumbai’s urban setting? Through a series of in-depth interviews with TM Mumbai residents and healthcare providers, this study aims to understand the obstacles and strategies of TM residents in Mumbai for accessing general healthcare. This research contributes to general pools of knowledge about Indian TM healthcare and research interventions for trans healthcare accessibility. It adds to burgeoning public health work on increasingly visible Indian TM communities and understands their grounded experiences with medical systems to contribute to ontological discourses about defining transness in/outside medical contexts

Methodology

This study was composed of interviews with residents of the Mumbai Metropolitan area, chosen due to its accessible urban population and the presence of the Humsafar Trust, a prominent local NGO for LGBTQ+ advocacy. Participants (eight TM individuals and three healthcare providers) were recruited primarily through the Humsafar Trust. Interviews were in person and semi-structured in Hindi, English, or a mix depending on participant preference. The interviewer has a Hindi background, but a translator was available if needed. Interviews averaged around forty minutes, typically conducted at the participant’s residence or work. Recorded interviews were first processed through secure third-party transcription software and then reviewed and coded manually by the researcher. Hindi transcriptions were translated into English by the researcher, with the help of the translator, if necessary. Participants varied in age, occupation, education, and living status. Most TM

participants were trans men, and all healthcare providers were cisgender (their gender aligns with their birth assignment).

Table 1. Demographic characteristics of trans-masculine study participants (*N=8)*.

Characteristics	Number	Percent
Gender identity[15]		
Trans man	6	75.0%
Trans-masculine non-binary	1	12.5%
Non-binary trans man	1	12.5%
Age		
18 - 25	3	37.5%
26 - 35	2	25.0%
36 - 45	3	37.5%
Origin		
Mumbai	6	75.0%
Other	2	25.0%
Primary Interview language		
English	3	37.5%
Hindi	5	62.5%
Religion		
Hindu	5	62.5%
Atheist/Agnostic	1	12.5%
Buddhist	1	12.5%
Unsure	1	12.5%
Occupation		
Employed	4	50.0%
Unemployed	1	12.5%
Student	3	37.5%
Education level		
Graduate	1	12.5%
Undergraduate	2	25.0%
Secondary school (12^{th})	5	62.5%
Living status		
Hostel	1	12.5%
With family	6	75.0%
With partner	1	12.5%

Table 2. Demographic characteristics of healthcare worker study participants (*N=3).*

Participant	Age	Gen.	Interview Lang.	Origin	Occupation	Edu. Level
Part. 1a	32	CW*	English	Goa	Doctor	Graduate
Part. 2a	32	CM*	Hindi	Mumbai	Counselor	Graduate
Part. 3a	52	CM	Hindi	Mumbai	Counselor	Graduate

***** *CW = cisgender woman, CM = cisgender man*

TM participants had two requirements: **(1)** they must be assigned female at birth and identify as transgender, and **(2)** they must currently reside in Mumbai or one of its surrounding suburban areas. These interviews centered around four themes: their journey, current experiences with healthcare services, perspectives on healthcare, and resilience. Healthcare provider interviews covered their healthcare journeys and perspectives on the health needs of transgender patients. All three healthcare workers declined to be recorded but agreed on in-depth notes taken during their interview. The researcher also conducted site visits to the Family Planning Association of India's Mumbai Avabai Wadia Health Center, queer-friendly family planning and sexual/reproductive healthcare center, and STI facilities at the Lokmanya Tilak Municipal General (Sion) Hospital, a free public hospital.

Many ethical considerations were applied to this study upon approval by the School for International Training (SIT) ethics review. Responses remain anonymous, names and revealing details altered, and participants received standardized honorariums provided by the SIT stipend. Interviewees were also briefed about the scope and range of the study and their participation, verbally and via consent form. They were made aware of the researcher's positionality as an Indian-American TM person. Every effort has been made to ensure participants' stories are treated with privacy and respect. Copies of the consent forms, recordings, and identifiable data, including real names, remained only with the researcher. As much as possible, direct quotes have been taken from interviews to avoid misinterpretation. It is very important to the

researcher, who is trans himself, that this study does not exploit the trauma of trans experiences for shock value or consumption. Instead, these data are used solely for the betterment of trans care and the visibility of TM needs.

Results and Discussion

Participants' responses revealed unaddressed systemic, medical, and personal obstacles to TM individuals' access to general healthcare, particularly prior to medical transition. One pre-surgery participant, Rishi (they/ze, 19), describes going to the doctor: "I don't know, maybe it was my childhood likeness, but I used to have a lot of fun. I think that is the major difference… now I just dread it." This feeling of dread discourages Rishi and other participants from seeking the medical care they need. Others echo Rishi, one stating something must be "seriously messed up" for him to go to the doctor.[16] Another participant (Karan, he/him, 25) used to "run very far away from any doctor… no matter how high the fever or anything."[17] This study finds that these barriers to care result from overlapping factors presented below, including increased health concerns, ignorance and stigma, the pressure to disclose one's identity, and forces of reduction to one's body and exclusion in medical settings. Participants also disclose strategies they employ for navigating medicine and coping with medical stressors, as well as ways they believe their healthcare could improve.

Added Health Risks

When Data supports that TM individuals have an increased risk of physical and mental health problems.[18] TM individuals in Mumbai are shown to experience negative mental health consequences due to several factors, including stigma, family rejection, and minority stress—the theory that stigmatization and discrimination impact the health of minority communities.[19] Most TM participants corroborate this, citing previous or ongoing mental health stressors for themselves and their community. Rohit (he/him, 39) says, "maybe after facing this stigmatization, [trans men] feel

mental depression, or some other mental thing," relating the negative mental health outcomes of TM people to their stigmatization from society. The interviewed doctor (she/her, 32) asserts, "they want more attention, more counseling than other people because they are suffering emotional issues, depression, HRT [hormone replacement therapy] changes." Divyang's (he/him, 36) account of his past mental health reflects this description, as he recalls suffering from depression and anxiety:

> Things were going on and I didn't have a *support system*.[20] I didn't speak about them. It falls on us alone … you can get *depression* and *anxiety* when *changes* are happening in your body. Or then like after you start your journey with *T* [testosterone], the *mood swings* start to happen (trans. Hindi).

Mood swings came up frequently during interviews, a recognized side effect of testosterone supplements.[21] One participant describes having had such bad mood swings that sometimes he could not even think or concentrate.[22]

Gender dysphoria—discomfort caused by an incongruence between one's gender and their sex assigned at birth—is a known stressor for many trans people, which can improve through gender-affirmation and treatment.[23] Several interviewees mention the mental risks of gender dysphoria and body discomfort, including Suresh (he/they, 20): "in trans healthcare, I think they should also mention mental health. Dysphoria and body stuff, eating disorders… can be very interconnected." These accounts highlight several overlapping mental health risk factors for TM participants: stigmatization, lack of support, the side effects of medical transition, as well as gender dysphoria and related issues. Interviewees' stories support the theory that in this context, TM people are at higher risk for mental health issues.

Living as TM in Mumbai can have physical health impacts as well as mental, as the two are so often intertwined. Indeed, Fredriksen-Goldsen et. al (2014) demonstrate that physical health problems disproportionately affect trans adults, including lack of access to healthcare and lack of physical activity,[24] which

manifest in several interviewees' answers. Rohit, a trans man and counselor, explains:

> [Mental health] affects your physical health, also. Because if you're not mentally healthy, you may not care about your health, also. If you are trans man, you need a proper diagnosis, you need to properly care about yourself, your health, your food, your diet, other things also. Apart from that, you're facing also physical violence.

He asserts that poor mental health can lead to TM people neglecting to take care of themselves physically and notes the real threat of physical violence for trans men in India. Other participants corroborate Rohit's narrative; two participants mention quitting their physical activity of choice until after medical transition.[25] Dysphoria and prejudice can keep TM people out of physical activities they love, which is a lack of exercise that can impact physical health. It is not just poor mental health keeping them from good physical health, but the systemic discomfort they face as trans people in society.

Other gender-affirming practices, such as chest-binding, can cause undertreated physical side effects despite their important mental health benefits.[26] Rishi describes severe pain in their back from binding, relating it to the extreme heat of Mumbai and the lack of official binder brands in India, and asserting that a "normal" doctor would not understand the "comfort, affirmation, and security" of binding. However, they feel that consulting a doctor about this harm would not be worth it. Physical health risks come along with avoiding the doctor's office as well. Several participants describe only seeking treatment for severe health concerns, which could lead to the neglect of legitimate treatment needs. The fear of discrimination in healthcare settings is associated with transgender peoples' worse general health outcomes, causing delays in care at the "forefront of health challenges for transgender adults".[27]

Data corroborate participants' narratives that existing in Mumbai as a TM person can bring negative mental, emotional, and physical health risks. TM individuals can face mental illness such as anxiety and depression due to the stigma they face from multiple

sides. They can experience mood swings, side effects of HRT, and also distressing gender dysphoria. Physically, these mental health issues can lead to TM individuals struggling to take care of their health, especially due to the lack of access to affirming physical activity and safe healthcare spaces.

Trans Kya Hota Hai?: Ignorance

Medical ignorance—whether it presents as uninformed reactions, questions, or insufficient care—appears as a barrier in all participants' interviews. This ignorance manifests more in public medical settings, but several participants mention private doctors' ignorance as well. Multiple report uncomfortable experiences during body scans; in the following, Aakash (he/him, 30) gets a back CT, and Suresh gets a chest X-ray.

> Aakash: The guy who took the CT scan came and asked me, "sir, why don't you have a penis?" Then I asked, "What?" [He replied,] "Sir, I can't see your penis on the scan. What is this?" Then I said, "I'm a trans person. I'm a transgender person." [He said,] "Okay, okay, okay." So, the medical people are not aware.
>
> Suresh: So, they thought I was a guy, and then I take my shirt off and they can see my binder and the guy was like, "oh, you're a girl?!" … And he's so confused and I'm so confused. My mom just goes and calls the lady doctor and all that. That was a weird experience because it's like, how do you explain [to] people?.

Aakash and Suresh were put in the position of educating medical professionals who did not understand them despite treating them. These kinds of ignorant comments demonstrate how uneducated some healthcare professionals remain about how to speak to transgender patients. Doctors often display "shock"[28] upon learning patients are trans, asking questions like "*trans kya hota hai* [what is trans]?,"[29] "wow, how does this happen?," and "did someone *force* you to do this?"[30] These questions make it so participants have had to educate doctors about themselves in uncomfortable ways. Once, a

private doctor told Suresh, "'you don't look trans… you just want to be a tomboy" like he was "the first trans person they've ever seen." Once, after Divyang recounted his life story at length for a Gender Identity Disorder diagnosis, the doctor simply asked him, "why do you want become this?" (transl. Hindi). After hearing his answer, he then heard the doctor ask that same question to the next ten trans men, making Divyang feel "*ganda*": dirty, immoral, or impure.

This kind of questioning reveals systemic undereducation that demands trans people confront ignorance and take responsibility for educating doctors. As the interviewed doctor says, "we [doctors] didn't have any knowledge about the community when we entered this field… there is no specific point or topic for the LGBTQ community" in doctors' syllabi. This ignorance forces TM patients into situations of confusion, awkwardness, and frustration. As Divyang puts it, "you [the doctor] are providing healthcare, so you need to know everything… I can give you suggestions, but I am not the authority."

Always People See You as Suspicious: Stigma

While ignorance in the previous section covers more unknowingly hurtful behavior directed towards TM people in healthcare settings, outright stigmatization against transness and its perpetuation is quite common for interviewees. Rohit explains,

> Always, people see you as suspicious, like "*yeh toh ladki hai, ladke jaise kyun chal raha hai* [she is a girl, why is she walking like a boy]?" … *toh is type ki chiz hoti hain* [so these kinds of things happen] sometimes in healthcare centers, also. Doctors see you in the boy outfit, but when you speak your voice is very soft like a girl. And when you say your name or your gender, the doctor will be surprised and say something, like *"aap toh ladki ho, aap ladke jaise dikh rahe ho* [you are a girl, you look like a boy]." So, it sometimes feels a little bit uncomfortable and stigmatized…

Suresh agrees, asserting that when they find out you are trans, doctors' "whole outlook on you just changes… They treat you like

absolute garbage or they treat you like some alien,” and he explains that this discourages him “getting into the healthcare system.”

Many participants discuss this alienating gaze and treatment when talking about their experiences in healthcare systems. While visiting a public hospital after an accident, Karan experienced this alienation when he had to show the staff an ID displaying his deadname and female gender-marker. Hospital staff asked him “are you a girl or a boy?” (transl. Hindi), made him state his deadname out loud even though it was visible, and misgendered him. He moved on to the doctor:

> The doctor was an *educated* person, but he also saw me like this. My *case file* was there [listing me as feminine], so he gave me very weird looks. This was after I had been in an accident. He didn’t ask me anything, but he looked at me in a way that was very weird for me… I felt very awkward. He didn’t say anything to me, he just checked me like that [quickly]. [He] looked at my legs a little. He gave me a normal *checkup* and gave me something to take. After a minute he sent me outside. That’s why I don’t go to government hospitals (trans. Hindi).

This story highlights several layers of stigmatization. It showcases the pervasive nature of stigma in the medical system, where not just doctors but other medical staff who interact with patients can perpetuate it. The fact that he is required to show his legal sex and deadname for treatment underscores the systemic nature of this mistreatment, larger than doctors and nurses. Additionally, his half-hearted check-up suggests that this awkward, alienating feeling, even from an “educated” doctor, can hinder a trans patient’s care. Karan, like Suresh, has learned that he cannot feel safe at a public hospital even if he must save money for private.

Some participants discussed being mocked or discriminated against by providers. Aakash describes a moment when he heard two healthcare workers discussing his body: they said, “he’s a trans, he’s not a boy ... I felt very bad about that.” He shares his experience of being admitted to the female ward of a psychiatric institution for depression in 2020:

> I said that "I don't want to be here. Give me a separate room. I can't stay here." Then they say, "you are a female." Then I said that "I'm not a female, I'm a trans person, I am an intersex person." Then the doctor said that "he's having grandiose things. Admit him." Then they gave me sedation and I slept for five days…

This experience—providers gossiping about Aakash's body, diagnosing him with grandiose behavior, and sedating him for being trans—exemplifies the kind of stigmatization and mistrust that Rohit described. It is worth recalling that the IPS professed to de-pathologize trans identities in 2018, two years prior to Aakash's encounter. This contradiction reveals how systemic discrimination can contradict official guidelines because stigmatized sociocultural understandings of transness may lag behind policy. Aakash's further words echo through this study: "if I treat the people like how they treat me, I could have took a gun and shot everyone, but I decided to be a good person… every trans person in India goes through this. It's not my experience, it's the experience of everyone."

"Body Secrets" and Disclosure

Participants discuss the often intense obligation to reveal irrelevant details about their lives, bodies, and identities to doctors. These kinds of compulsory disclosure can be exhausting and are one of the most prevalent deterrents to care in interviews. Rishi has avoided the clinic altogether since their preferred doctor left because returning would mean "explaining [their] entire situation" again. They further explain:

> Each time I would have to go back and [say], "Okay, so when I was sixteen I got to know I was trans, when I was fourteen, I got to know I was queer ... Yeah, I am not a trans man, I am a non-binary trans-masc. person. What does that mean? Okay. It means that-" You feel like a robot...

Rishi's explanation reveals one risk of disclosing one's trans identity: the responsibility to educate the doctor due to ignorance. They assert that this obligation to teach uneducated healthcare

providers about their personal journey discourages them from seeking healthcare. Suresh avoids the public sector due to the same fear of having to explain their “life story” to everyone: “I'm not a celebrity. I'm just a little different.” He asserts, “they should know as medical professionals.” Aakash sticks to his one doctor because he’s “done with talking this shit to everyone I meet.” These stories reveal the pattern of societal demand for transgender people to disclose and memorialize their stories, contributing to how energy-draining healthcare can be. Aakash describes having to explain himself to doctors as “hell.”

Sometimes, doctors ask harmful and personal questions upon learning their patient is trans. Suresh prefers not to come out to doctors out of “safety, because then people will ask you questions, most of them are very invasive.” Revealing you are trans does not just mean explaining what that means and how you came to know this about yourself, but also telling doctors what Aakash terms your “body secrets” and losing needed “privacy.” Karan recounts one instance when doctors were asking, “how do you guys have *sex*, what do you do?,” and he thought, “my parents haven’t even asked me these questions” (transl. Hindi). These violating questions from someone supposedly administering care are even more invasive than what family might ask. Disclosure becomes as much about safety and privacy as it is about having the energy to educate, as it can lead to unnecessary personal questions about TM individuals’ lives and bodies. These questions can be exhausting, dehumanizing, and violate their right to privacy and respect.

As he grieved the passing of a loved one, Suresh’s public psychologist immediately outed him to his mother as trans. The psychologist’s first question upon finding out was, “Does your mom know?... Okay, let me talk to your mom.” This betrayal was “terrible, because it was from a doctor, a professional.” The fact that a “professional” did not understand his need for autonomy makes him feel worse. Other participants express similar fear of being outed by healthcare providers, especially community doctors with connections to their family.[31] Throughout these interviews, the pressure to disclose is a recurring difficulty to TM healthcare

access. Whether the response is shock, ignorance, and stigmatization as described in previous sections, or these kinds of personal and familial violations, disclosure of "body secrets," and demands for explanation, these experiences with doctors make participants wary of revealing their identity to doctors. Such hesitancy can be a barrier to general healthcare and cause negative feelings towards doctors. Through compelled disclosure, some TM participants must exchange dignity, privacy, and safety for basic medical care.

Reduction of Trans People

Interview responses reveal the Mumbai medical system's reductionist perception of transness. Some participants expressed feeling reduced to their body at the doctor. "They look at it in a sense of what genitalia you have, which is a very idiotic way of living."[32] Through this forced gendering based on biological sex, many faced difficulties from healthcare when they first developed secondary sexual characteristics. Suresh recounts the process of going to the doctor before and after developing a female chest:

> As a kid, going to the doctor was fine. I have a flat chest and all, so it doesn't really matter. As I started going through puberty, going to the doctor was becoming more exhausting and more like they're gonna look at me like [I am] a girl.

Suresh highlights the exhausting power of the clinical gaze[33] by focusing on how doctors "look at" him—medical perception is gendered and focused on his bodily changes. The clinic became a gendering space for Rishi when ze started menstruating at ten: "I had to be taken to the doctor, and suddenly everything changed. I was no longer a kid. Now I was a girl." In that moment, the gaze through which the doctor looked at Rishi gave them gender. The fact that the doctor's office was the site of such a huge change highlights the power of medical perception over TM patients. All of a sudden, these children were reduced to their bodies as they began to resemble the "female" category more and more. Even before they

realized they were trans, the clinic transformed from a relatively “gender neutral” space[34] to an exhausting gendering process. Thus, the medical perception of TM patients can reduce them to their body as determined by sex characteristics, erasing everything else.

The medical system also reduces participants’ trans identities by erasing trans-masculinity in favor of trans women. Rohit explains: “[doctors] don’t even know what a *trans man* is, they’ve never heard a word like this. Because when the word ‘*transgender’* is said, they think of *kinnar*” (trans. Hindi). Here, Rohit refers to Indian trans-feminine communities commonly known as *hijras* or *kinnar,* who, while culturally and historically celebrated, are now often marginalized and feared in Indian society. Rohit and others argue that in these medical settings, trans-masculinity is overshadowed by the cultural relevance of marginalized trans-feminine communities. This comes with stigma as well, as *kinnar* are associated with sex work; Suresh complains that if he discloses his transness to a doctor, they think he is “getting laid insane and stuff,” because “the only … representation of trans people is the trans [sex] workers on the streets.” In these situations, the medical system reduces transness to trans women, neglecting the needs and identities of TM people.

Rishi connects this difference in visibility between trans men and women with the gendering medical gaze reducing people to their bodies. They state that being a trans woman has “been more visible,” but as a trans man, “especially pre-op, [doctors] just see your feminine features and [will] be like, ‘you’re just a masculine girl.’” This relates the invisibility of trans men to the doctors reducing them to their body’s “feminine” features and not taking their identity as seriously as they might a trans woman’s. This invisibility was evident at the Sion hospital as well, as both interviewed counselors had difficulty understanding what the researcher meant by trans men even when clarified, instead defaulting to talking about trans women. If transness is only understood through a trans-feminine lens, then TM patients may continue to be misunderstood and reduced to their bodies.

Two participants identify on the non-binary spectrum, and both express frustration at the rigidity of the male-female binary within medical spheres. Suresh explains that even though being non-binary is "such an important aspect of my identity, I can't say it to doctors," because "they won't see the 'they,' they'll see the 'he.'" To avoid confusion when stating their pronouns, they "just say he/him out of convenience" because "[doctors] won't understand a trans non-binary person." The medical gaze seems not just to reduce transness to trans women, but also to binary trans people.

Interviewees express the exhaustion and frustration of their trans experiences being reduced or invalidated by doctors; they detail being reduced to their body, confused with trans-feminine communities, and forced to fit into the gender binary. Other intersectional identities come up in interviews, such as being Dalit (low-caste), intersex, fat, or neurodivergent. All these aspects of TM lives can affect their healthcare needs, but they are often neglected by providers, worsening their quality of care.[35] In these examples, healthcare practitioners ignore TM people's lives and beings and instead see one-dimensional bodies through a reductionist lens.

"Double Stigma": The AFAB Experience

Even as they describe feeling different from a very young age, being raised female is an important part of many participants' lives, as they face what Rohit describes as "double stigma:"

> If you're born as a girl, it's a stigma, because they [don't give] importance to girl children in India. And if you identify as a lesbian, bisexual, or trans-masculine person, it's a double stigma… [English switched to Hinglish] It's clear that India is a *male-dominated state*. Here, males *dominate* the *females* a lot. Most people only want a *boy child* in India… if a girl is born, they feel like that she must be taught to get married and many other things. If you *identify* as a *lesbian*, *bisexual woman, or trans man*, they think that is *western culture,* not Indian *culture*… They get [queer AFAB people] married *forcefully*, sometimes *rape*

> happens—so much stuff is done to them—*conversion therapy*, *other bad treatments*. They are *verbally* and *mentally tortured*, so there is a *double stigma*.

Rohit suggests that the experiences of trans men in India are inseparable from their positionality before coming out because they face stigma from multiple sides as AFAB people.

In healthcare, having female organs influences a TM person's care; they can have gynecological and endocrinological issues which then can cause negative mental health side effects as well.[36] Rohit explains that those raised as women have less mobility, autonomy, and are more bound to familial duty. Some participants expressed fear that doctors with ties to their community might not protect the privacy of their patients and out them to their families, which matters more because they were socialized as women. Divyang explained why he did not come out to his family doctor: "I didn't tell him anything. I was scared because he's a *family doctor* and he knows my whole family, so what will happen if he tells them, and they don't *accept* me?" (transl. Hindi).

Participants describe instances in healthcare settings where they faced discrimination and violation due to being AFAB. Karan shares a moment in Pune where he was "touched" by a doctor: "it was the first time where I felt like I was a girl," which "doesn't happen anymore because of my *looks*" (transl. Hindi). Karan associates his assault with being AFAB, as it was a distinctly female-gendered experience. His story reflects Rohit's TM double stigma, as it manifested simultaneously as sexism and misgendering, trapping and disempowering him in a state of vulnerability. Suresh also discusses the misogyny AFAB trans people experience at the doctor, particularly in the public sector: "if you have a bigger chest, not a masculine chest, they'll treat you completely like some alien. Like, not alien, but completely like a woman, I guess." Suresh's conflation of being treated like an alien and a woman reveals how Mumbai public healthcare alienates feminine-presenting people. Having a feminine higher voice can also lead to dismissal or disrespect.[37] These treatment discrepancies

would extend to cis women, adding to the shared experience between all AFAB people.

In avoiding this kind of treatment, TM people must persistently ask themselves which doctors are safe and often prefer female healthcare providers over males as they better "understand the experience."[38] Rishi explains, "over a man I would see a woman when it comes to a doctor. Because no matter how man I am, I have been a woman," a fact they usually do not share for fear of invalidation. Aakash recounts when his preference for female treatment at an Ayurvedic facility was invalidated:

> I said [to] them that I prefer a female to touch my body. I'm not comfortable with men touching my body. Then she said that "I can't see your boobs." Then I said that it's not about boobs. It's about my body… They said that "we don't do cross things. Females do for females, men do for men," then how will a trans person get that? So, for the Ayurvedic massage, we have to get naked. I haven't done any surgery, and I am not comfortable around men. I told them this thing, but they are not ready to accept. I had to take that treatment with man. I felt very discomfort when the procedure was going. I was lying down naked, and I was not feeling good. It was a very bad experience for me. So, I want to do further, but if I get female assistance only.

Having an AFAB body means that Aakash does not feel comfortable being treated by men, but this experience is not understood or accommodated, arguably amounting to some level of medical assault. This has discouraged him from returning for necessary treatment, suggesting that the medical systems' failure to understand AFAB trans experiences can prove a barrier to TM healthcare.

According to interviews, AFAB people also have less visibility within queer life and healthcare, and many participants prefer to be around AFAB people with shared experiences.[39] Both public hospital counselors interviewed had not worked with openly TM people despite asserting that they would need the provided services. One supposes "they are scared to discuss *sexual issues*

with government doctors due to *shame*” (transl. Hindi).[40] The combination of AFAB double stigma, unsafety, and invisibility leads to unique negotiations TM people must make in healthcare settings.

Navigating Medical Spaces

Having discussed the barriers they face accessing healthcare—ignorance, stigma, the reduction of their transness, and AFAB double stigma—TM participants share their strategies for navigating medical spaces, what might discourage or encourage them from seeking help, and levels of disclosure with which they feel comfortable. Often, navigating medical systems means discovering if a doctor is “trans-friendly or not.”[41] Chandra (he/him, 36) starts “with a little information and [sees] how they respond” (trans. Hindi) before disclosing anything else. Some participants handle these general healthcare systems by avoiding disclosure entirely, revealing “as less as possible” about themselves.[42] This often means deciding to be understood as a girl out of safety. Rishi explains,

> If you are, anyway, going to gender my experiences as female, then you may as well do that assuming that I'm female. I don't want you to already know that I'm not a woman and still know that you're still misgendering. I'd be much happier if you're ignorant and doing it than knowing about it and purposefully.

Others pass as cisgender men. “I can't explain these things to all [in public healthcare] … I will act more masculine so that they will not get confused,” says Aakash, echoed by others. These strategies demonstrate the complex dynamics at play in participants’ general interactions with healthcare and the sacrifices they must make to seek it. TM patients in this context would seem not to assume safety going into a visit, instead prepared to fit in as best they can. Passing as cisgender is worth any emotional or mental effort for the sake of comfortable access to care.

Rishi prefers to consult an online "repository of doctors all around India, gynacs especially, and if they are safe… and there is a specific question in [the repository]: will they be friendly to trans people?" The need for this repository suggests the general lack of accessible trans-friendly healthcare available in India. Aakash says that now he has found trans-friendly doctors who know him, he has become "fixed to these doctors" and he goes to them for everything. The risk of trying new doctors is not worth it. There are also safe clinics people prefer, such as the one transgender clinic in Mumbai where everyone is sensitized and the Humsafar Trust's clinic.[43] There exists this kind of constant negotiation, trying to see how doctors respond, having to decide at any given moment how to act, how to reduce who you are.

Accessibility

Patterns emerge regarding the multifaceted healthcare systems in Mumbai specifically, including the relatively strong presence of accessible support organizations. Rohit explains, in Mumbai, "there are people who know where they want to go and approach [for healthcare] because there are a few support group teams" and "some organizations working for the community." Participants know of and mention utilizing services at organizations and facilities such as the Humsafar Trust, the Tweet Foundation, Gaysi, and the MITR transgender clinic.[44] This contrasts more rural areas where stigma overshadows any existing community, and "most doctors and psychiatrists on the rural side always support the family, not the person."[45] Mumbai's metropolitanism, history of LGBTQ+ advocacy, and size provide TM people more autonomy from their families, access to healthcare rights, and more knowledge.

Nevertheless, financial barriers still impede TM healthcare in Mumbai. With double stigmatization and discrimination, many TM people are already forced into a low socio-economic status, which can then worsen their health. Rohit explains how this cycle occurs:

> People know that they should be *physically fit*, but what happens is, if you don't have *acceptance* at home then you are forced to leave. If you are leaving home then your *education* will not be *complete*. You don't have a *proper job*, so you can't *earn* very much … So how well you will eat depends on if you are earning money (transl. Hindi).

This monetary concern often manifests in the difference between public and private. Anyone can access affordable healthcare through public government facilities, but many do not feel understood or respected there. While some TM participants have had negative experiences in private healthcare settings—Karan says, "private sector people can also be very, very weird" (transl. Hindi)—and great experiences in public,[46], many still discuss the benefits of saving up for the expensive private sector. Karan explains,

> In the *government* sector, like Sion, there are many problems. They treat you like they know everything. They will ask, "why do you have to do this? Why do you have to do all these *kharaab* [bad] things?" (transl. Hindi).

On a more infrastructural level, Aakash criticizes the alienating, overcrowded, and gender-segregated nature of public hospitals, which means TM people "will not be able to stand in the queue because of bullying." Even as TM people are in a higher need of private healthcare for trans-friendly treatment, they also are at higher risk for poverty. They may not be able to afford private healthcare due to marginalization and discrimination. "My opinion is to go only to *private*, take a little time, save money, and go. Our government does not understand," suggests Karan (transl. Hindi), but some health seekers may not have the time or money to go private.

In Mumbai, accessing healthcare also requires Hindi proficiency. Aakash was raised in Kerala with Malayalam; he shares his experience with Mumbai's language barrier: "I don't have language … I know a little bit of Hindi only; I can't go to the doctor." Especially as Aakash and others describe having to explain who they are and what that means to doctors so often, struggling to communicate would further hinder their understanding. These

findings suggest that making healthcare more inclusive of trans-masculinity also means making it financially and linguistically accessible, as well as improving overall trans opportunities.

Respect and Sensitization

Participants were asked to share times when they felt respected in healthcare and what could improve their care. For some, respect is as simple as normal treatment and correct gendering.[47] Rishi explains, "I won't get offended over a healthcare provider trying." Instead, ze classifies respectfulness based on "willingness to listen," a willingness to change one's perspective, and a willingness to ignore the "other stuff" that does not align with a patient's gender expression. Rishi also felt respected when "[their doctor] was telling me about how all of this [discomfort] is majorly routing from my gender dysphoria," suggesting that competent healthcare means knowing how gender dysphoria manifests—knowing about trans experiences.

Respect means not asking unnecessary questions. Aakash sees one doctor whom he loves because "she don't go deeper into me like that." This sentiment is echoed by the interviewed queer-friendly doctor, who speaks about the importance of consensual self-disclosure: "we do not ask them or force them to explain their identity… while doing treatment, I am taking consent from them that, 'if you are ready to tell me about your health then I will treat you better.'" Her focus remains on health, rather than gender, even as she acknowledges the relevancy of the person's context for their treatment. She also emphasizes giving patients the autonomy to reveal how much they feel comfortable with, showing them humanizing respect. This is a sentiment shared by many participants as they discuss respectful interactions with healthcare providers.

Everyone interviewed mentioned the importance of sensitization in both private and public to improve healthcare for TM people. Rohit emphasizes human acceptance over law:

> So many *laws* have been made by now, but not everybody needs to *follow* them. How we *treat* someone *as a human* is

> more important. So, it would be better if there were more *sensitization* on a *personal level* (transl. Hindi).

Underneath all these real systemic barriers, Rohit highlights the personal aspect of TM people’s interactions with the medical system—sensitization means treating trans patients like people. He explains that sensitization means understanding who one is treating, what their culture is, and how to treat them equally, but most trans healthcare is lacking such understanding.

The doctor interviewed explains that through sensitization, they learn about how trans people are “discriminated from society, so if I pronounce [misgender] them wrongly, that feels bad to them.” This small amount of understanding of Mumbai trans life teaches the doctor why pronouns are important and how misgendering perpetuates societal discrimination. Sensitization programs occur in some medical settings but not all, according to the interviewed doctor. For her and several TM participants, society and culture are becoming more inclusive with the help of these trainings, but more is needed. Indeed, counselors interviewed at the public Sion hospital told the researcher trainings would be helpful for treating trans patients so providers can understand their lives better. Sensitization means understanding trans identities, life, and discrimination to treat them with respect and humanizing understanding.

“I am my Own Therapist”: Resilience

Due to the inaccessibility of mental health resources and the heavy stigma TM people face in Mumbai, participants often describe alternative methods for mental health support and getting through medical obstacles. Ending with coping methods highlights their agency and personhood, as they have found ways to remain resilient through traumatic and demoralizing experiences. When asked about how they navigate and cope with difficulties, several TM participants described the families they have found, especially with trans men and AFAB queer people. Those whose families do not understand them or have taken a while to accept them have

demonstrated an incredible ability to manifest home and community for themselves.

Others find strength in personal ways: Divyang explains, "I sit alone and I talk to the moon… my soul, my mind is very relaxed." He explains, "I can manage myself; I can make a *solution* for myself. I am capable of that. So, I will do that first. If I can't, then I go to *other people* to *talk* about it" (transl. Hindi). Aakash states: "I am my own therapist. Whenever I feel bad or I get treated bad, I'll make some art." The communal and personal resiliency strategies that participants discuss remind us of their strength without taking away from the struggles they face.

Conclusion

While this study cannot fully represent the experiences of TM Mumbai residents, findings reveal understudied barriers to their healthcare access, which are particularly prevalent in public health settings. Firstly, TM people in Mumbai can face increased health risks, including the stress of stigma and dysphoria, the lack of access to safe and affirming physical activity, and the physical side effects of transition care. Due to these health factors, it is concerning that TM Mumbai residents would feel unsafe or unwelcome in medical spaces. Participants express disappointment and outrage at the ignorance, stigma, and reductive perceptions they face, such that they must weigh the risks of disclosure (i.e. the responsibility to educate, answer invasive questions, mistreatment, and violation) against their right to comprehensive treatment. Many said they had never been asked these interview questions before, perhaps accounting for the shock that echoes through their words at having to make such difficult negotiations. Female socialization magnifies TM discrimination and immobility as well, causing many TM patients to seek treatment from female providers and find community primarily with other AFAB people. All of these struggles often manifest more strongly in public healthcare settings, meaning that for the majority without the money to pay for private, good, trans-friendly healthcare remains inaccessible. The systemic

disenfranchisement of trans people combined with the impossibly complex context of socio-economic inequality in India means good public healthcare must be trans-competent.

In navigating these exclusive and harmful spaces, participants share a variety of strategies, such as acting more feminine or masculine, hiding parts of themselves, and sticking to the trans-friendly doctors they can find. They assert that healthcare professionals need more sensitization and understanding about trans experiences. Despite the lack of available support, they exhibit resilience by building community and finding comfort individually.

It can be extrapolated from these findings that the major problems of ignorance, stigma, reduction, AFAB marginalization, and unaffordability impact the accessibility of general healthcare for TM residents of Mumbai. Within trans healthcare studies in India, there is a draught of information about TM needs and barriers. While limited in length and scope, this study provides much-needed data about the Mumbai TM population’s healthcare experiences, which have yet to be adequately studied or addressed. These results corroborate broader studies about TM health obstacles such as stigma and inaccessibility,[48] while providing context and experiences specific to the socio-cultural and economic setting of Mumbai. This study works towards the visibility of trans men within LGBTQ+ research and contributes to bodies of knowledge in trans studies, medical anthropology, and public health in India. Data about the need for respect and sensitization in the medical sphere, as provided by participants, can help strengthen intervention initiatives for improving trans health and liberation.

Limitations and Further Study

Due to this study’s limited duration and resources, the scope of its results is also limited. Although further empirical applications can be extrapolated, this paper only consults the opinions of eleven people from Mumbai. Additionally, the interviewer’s limited Hindi skills and inexperience with Marathi meant data may have been lost

in translation, or interviews may not have flowed as well as possible.

Future studies should expand the length and scope of this research to analyze results with a larger sample size more indicative of the needs of the full TM community in Mumbai. A more scoping review of TM routine healthcare in India would also be a welcome addition to trans healthcare scholarship, allowing for better comparisons of regional specificities in trans healthcare across the country and the world. Additionally, research needs to be done into the successful implementation of intervention strategies proposed here—particularly TM sensitization—and how to maximize their effectiveness. In all, the researcher encourages any and all respectful research done for the TM community in India and across the world. It is essential for our needs to be met and for our community to find its voice.

Notes

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3. The Transgender Persons (Protection of Rights) Act, No. 40 (2019).

4. “Our Health Matters: Indian Trans Men and Transmasculine Health Study,” *Our Health Matters,* Oct. 2023, accessed Jan. 8, 2025, https://ourhealthmatters.in/topline-report.

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6. Yadavendra Singh et al., “Gender Transition Services for Hijras and Other Male-to-Female Transgender People in India: Availability and Barriers to Access and Use,” *International Journal of Transgenderism*, vol. 15, no. 1 (2014): 1-15, https://doi.org/10.1080/15532739.2014.890559.

7. Venkatesan Chakrapani et al., “Barriers to free antiretroviral treatment access among kothi-identified men who have sex with men and aravanis (transgender women) in Chennai, India,” *AIDS Care,* vol. 23, no. 12 (2011): 1687-1694, https://doi.org/10.1080/09540121.2011.582076.

8. Shamayeta Bhattacharya and Ghosh, Debarchana, “MAHI: a multidimensional access to healthcare index for hijra, kothi, and transgender individuals,” *International Journal of Transgender Health* (2024): https://doi.org/10.1080/26895269.2023.2301306.

9. Ayden Scheim et al., “Health of transgender men in low-income and middle-income countries: a scoping review,” *BMJ Global Health* (2020): https://doi.org/10.1136/bmjgh-2020-003471.

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11. Venkatesan Chakrapani et al., "Affirming and negotiating gender in family and social spaces: Stigma, mental health and resilience among transmasculine people in India," *Culture, Health & Sexuality* vol. 24, no. 7 (2021): 951-967, https://doi.org/10.1080/13691058.2021.1901991.

12. Our Health Matters team, "Our Health Matters: Indian Trans Men and Transmasculine Health Study;" and Venkatesan Chakrapani et al., "Access to transition-related health care among transmasculine people in India: A mixed-methods investigation," *PLOS Global Public Health,* vol. 4, no. 10 (2024): https://doi.org/10.1371/journal.pgph.0003506.

13. Ayden Scheim et al., "Health of transgender men in low-income and middle-income countries: a scoping review."

14. Chakrapani et al. (2023); *Our Health Matters* (2023); Raghuram et al. (2024); Scheim et al. (2020).

15. For this study, the researcher purposely does not focus on how trans participants define themselves or ask them to articulate their gender identities for larger audiences. Terminology such as "non-binary trans man" were volunteered by the participants who used them, but not explained due to their irrelevancy to the subject at hand, which is healthcare. Regardless of their gender identity label, all interviewees here self-identified as trans-masculine.

16. Suresh, interview with the author, April 16, 2024.

17. Karan (translated from Hindi), interview with the author, April 23, 2024.

18. Ayden Scheim et al., "Health of transgender men in low-income and middle-income countries: a scoping review."

19. Venkatesan Chakrapani et al., "Affirming and negotiating gender in family and social spaces: Stigma, mental health and resilience among transmasculine people in India."

20. In translated quotations, italics indicate words retained from the original, untranslated. These moments have important implications for the queer expressivity of both languages in the global postcolonial setting. Due to the natural hybridity of Mumbai Hindi and its native incorporation of many English words, notation is determined at the researcher's discretion.

21. R. B. Santos et al., "Gender-Affirming Hormone Therapy: Physical and Sociopsychological Effects, Impact and Satisfaction," *Cureus* vol. 15, no. 3 (2023): https://doi.org/10.7759/cureus.36484.

22. Karan 2024.

23. Louis Lindley and Galupo, M. Paz, “Gender Dysphoria and Minority Stress: Support for Inclusion of Gender Dysphoria as a Proximal Stressor,” *Psychology of Sexual Orientation and Gender Diversity* vol. 7, no. 3 (2020): https://doi.org/10.1037/sgd0000439.

24. Karen I. Fredriksen-Goldsen et al., “Physical and Mental Health of Transgender Older Adults: An At-Risk and Underserved Population,” *The Gerontologist* vol. 54, no. 3 (2014): https://doi.org/10.1093/geront/gnt021.

25. Rishi 2024; Suresh 2024.

26. B. A. Jarrett et al., “Chest Binding and Care Seeking Among Transmasculine Adults: A Cross-Sectional Study,” *Transgender health* vol 3, no. 1 (2018): https://doi.org/10.1089/trgh.2018.0017.

27. Kristie L. Seelman et al., “Transgender Noninclusive Healthcare and Delaying Care Because of Fear: Connections to General Health and Mental Health Among Transgender Adults.” *Transgender Health* vol. 2 (2017): 117-28, https://doi.org/10.1089/trgh.2016.0024.

28. Rohit (translated from Hinglish), interview with the author, April 9, 2024.

29. Karan 2024, translated.

30. Chandra (translated from Hindi), interview with the author, April 9, 2024.

31. Divyang (translated from Hindi), interview with the author, April 9, 2024.

32. Suresh 2024.

33. Here the researcher invokes the Foucauldian medical gaze as discussed in *The Birth of the Clinic*, in which Foucault demonstrates the power of a kind of clinical “gaze” over patients. Through this gaze, the medical practitioner, in an attempt to understand and order someone’s medical existence, “must subtract the individual, with his particular qualities” and the disease becomes only what exists on “the plane of visible manifestations.” The medical gaze reduces a patient to a disease, and creates that disease such that its identification depends on physical, bodily similarities to others. The patient as an individual, their life, and social conditions, all lose value to the gaze in favor of spaces on their body. This reducing gaze rings true for the examples raised in this section wherein trans patients are reduced to sites on their body, specifically their genitalia, and ordered as such. (Michel Foucault, “Spaces and Classes,” *The Birth of The Clinic* (Tavistock, 1973)).

34. Rishi 2024.

35. Aakash 2024; Rishi 2024; Suresh 2024.

36. Medical doctor, interview with the author, April 17, 2024.

37. Suresh 2024.

38. Rohit 2024; Suresh 2024.

39. Suresh 2024; Rishi 2024; Aakash 2024; Rohit 2024.

40. Counselor 1 (translated from Hindi), interview with the author, April 23, 2024.

41. Suresh 2024.

42. Rohit 2024.

43. Pravin (translated from Hindi), interview with the author, April 9, 2024.

44. Aakash, Rohit, Pravin, and Karan, 2024.

45. Rohit 2024.

46. Rishi 2024.

47. Suresh and Karan, 2024.

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