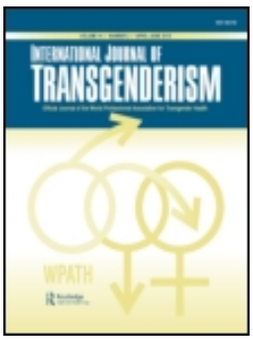

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Gender Transition Services for Hijras and Other Male-to-Female Transgender People in India: Availability and Barriers to Access and Use

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ABSTRACT. This qualitative investigation explored access to and use of gender transition services by hijras and other male-to-female transgender people in the public and private hospitals in 7 Indian cities. We conducted 7 focus groups ($n = 42$ participants) and 30 in-depth interviews with a purposive sample of hijras/transpeople and 22 key informant interviews with service providers. Findings reveal a near-absence of gender transition services in public hospitals. Lack of free sex reassignment surgery (SRS) in public hospitals and the prohibitive cost of SRS in private hospitals seem to be the key reasons behind why some hijras/transpeople go to unqualified medical practitioners for surgery or undergo *Dai Nirvan*, a traditional but risky method of removing male genitalia practiced within the hijra communities. Similarly, unwillingness among qualified medical practitioners to prescribe hormone therapy compels many hijras/transpeople to self-administer hormones. The lack of national guidelines on gender transition services and ambiguous legal status of SRS mean that even qualified medical practitioners are hesitant to perform SRS. Findings highlight the need to provide free or affordable gender transition services in public hospitals, to develop national guidelines on gender transition, and to equip health care providers to provide technically and culturally competent gender transition services.

KEYWORDS. Transgender, hijras, *Nirvan*, gender transition services, use of sex reassignment surgery, India

Male-to-female (MtF) transgender and transsexual people in India are highly heterogeneous in terms of their self-identities, social structure, and subculture-specific practices and norms (Chakrapani, Newman, Mhaprolkar, & Kavi, 2007; Kalra, 2012; Nanda, 1986). Some of the several indigenous identities (or labels) of gender-variant people in different parts of India

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include *hijras* and *kinnars* (most parts of north India), *aravanis* or *thirunangai* (in Tamil Nadu), *yellamma* (Karnataka), *jogti hijra* (in certain parts of Maharashtra), and *shiv-shakthi* (Andhra Pradesh; Chakrapani, 2010; Reddy, 2006). Leaders and activists from these communities do not always agree with the "definitions" of these identities or labels and question the inclusion of persons who belong to these diverse groups under the umbrella term *transgender* (Chakrapani et al., 2007; Chakravorty, 2007). For example, preferring to call themselves only hijras and not transgender, some hijra community leaders suggest that the term *transgender* be used to refer only to those MtF transgender people who do not come under hijra social structures (such as *gurus* and *chelas*—i.e., masters and disciples, respectively) and who do not follow the hijra subculture norms and customs (Chakrapani, 2010). For convenience, in this article the term *MtF transgender people* will be used to refer to biologically male-born gender-variant people with a range of indigenous identities as well as those who identify as transgender or transsexual.

A positive and enabling policy environment seems to be emerging for addressing the health and social service needs of transgender people in India. Recently, the government of India in its draft 12th 5-year plan has explicitly stressed the "empowerment of the transgender community by advocating that line Ministries [such as Ministry of Social Justice and Empowerment, and Ministry of Education] support their education, housing, access to healthcare" (Planning Commission, 2012) and in its approach paper specifically mentions that "the health policy must focus on the special requirements of . . . [the] lesbian, gay, bisexual, and transgendered (LGBT) community" (Planning Commission, 2011). Even though the barriers faced by hijras in accessing general and sexual health services (Chakrapani, Babu, & Ebenezer, 2004; Math & Seshadri, 2013) and antiretroviral treatment from public hospitals (Chakrapani, Newman, Shunmugam, & Dubrow, 2011) have been documented, the current situation of availability of and access to gender transition services of transgender people in India is largely unknown. This is despite that sex reassignment surgery (SRS) and hormone therapy are considered to be essential health services for transgender people to help them in changing their body to be congruent with their gender identity (Coleman et al., 2011). This article addresses this information gap by exploring MtF transgender people's access to and use of gender transition services—especially SRS and hormone therapy. The study findings may inform health policies and programs for gender transition services for transgender people in India.

We asked several specific questions that would guide this qualitative study:

1. What do MtF transgender people do to meet their gender transition services (with a focus on SRS and hormone therapy)?
2. Do MtF transgender people have access to safe and affordable SRS and hormone therapy?
3. What barriers, if any, do MtF transgender people face in accessing and using SRS and physician-prescribed hormone therapy?

METHOD

Study Sites

In the last quarter of 2012, we conducted this qualitative study in seven Indian cities: Delhi, Kolkata, Chennai, Bengaluru, Mumbai, Vadodara, and Imphal. These study sites were selected to capture the range and diversity in experiences of the different transgender subgroups in accessing gender transition services. Thus, the principle of "maximum variation sampling," a kind of purposive sampling technique, was used in the selection of sites for including urban and rural sites as well as sites from different regions in India. Such diversity in the study sites will then help in transferability of findings to other settings (Patton, 1990).

Data Collection

We conducted seven focus groups and 30 in-depth interviews with MtF transgender people and 22 key informant interviews with health care providers, transgender community leaders, and lawyers. The duration of in-depth interviews ranged from 30 to 60 min; focus groups

lasted between 1.5 and 2 hr. Interviews and focus groups were conducted by trained field researchers who themselves were hijras or trans-identified people. Key informant interviews with most of the health care providers were conducted by a physician who was trained in qualitative data collection techniques.

Focus Groups and In-Depth Interviews with MtF Transpeople

Local community-based or nongovernmental organizations working with hijras/transgender people in each of the seven study sites assisted in recruitment of potential participants, most of whom were beneficiaries of those agencies. Recruitment was conducted primarily by word of mouth; no posters or fliers were used.

Seven focus groups were conducted among MtF transgender people: one focus group in each of the seven sites. Even though ideally a focus group needs to contain homogeneous participants to create a safe environment for discussion, MtF transgender people in different stages or with different experiences of gender transition were invited to participate (e.g., a mix of transgender people who had undergone SRS, who were considering SRS, who were undergoing hormone therapy, and who had had breast augmentation surgery). Similar logic was used in identifying a purposeful sample of 30 MtF transgender people for the in-depth interviews.

Semistructured topic guides were used in the focus groups and in-depth interviews covered topics such as availability of SRS, breast augmentation, and hormone therapy in public and private hospitals; costs of those services; traditional surgery (*Dai Nirvan*) practiced within the hijra community; experiences in accessing and using gender transition services; and suggestions for improving access to and use of services.

Key Informant Interviews

Purposive sampling was used to identify "information-rich" key informants who had the necessary experience and expertise. We conducted 22 key informant in-depth interviews with health care providers ($n = 12$), MtF transgender community leaders ($n = 7$), and lawyers ($n = 3$). From the seven study cities, the different categories of health care providers who were interviewed included psychiatrists ($n = 3$), a psychologist ($n = 1$), plastic surgeons ($n = 2$), an endocrinologist ($n = 1$), a urologist ($n = 1$), a nurse ($n = 1$), a pharmacist ($n = 1$), and a skin specialist ($n = 1$).

A semistructured topic guide was used for conducting these interviews. Interviews with health care providers focused on understanding their current practices in providing gender transition services, whether they think these services need to be available for free, and in which facilities those services should be made available. In-depth interviews with the transgender community leaders gathered their experiences and perspectives in relation to availability of and access to SRS and hormone therapy for MtF transgender people in their respective states. Interviews with lawyers focused on obtaining their perspectives on the legal status of "emasculation" and SRS.

Data Analysis

In-depth interviews and focus groups were audiotaped, transcribed verbatim in local languages (Tamil, Marathi, Hindi, Kannada, Gujarati, Bengali, and Manipuri), and translated into English for data analysis. We explored interview and focus group data using a thematic analysis approach (Guest, MacQueen, & Namey, 2012) with techniques, such as constant comparison method, adapted from grounded theory approaches (Charmaz, 2006; Strauss & Corbin, 1990).

Analysis involved first-level coding and first-level inferencing from analysis of the transcripts and notes from interviews and focus groups. Coding was conducted through NVivo7 qualitative data analysis software. A preliminary codebook was developed based on the topic guides used for conducting focus groups and interviews. The codes were then applied when conducting targeted analysis of the text segments. Where necessary, in vivo codes (using the language of the participants) were also identified and added to the codebook. Focused coding and a constant comparative method were used initially. Themes were identified by looking for

similarities, differences, and other relationships between categories. Illustrative quotations corresponding to inferences were drawn from the interviews and focus groups.

For enhancing the validity or trustworthiness of the findings, we used data source triangulation among several data sources (MtF transgender people, health care providers, and community leaders) and methods triangulation using two different methods (in-depth interviews and focus groups; Denzin, 1989). In addition, we conducted "member checking" (Lincoln & Guba, 1985) with some of the key informants and community members, and their feedback was taken into consideration in arriving at final inferences.

Ethics and Consent

The participants, except key informants, were each given an honorarium of 250 Indian rupees. The study protocol was reviewed and approved by the Institutional Review Board of the Centre for Sexuality and Health Research and Policy (C-SHaRP), a research agency that specializes in conducting applied and policy-oriented health research among marginalized communities. All participants provided informed consent. No names or any other personal identifying information were collected, and all personal identifiers were removed from the transcripts.

Sociodemographic Characteristics

MtF Transgender People Who Participated in the Focus Groups

Table 1 shows sociodemographic data collected on the focus-group participants. Participants' ages ranged from 18 to 47 years. Only 16% were college graduates. Nearly half of the participants' monthly income was more than INR 5,000. Fifty-seven percent identified as hijra or equivalent indigenous identity and the remaining as "transgender" (English term). About one third of the participants were employed in nongovernmental agencies, and 60% were engaged either in *mangti* (refers to asking for money from shopkeepers and the general public), *badhai* (refers to asking for money or materials during occasions and functions such as marriage and birth of male babies and opening of new shops), or sex work for survival.

MtF Transgender People Who Participated in the In-Depth Interviews

Table 1 shows sociodemographic data collected on interview participants. Participants' ages ranged from 21 to 54 years. Only 17% were graduates. Nearly three fifths identified as "transgender" (English term), about one fifth (23%) identified as hijra, and four persons identified as woman. About one third of the participants reported having engaged in sex work.

Key Informants

Key informants' ages ranged between 28 and 65 years, and their experience in working with transgender communities ranged between 2 and 15 years.

FINDINGS

We present findings related to availability of and access to three gender transition services—SRS, breast augmentation, and hormone therapy—for MtF transgender people in public and private hospitals in seven cities. Based on the approaches of Penchansky and Thomas (2001) and Gulliford et al. (2002), we extended the concept of access to include personal, financial, organizational (health care system) and policy barriers. All of these barriers are presented in an integrative manner in this section (see Table 2). As Dai Nirvan, a traditional method of male genital removal, is still practiced within some sections of hijra communities, we have provided statistics for this service in addition to the in-hospital services.

SRS in Public and Private Hospitals

Both MtF transgender persons and health care providers reported a near lack of free gender transition services in public hospitals. Only one medical-college–attached public hospital in Chennai has a free SRS program (limited to removal of male genitalia and creation of vagina) for MtF transgender people following an order

TABLE 1. Sociodemographic Characteristics of Focus Group and In-Depth Interview Male-to-Female Transgender Participants

Characteristics	Focus group participants ($n = 42$) *n* (%)	In-depth interviews ($n = 30$) *n* (%)
Age (years) *M* (*SD*)	27.4 (6.1) (range = 17–46)	27.1 (6.9) (range = 19–54)
Education		
Illiterate	4 (9.5)	2 (7)
Primary (5th grade or less)	8 (19)	1 (3.3)
6th to 11th grade	13 (31)	10 (33.3)
High school degree	7 (17)	10 (33.3)
College degree	10 (24)	7 (23.3)
Total	42 (100)	30 (100)
Employment		
Daily-wage laborer	18 (43)	
Community-based agency staff	6 (14.3)	9 (30)
Begging		7 (23.3)
Private company staff	5 (12)	
Beautician	5 (12)	3 (10)
Sex work	2 (5)	7 (23.3)
Unemployed	1 (2.4)	2 (7)
Bar dancer		2 (7)
Other	5 (12)	
Total	42 (100)	30 (100)
Living status		
With parents	20 (48)	13 (43.3)
Alone	13 (31)	9 (30)
With guru	8 (19)	8 (27)
With husband	1 (2.4)	
Total	42 (100)	30 (100)
Gender-related self-identity		
Hijra	24 (57)	7 (23.3)
Transgender	18 (43)	19 (63.3)
Woman		4 (13.3)
Total	42 (100)	30 (100)

TABLE 2. Multilevel Barriers Faced by Hijras and Other Male-to-Female Transpeople in Accessing and Using Gender Transition Services in Public and Private Hospitals

Level of barrier	Themes identified
Health care system barriers	• Lack of availability of free SRS and hormone therapy in public hospitals • Lack of expertise among health care providers regarding gender transition services
Policy barriers	• Lack of national policy/practice guidelines for gender transition • Lack of clarity on the legal status of SRS by qualified surgeons
Community-level barriers	• Preference for traditional Dai Nirvan among some sections of hijra communities • Relative nonacceptance of surgeon-performed SRS (that involves vagina creation) among some senior hijra gurus as they do not agree with the need of hijra-identified people for a vagina.
Personal barriers	• Lack of awareness among hijras about SRS offered by qualified surgeons • Inadequate resources to pay for gender transition services (SRS, breast augmentation, hormone therapy) available in private hospitals

Note. SRS = sex reassignment surgery.

from the state government of Tamil Nadu in 2009. One public hospital in Mumbai and a semiautonomous government hospital in Delhi provide SRS on an ad hoc basis and in both these hospitals the costs for SRS need to be partly borne by the patients. Across all the sites, participants expressed the need for SRS to be provided in the public hospitals:

> If the government wants to do something for our [hijra] community then it must provide free SRS or at least [emasculation] through government hospitals. People in our community starve to save money to undergo this operation. (Hijra-identified person who has undergone SRS, Delhi)

A total of 20 private hospitals in the six study cities (except Imphal) were listed by the participants as offering one or more type of gender transition–related surgery (SRS and/or breast augmentation). For example, in Bengaluru, SRS is provided by at least four or five private hospitals. As these hospitals charge heavily (SRS costs 2,500 to 3,000 USD), many transgender people from Bengaluru and other parts of Karnataka go to nearby states for "emasculation" by nonmedical practitioners in Andhra Pradesh or a qualified private medical practitioner in Tamil Nadu.

In Imphal, none of the participants (including health care providers) were aware of SRS being provided by qualified surgeons in their city or state. A psychiatrist key informant in Imphal explained that lack of surgeons to perform SRS means many MtF transgender people go to other states:

> There are so many surgeons in the state but no one does SRS. Once my doctor friend shared with me that there was one person who asked him to remove his private part. My friend was shocked as he was not aware of TG [transgender] issues. He had never performed SRS ... Hence, many [transgender people] go to Kolkata or Delhi [to private hospitals]. (Psychiatrist key informant, Imphal)

SRS offered in private hospitals seem to be mainly used by MtF transgender people who are from middle and upper class backgrounds. As a private practitioner offering SRS said,

> [n]one of our SRS clients relate to or from hijra community ... None of my clients wish to join hijra *gharana* [clan or house] or have a hijra guru [master]. They want to be women and want to be accepted that way and live that way. After SRS, they live as a woman and do not join hijra community. (Plastic surgeon key informant, Delhi)

In contrast, MtF persons who have undergone free SRS provided at the government hospital in Chennai were mostly from aravani (hijra) communities. However, even in Chennai some aravanis in sex work save money to undergo SRS in private hospitals as they perceive that the quality of SRS performed in private hospitals is better than that in public hospitals. In other cities, where no government hospitals provide free SRS, hijras and other MtF transpeople save money from begging and sex work to pay undergoing SRS in private hospitals. For example, a participant said,

> I saved money [for SRS] from whatever income I got through my work. I went to work every day when I was a male ... Almost 5 to 6 years I had to work for saving this money. I had to face lots of troubles and tough times ... I spent whatever I saved. I could go for this surgery [in private hospital] only because I had enough money with me. (Transgender-identified person, Delhi)

While in some cities the private hospitals that offer SRS are known to everyone, in other cities it is kept as a secret, probably to avoid potential legal issues. As one transgender-identified person said,

> I have a friend who has undergone this sex change operation. She gave me the information about the [private] hospital and the doctor. It is not easy to find out about the place [that offers SRS], we have to know

> someone who has already undergone the operation and the message is passed by that concerned person to others—that too, only if they ask and pledge to keep it confidential. (Transgender-identified person, Delhi)

Participants complained of lack of proper presurgical counseling before SRS. Except for the government hospital in Chennai, pre- and postcounseling are unheard of or, if claimed to be offered, was perceived to be tokenistic. Participants also reported that one institute in Bengaluru has recently begun to provide counseling for SRS, although it does not offer SRS.

Health care provider key informants cited lack of demand from hijras and other transgender people as a reason for government hospitals not offering SRS and other gender transition services. In contrast, hijra/transgender community leaders attributed the lack of services to the ignorance of government health care providers about the gender transition service needs of transgender people. Hijra participants pointed out that even in Chennai, where free SRS is provided in at least one public hospital, other services such as hormone therapy or laser therapy for facial hair reduction are not provided.

Health care providers pointed out that they follow either the International Classification of Diseases (ICD-10) or the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*) by the American Psychiatrists Association for diagnosing "gender identity disorders." However, they opined that most health care providers may not be following the international guidelines such as those of World Professional Association for Transgender Health (WPATH). They pointed out the lack of national guidelines on gender transition services and expressed the need for guidelines from the government. A plastic surgeon key informant noted,

> There is nothing in our medical curriculum, even MBBS, MS, MCh [plastic surgery] level which talks about gender reassignment surgery. We don't have any local SRS guideline or any regulatory body. (Plastic surgeon, Delhi)

Sometimes, prejudice of the health care providers seems to masquerade as "ethical concerns" in offering SRS. In one site, a government hospital has appointed an "ethical committee" to examine whether SRS can be offered to a hijra-identified person who was recommended for SRS by a psychiatrist from the same hospital. This hijra-identified person reported that an ethical committee member remarked, "It is unethical to harm a biologically normal male body." She also felt that the formation of the ethical committee was basically to buy time to deny providing SRS services in that government hospital.

Even though Indian laws are silent on the legality of SRS, health care providers who currently offer SRS felt that many doctors were worried that they could be sued by the parents for changing their child's sex (even if their "child" is a legal major) or even by the patients themselves if something goes wrong. For example, a psychiatrist said,

> Persons under 18 years of age request for surgery [SRS]. And what if a person wanted to reverse the sex change operation [to put back the male genital]? How can we address these issues? We need to consider all these legal issues related to SRS—otherwise it will be very complicated for the medical professionals. (Psychiatrist key informant, Imphal)

A transgender-identified participant shared her experience that highlighted the concerns of doctors about legality of SRS. She said,

> [Government medical college] doctors worked so hard for me. They got necessary permission [from the management] for this surgery ... Although I was an adult at the time [of assessment], they needed my parents' consent. My parents did not give it ... Doctors did not want to face any legal issue. For that reason they did not accept my consent for SRS. I had a hard time convincing them. (Transgender-identified person who has undergone SRS, Kolkata)

Breast Augmentation

MtF transgender participants reported that these days many prefer breast augmentation in the form of saline or silicone implantation. In some of the public hospitals in Chennai and Mumbai, breast augmentation surgeries with saline or silicone implants are conducted. But transgender people need to purchase the implants, which costs about INR 20,000 to 30,000 (400 to 600 USD).

Participants from Chennai opined that the results of the breast surgeries performed in the public hospitals were not good. Chennai and Bengaluru participants complained of sepsis of the operated area and slippage of the breast implant due to rupture of the stitches. Also, they added that many people live under the stress of possible damage to their silicon breasts. For these reasons, many preferred to have breast augmentation surgery in private hospitals despite high costs. As one participant said,

> [m]any of my [transgender] friends faced bitter experience in government hospitals. They reported that water-like substance oozes out of breasts. Sometimes, operation stitches get opened. I decided not to suffer like them. So I get admitted in a private hospital as health is important than money. (Thirunangai-identified person who has undergone breast augmentation surgery, Chennai)

Some transgender participants reported that transgender persons in sex work are more likely to prefer breast augmentation surgery when compared to those who are not. As one participant noted,

> [p]eople who ... engage in sex work, they go for breast implants. Hijras who go for begging take [hormone] tablets. (Transgender-identified person who has undergone hormone therapy and who is contemplating breast implantation surgery, Bengaluru)

Related to this, community key informants and health care providers noted that some proportion of hijras may actually be compelled to engage in sex work to earn money for this surgery, the cost of which ranges between INR 40,000 and 70,000 (~100 to 1,200 USD). For example, a nurse from Imphal said,

> Only very recently I heard that breast operation [augmentation] is available in one of the private hospitals [in Imphal] and it costs INR 60,000 ... I don't think TG community would be able to provide such high fees. (Senior nurse key informant, Imphal)

Participants complained of lack of proper counseling, in both public and private hospitals, for transgender clients who seek breast augmentation.

Hormone Therapy

In general, transgender people in all the study sites reported having easy access to hormone pills and injections from pharmacies without medical prescription but at relatively higher costs. As a hijra-identified person said,

> [t]he injections are very expensive. Injections like [x] are quite affordable they cost around 400 rupees per injection which has to be administered twice or thrice a week. But what happens is most of our friends prefer taking it every day and it becomes overdosage. They do this to see the changes [in the breast size] faster and quicker. But this leads to tremendous weakness and their body can't adapt to large amount of medicines. (Hijra-identified person on self-administered hormone therapy, Delhi)

Only at the Imphal study site, transgender people need to travel to Myanmar border to get cheap hormone pills or injections that are smuggled across the border. As one transgender person at the Imphal site said,

> [i]nitially I used to go to Tumu (bordering town of Moreh in Manipur) at Myanmar to get hormone injections from my TG friend who runs a beauty parlor there

> . . . Except for the progesterone injection made in India, all other hormone medicines are brought from Myanmar. I used to take a hormone pill called "U-Lite" and some other pills bought from Myanmar. (Transgender-identified person who is self-administering hormones, Imphal)

Female hormones are self-administered by many MtF transgender people because of lack of qualified medical practitioners who are willing to provide hormone therapy. In four of the seven study sites, however, participants reported the presence of at least one qualified private practitioner who is sensitive and willing to provide hormones. In those private clinics, getting written consent for starting hormone therapy seems to be the norm. For example, one participant said,

> In the consent form it was written that "You are responsible for any problem or side-effects such as pimple, cracked lips or anus due to hormone treatment. We will just help you to get the treatment done. You shall take injections on your own risk." (Hijra-identified person who has undergone hormonal therapy in a private clinic, Vadodara)

Even if transgender people were aware of sensitive doctors they reported not using those doctors' services to avoid delay in starting the hormone therapy as the doctors routinely order blood tests (such as liver and kidney function tests) before starting the therapy. Participants reported that transpeople usually consult doctors only when they experience complications from self-administered hormone pills or injections. Even after previous experience of adverse effects (such as temporary liver dysfunction), some persons reported that they had continued taking hormone injections and pills without medical supervision.

Participants were aware that self-administration of female hormones poses health risks. Participants attributed symptoms such as body weakness, obesity, body heat, severe pain in limbs, increased appetite, and drowsiness to self-administration of hormones. Some persons on hormone therapy were concerned about the possibility of life-threatening side effects such as kidney failure and heart problems. Transgender persons under physician-prescribed hormone therapy seem to have a relatively better understanding about temporary side effects:

> When I got [hormonal] injection for the first time, I had pimples on my face and the anus skin was torn. I showed it to doctor. She said it is normal . . . Gradually, all these symptoms vanished. Body hair stopped growing, and breasts started getting fuller . . . Doctor told me earlier that first reaction of injection would be on face. (Transgender-identified person, Vadodara)

Similar to the legal concerns about SRS, concerns seem to exist among health care providers regarding the legality of providing hormone therapy to transpeople. Even qualified doctors who do provide hormone therapy do not prescribe hormone regimens using their prescription pads, for fear of any legal problems.

> [Doctor] prescribed the medicines [hormones] in a plain sheet. . . . These medicines have a lot of side effects. If the person who is prescribed such medicines develops some complications then they will always blame the doctor. So the doctors do not prescribe [hormones] in their prescription pads. (Transgender-identified person who has undergone SRS, Delhi)

Dai Nirvan

Dai Nirvan refers to the traditional method of removing male external genitalia by an experienced hijra-identified person called *Dai maa* or *Thai amma* (in Tamil Nadu). Participants reported that Dai Nirvan is practiced in six of the seven study states, and lack of money to pay for SRS in a private hospital seems to be a key factor in going to Dai maa. As a hijra said,

> [p]rivate doctors charge us very high for [sex change operation]. They charge even one or two lakh rupees [2,000 to 4,000

> USD]. . . . But Dai maa performs Nirvan and it is quite cheap. So, most of us [hijras] go for Dai Nirvan. (Hijra-identified person who has undergone Dai Nirvan, Delhi)

Cost factor alone, however, does not seem to explain why hijras undergo Dai Nirvan. Hijras view Dai Nirvan as part of their subculture and believe that it has several advantages. In addition, relatively older hijra gurus are much more familiar with Dai Nirvan than with SRS offered by licensed surgeons. Thus, some of the senior hijra gurus prefer their chelas (disciples) to undergo Dai Nirvan. As one hijra said,

> [i]n our [hijra] community Dai Nirvan is preferred over SRS. My guru might order me to go for Dai Nirvan instead of SRS. In such situations we cannot say no to her [guru] even if I want to undergo SRS [vagina creation]. We have to abide by the rules [of hijra community]. (Hijra-identified person who has undergone Dai Nirvan, Delhi)

In contrast, in some sites (Mumbai and Chennai), at least some gurus seem to support their chelas' decision to undergo SRS or emasculation by a qualified medical practitioner. In fact, a health care provider in Mumbai noted that "most of our [SRS] clients are brought here by their gurus . . . They take care of the expenses as well (Plastic surgeon key informant, Mumbai).

Usually hijra gurus refer chelas (disciples) to Dai maa. Dai maa usually charges much less money compared to qualified surgeons; sometimes the Dai maa does not charge at all. Not all hijras, however, prefer Dai Nirvan. As one participant said,

> Dai Nirvan is quite cheap. Most hijras go for it because of the low cost. But we have lots of complications in Nirvan—the hole [urethra] gets closed and it is always better to go for SRS. (Thirunangai-identified person who has undergone Dai Nirvan, Tamil Nadu)

Many hijras seem to believe that Dai Nirvan has several advantages when compared with emasculation or SRS by a qualified medical practitioner. When a hijra who has undergone Dai maa Nirvan was asked what she thought about Dai maa Nirvan, she said,

> It [Dai Nirvan] is absolutely safe and the person who did it for me was very clean in her work. It is done in a home. There is always a risk of getting lots of problems in getting operated by a doctor—problems with stitches, the wound doesn't heal quicker, and the person becomes very weak, and starts to gain more weight. These problems don't occur with Dai Nirvan; we remain stronger and take care of ourselves. (Hijra-identified person who has undergone Dai Nirvan)

Thus, some hijras seem to perceive Dai maa Nirvan as safe and also believe that emasculation by a doctor has disadvantages. A doctor too commented,

> Many hijras believe that persons who get emasculated by Dai maa will be more feminine and beautiful in comparison to one who gets emasculated by doctors . . . Those who get [operated] by Dai maa are more valued. (Plastic surgeon key informant, Delhi)

Trends, however, seem to be changing. Some hijra participants felt that the younger generation hijras prefer to undergo SRS and to become "complete females." However, going against the norms of the hijra community does seem to have some costs to the individual. As a hijra-identified person who has undergone SRS explained,

> [g]enerally [hijra/TG] people who have undergone emasculation [alone] is preferred for Badhai and seen as one of the [hijra] community members. But persons like me who has undergone SRS [vagina creation] finds it difficult to get along with the community as others [hijras] discourage it [vagina creation]. So, if I want to go for Badhai and I want to live with my hijra community then I have to go for emasculation alone. The person who goes

> for a complete sex change [SRS] can go for other professions. (Hijra-identified person who has undergone SRS, Delhi)

The apparent resistance among hijra community leaders to their chelas undergoing SRS also seems to be due to another factor—that hijra communities might face problems if others in the society come to know that they are biological males as hijras are generally perceived to be born with ambiguous genitalia. As one hijra participant noted,

> [s]ociety thinks that hijras are [intersex people]. So it will be risky for hijras if they get admitted in hospitals for SRS. People around them will then come to know easily that this is not something they have got by birth. So, hijras might face a lot of problems . . . our livelihood may be affected. (Hijra-identified person who is undergoing hormone treatment, Kolkata)

DISCUSSION

We found a near absence of gender transition services for MtF transgender people in the public hospitals of seven Indian cities, four of which are metropolitan cities. Except for one government hospital in Chennai, none of the government hospitals in the six other cities had a dedicated free SRS program for MtF transgender people. Even though some private hospitals in these cities do offer SRS services, the costs were too high to be afforded by many transgender people. Several barriers were found in relation to access to and use of SRS, breast augmentation, and hormone therapy (see Table 2).

Lack of free SRS and hormone therapy in the governmental hospitals is a key systemic barrier. While the health care providers in this study were of the view that government hospitals do not offer gender transition services because of lack of demand, hijra/transgender community leaders thought that it was because health care providers were simply ignorant of the need for providing gender transition services for hijras and other transgender people. Even in Tamil Nadu, where free SRS is supposed to be provided in a few government hospitals, only one government hospital in Chennai has a long-standing free SRS program, and thus free SRS is relatively inaccessible to many transgender people from other parts of Tamil Nadu.

It is not the lack of expertise in gender transition–related surgeries that seems to prevent surgeons from performing those surgeries in public hospitals. Male genital removal (orchidectomy and/or penectomy), for example, is performed among patients with invasive testicular or penile cancer (Lerner, Jones & Fleischmann, 2006; Skoogh et al., 2011), and vaginoplasty is performed even on biological females with certain urogenital conditions (Cervellione et al., 2010; Stein, Fisch, Bauer, Friedberg, & Hohenfellner, 1995). General and plastic surgeons, whether in public or private hospitals, should therefore be familiar with these procedures. Our findings suggest that moral positions taken by health care providers might be partially accountable for the lack of gender transition services in public hospitals.

Our findings suggest that at least some proportion of hijra-identified persons seems to still use the traditional Dai Nirvan, despite its risks, partly due to lack of availability of free SRS in public hospitals and high costs for undergoing SRS in private hospitals. Therefore, SRS provided in private hospitals seemed to be accessed primarily by transpeople who could afford to pay.

Lack of national guidelines or standards of care for transgender people who require gender transition–related services was raised as a critical issue by the health care providers in this study. Although Indian psychiatrists in general follow ICD-10 or *DSM-IV*, our interviews with psychiatrists and surgeons who perform SRS indicate that many health care providers may not be aware of WPATH's authoritative guidance document, *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People*, which is now in its seventh edition (Coleman et al., 2011). Some health care providers have pointed out the need for possible modifications of WPATH's guidelines for the Indian context and Asian context more generally (Chakrapani & Velayudham, 2008). Even the authors of

WPATH guidelines have stressed the importance of taking into consideration cultural and local contexts (Coleman et al., 2011). Considering the need to take into account the Indian context, an interim national guidelines on SRS for MtF transgender people was drafted by a group of experts on gender transition (plastic surgeons, psychiatrists, counselors) in a meeting convened by UNAIDS India in 2011 (personal communication, Mr. Ashok Row Kavi, former consultant of the UNAIDS India office). At the time of writing this article, no statement from the Ministry of Health on the endorsement of these interim guidelines or on the development of comprehensive national guidelines on gender transition for transgender people was publicly available.

Health care system barriers have interconnections with legal aspects. Doctors are concerned about potential adverse legal implications if they offer surgery or prescribe female hormones to biological males. For example, even though there are no specific laws for or against SRS, many doctors are concerned that they could be sued by the parents for changing their child's sex (even if the "child" is a legal major) or even sued by the transgender patients themselves if something goes wrong. Under Section 320 of the Indian Penal Code "emasculation" (in the legal context, removal of testis) is explicitly mentioned as a grievous injury and a punishable offence, irrespective of whether the person who was castrated had given consent (Peoples' Union for Civil Liberties–Karnataka, 2003). Even though no unqualified or qualified medical practitioner seems to have been arrested for providing "emasculation" surgery, the fear of potential arrest remains among health care providers.

A similar scenario exists for hormone therapy for MtF transgender people. Firstly, doctors are unclear about the legal implications of prescribing female hormones to self-declared transgender people or hijras. This is exemplified by their practice of prescribing hormones on plain paper and not on their official prescription pads. Secondly, hijras could not afford the charges of physician-prescribed hormone therapy. Consequently, hijras often rely on their peers' knowledge and experience in selecting and using the brands and dosages of female hormonal tablets or injections, thus facing high chances of adverse effects due to overzealous or wrong dosage.

At the hijra community level, community norms and prevalent community practices seem to influence whether hijras would undergo emasculation (or SRS) by a qualified surgeon, Dai maa, or an unqualified medical practitioner. Some hijra gurus seem to discourage, if not prevent, hijras from undergoing SRS procedures such as vagina creation, stating ideological reasons such as hijras need not "completely" become a female physically, and having ambiguous genitalia (i.e., just removal of male external genitalia) is a key aspect of hijra subculture (Nanda, 1986). In contrast to this view of senior hijras on SRS, findings from this and other studies (Chakrapani et al., 2004; Chakrapani, Mehta, Buggineni, & Barr, 2008) also indicate that the younger generation of hijras want to make use of all available SRS procedures (including vagina creation) that will help them to physically become more like a biological female.

Lack of availability of free SRS in public hospitals and lack of money to pay for private hospital services seem to be the key reasons why many hijras choose Dai Nirvan or go to unqualified medical practitioners for emasculation. Besides the cost factor, some hijras seem to prefer Dai Nirvan for other reasons as well: less bureaucracy involved with "approval" for surgery (when compared with hospital-based surgery), personalized care, and lack of discrimination. Many hijras believe that those who undergo Dai maa Nirvan will be more feminine when compared with those who undergo surgery by a qualified medical practitioner. These beliefs also then pose barriers to using SRS offered by qualified medical practitioners.

Limitations and Strengths

An inherent limitation of using a qualitative approach with purposive sampling is an inability to generalize the findings. Our intention was, however, not to generalize but to understand in-depth the range of experiences of MtF transgender people in accessing gender transition

services. In particular, the study sample may be more representative of lower socioeconomic MtF transgender populations especially those who have indigenous gender-related identities such as hijras and aravanis/thirunangais and those who are accessing the services of community-based organizations working with transgender people; middle- and upperclass, well-educated MtF transgender populations and those who are accepted by and living with their family members may have a different set of experiences and needs in relation to accessing and using gender transition services.

Although the study had limitations, as far as we know, it is the first multisite study that has documented the current situation of MtF transgender people's access to and use of gender transition services in India. Also, we have used multiple sources (MtF transgender people, health care providers, and community leaders) as well as multiple methods (focus groups and in-depth interviews) to triangulate the information and understand multiple perspectives. The validity of our findings is further increased by the close work with transgender communities at all stages of this study—planning, implementation, and data analyses–and by having trained hijra-/transgender-identified field researchers.

Implications for Practice and Policy

With official government documents now explicitly mentioning the need to improve access to health care of transgender communities (Planning Commission, 2011, 2012), it is important to develop a detailed implementation plan for the same on the part of both union and state governments of India. Given that health is a state subject, it is crucial that state governments provide free gender transition-related services for needy transgender people. Experiences and lessons learnt in providing free SRS through government hospitals from the state of Tamil Nadu can be used to offer SRS and other gender transition services through public hospitals in other states. For instance, the issuance of identity cards for the transpeople by the Tamil Nadu Transgender Welfare Board of the Department of Social Welfare and support from thirunangai community leaders facilitated access to free SRS services for trans people in Tamil Nadu (Chakrapani, 2011). To start with, a team of health care providers in one or more government hospitals in at least one city of each Indian state can offer a range of gender transition services for transgender people. Such a team can comprise general surgeons, plastic surgeons, endocrinologists, internal medicine physicians, urologists, psychiatrists, and psychologists. Appropriate technical and cultural competency training for health care providers in public hospitals is thus needed.

Currently, SRS service providers use different guidelines or no specific guidelines, potentially resulting in wide variation in the criteria for offering certain procedures and in the quality of services. This points out the need for national clinical guidelines or standards of care for gender transition services (including SRS and hormone therapy) for transgender people. Taking into account some of the culture-specific aspects (e.g., presence of hijra and other indigenous transgender populations in India for several centuries), existing international standards of care such as WPATH guidelines need to be adapted to the Indian context. One possibility is to expand on the interim national guidelines on SRS for MtF transgender people that was prepared by a national-level expert group convened by UNAIDS India in 2011.

Implications for Future Research

Future research can focus on the satisfaction of hijras and other MtF transpeople regarding the services available in public and private hospitals, and the quality of those services. Quantitative studies among transpeople are needed to document the extent of current and intended use of gender transition services and to better understand the various dimensions of access—availability, accessibility, affordability, accommodation, and acceptability (Penchansky & Thomas, 1981). Also, access to and use of gender transition services for female-to-male (FtM) transpeople is a neglected area that needs to be studied. Policy-oriented research is needed on designing and evaluating cost-effective models of gender transition care within public health care settings. Operations research

is also needed regarding how best to incorporate the gender transition care needs of transpeople into existing medical and nursing curriculum so that future generations of health care providers are technically and culturally competent in providing gender transition services to both MtF and FtM transpeople in India.

CONCLUSIONS

This study has documented the perspectives and experiences of MtF transgender people regarding access to and use of gender transition services in seven major cities in India. We found a near lack of gender transition services in tertiary-level public hospitals and high costs for SRS in private hospitals. Lack of free or affordable services indirectly led many MtF transgender people to undergo Dai Nirvan or to seek unqualified medical practitioners for removal of male genitalia. Our findings suggest the need to provide safe and affordable, or free, gender transition services in public health care settings, to equip health care providers to provide technically and culturally competent gender transition services, and to ensure a supportive legal environment and policies to promote the health of transgender people in India.

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