

Addressing Healthcare Barriers and Stigma in Transgender Populations: A Multidisciplinary Approach

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Received: 20th Feb, 2026 | **Revised:** 4th Mar, 2026 | **Accepted:** 25th Mar, 2026 | **Available Online:** 10th Apr, 2026

ABSTRACT

Transgender individuals face pervasive stigma and healthcare barriers, including disrespect of their gender identity, exclusion from basic facilities, and economic exploitation, which together severely harm their physical and mental well-being. In India, cultural narratives such as the film *I Am Vidya*, A. Revathi's autobiography *The Truth About Me: A Hijra Life Story*, and Laxmi Narayan Tripathi's *Me Hijra, Me Laxmi* vividly portray experiences of family rejection, unsafe restroom access, and the erosion of hijra livelihoods through impostors who pose as hijras for extortion at ceremonies. This paper offers a multidisciplinary review of scholarship, policy documents, and life narratives from 2010–2025 to analyze how stigma, infrastructure gaps, and socio-economic predation intersect to restrict healthcare access. It identifies major gaps in provider training, WASH (Water, Sanitation and Hygiene) infrastructure, and policy enforcement, and suggests integrated reforms including cultural competency education, transgender-inclusive sanitation, targeted action against impostors, and universal coverage for gender-affirming care.

Keywords: transgender, hijra, healthcare barriers, stigma, WASH facilities, cultural narratives, policy reform.

How to cite this article: Sharada YS, Nirmala V. Addressing Healthcare Barriers and Stigma in Transgender Populations: A Multidisciplinary Approach. *Int J Drug Deliv Technol.* 2026;16(31s):378-383. DOI: 10.25258/ijddt.16.31s.45

Source of support: Nil.

Conflict of interest: The authors declare no conflict of interest.

Introduction

Transgender individuals, whose gender identity does not align with their sex assigned at birth, experience substantial health disparities when compared with cisgender populations, including higher burdens of depression, anxiety, HIV, suicidal behavior, and untreated chronic conditions. In India, the hijra community constitutes a socially recognized yet highly stigmatized third-gender category located at the intersection of caste, class, religion, and postcolonial state regulation. Despite legal recognition and some policy advances, hijras and other transgender persons still face profound obstacles in accessing respectful, affordable, and continuous healthcare.

Cultural narratives offer critical windows into these lived realities. The film *I Am Vidya*, based on the life of a transgender woman, documents the protagonist's early gender nonconformity, harsh family rejection, and eventual migration to cities, where she undergoes unsafe, informal castration procedures outside formal

healthcare systems due to lack of access to trained, non-discriminatory providers. A. Revathi's autobiography *The Truth About Me: A Hijra Life Story* similarly recounts severe violence in childhood, expulsion from school, joining a hijra household (gharana), and repeated humiliations in hospitals where staff refuse to touch her or insist on using her deadname, illustrating how interpersonal stigma in clinical settings drives avoidance of care. Laxmi Narayan Tripathi's *Me Hijra, Me Laxmi* adds another dimension, describing how, even after achieving celebrity status and contributing to the Supreme Court's NALSA (2014) judgment that recognized transgender persons' rights, she continued to face exclusion from gender-appropriate restrooms and public spaces, demonstrating the gap between legal recognition and everyday practice.

A particularly neglected barrier is the lack of safe and inclusive sanitation facilities. Transgender people, especially hijras, often must decide between entering men's toilets, where the risk of harassment and sexual

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violence is high, or women's toilets, where they may be forcibly removed or verbally abused. Many cope by deliberately limiting fluid intake and avoiding public spaces, which increases the risk of urinary tract infections, kidney problems, and dehydration, and reinforces social isolation that further delays seeking medical help. At the same time, economic exploitation complicates survival. In several cities, non-transgender men have been documented disguising themselves as hijras to extort money during weddings, shop openings, and other ceremonies, leading to police crackdowns, public hostility, and loss of traditional ritual incomes for genuine hijra communities.

Against this backdrop, this paper integrates social-science analyses, public health research, policy documents, and autobiographical accounts to examine how interpersonal stigma, infrastructural exclusion, and economic predation jointly shape transgender individuals' health trajectories. It also proposes a set of policy and practice recommendations aimed at transforming both health systems and the broader socio-cultural environment into safer, more equitable spaces for transgender populations.

Literature Review

Cultural Narratives and Lived Experience

Autobiographical works and films provide nuanced understandings of transgender lives that statistical surveys often miss. *I Am Vidya* portrays the protagonist's journey from a childhood marked by taunts and physical abuse through a perilous urban life where she relies on informal networks and unregulated surgeries to affirm her gender, exposing the grave health risks that arise when formal healthcare is inaccessible or hostile. Scenes of surgery in unhygienic settings, lack of pain management, and absence of follow-up care highlight the dangerous vacuum created by exclusionary health institutions.

In *The Truth About Me*, Revathi describes being beaten by family members for feminine behavior, running away, and eventually being accepted into a hijra community that provides shelter but also expects her to participate in begging and sex work to survive. Her recollections of hospital experiences—such as staff mocking her gender presentation, refusing to address her by her chosen name, or denying basic services—show how discrimination in healthcare is not a single event but an accumulation of insults and

refusals that erode trust and discourage future visits. These accounts illuminate how social stigma becomes internalized, leading to self-blame, low self-esteem, and reluctance to seek preventive or routine care even when it is technically available.

Tripathi's *Me Hijra, Me Laxmi* emphasizes the political and activist dimension of hijra identity, narrating her role in national and international advocacy for transgender rights and her experience as the first transgender person to become a television newsreader in India. Yet her narrative also underscores the everyday challenges she and others face in workplaces, television studios, and public venues that lack gender-inclusive restrooms or dress-code flexibility. These stories highlight how even highly visible, legally recognized transgender figures remain vulnerable to structural discrimination, underscoring the disconnect between progressive judgments and their implementation.

Taken together, these narratives reveal the complex pathways through which transgender individuals navigate identity affirmation, community belonging, and survival in a context of intense social stigma and limited institutional support. They also provide concrete examples of how inadequate healthcare, violence, and economic marginalization intertwine, thus serving as vital qualitative evidence that enriches and contextualizes quantitative research on health disparities.

Recent regional developments also illustrate a gradual but significant shift towards institutional inclusion of transgender persons in India. A Telugu-language report on a Greater Hyderabad Municipal Corporation (GHMC) meeting describes new initiatives to offer formal employment opportunities and skills-based training to transgender people, signalling a move away from seeing hijras only through begging and ritual performances and towards recognizing them as municipal workers and urban service providers. A related community audio message clarifies that "hijra" refers to a specific cultural and traditional system, whereas "transgender" is a broader gender identity category; many transgender individuals do not join hijragharanas and instead pursue schooling, salaried jobs, or business. The speaker also notes that within hijra traditions there are devotional figures such as *jogini* and *jogappa*, who remain in villages, perform worship, and carry village goddesses in processions under different regional names. Together, these

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examples highlight the internal diversity of hijra and transgender experiences in India and show how contemporary policy discussions are beginning to address both cultural specificity and broader identity-based rights (V6 Velugu; Vasavi).

Sanitation, Public Space, and Health Barriers

Access to safe and dignified sanitation is a fundamental human right and an important social determinant of health, yet transgender-inclusive WASH infrastructure remains scarce in India. An influential policy brief on transgender-inclusive WASH practices notes that public toilets, schools, workplaces, and healthcare facilities overwhelmingly adhere to a binary male/female design that does not account for non-binary and transgender users. Transgender persons report verbal harassment, physical assault, and expulsion from toilets, prompting many to restrict fluid intake or avoid leaving home, which can lead to urinary tract infections, kidney stones, and other urological problems.

Legal frameworks have recognized the need for change. The Supreme Court's NALSA judgment directed central and state governments to provide separate public toilets and other facilities for transgender persons, but implementation has been patchy and uneven. Research examining routine healthcare access among transgender persons in India has found that these sanitation-related fears contribute significantly to avoidance of hospitals and clinics, especially when visits involve long waiting times with no secure restroom options. Transgender students and employees have also reported dropping out of educational institutions or leaving jobs when they cannot safely use campus or workplace toilets, linking infrastructure design directly to educational attainment and economic stability.

This literature establishes that toilets and other WASH facilities are not merely technical amenities but central to questions of dignity, safety, bodily integrity, and health equity. Transgender-inclusive design—such as gender-neutral stalls, clear signage, and non-stigmatizing placement—must therefore be understood as a crucial component of broader healthcare reform and social inclusion initiatives.

Economic Exploitation, Impostors, and Public Perception

Economic marginalization is another key barrier to healthcare. Due to discrimination in education and formal employment, many hijras depend on traditional ritual performances at births and weddings, as well as begging and sex work, to survive. However, media reports and local investigations have revealed the rise of non-transgender men who dress as hijras to extort money aggressively from shopkeepers, motorists, and families, particularly during nighttime or festive occasions. One widely reported case in Hyderabad in 2025 documented a gang of such impostors who demanded large sums at housewarmings and store openings, damaging public perceptions of hijras and prompting police crackdowns on anyone perceived as part of these groups.

This impostor phenomenon has multiple consequences. First, it undermines the cultural legitimacy and financial stability of genuine hijra communities, who find that households and businesses become less welcoming or refuse traditional donations altogether, thereby shrinking an already precarious income base. Second, it reinforces stereotypes of hijras as inherently aggressive, criminal, or extortionist, which in turn influences how they are treated by law enforcement, employers, landlords, and healthcare professionals. Third, as incomes decline, hijras may be forced to prioritize immediate survival—food, rent, debt repayment—over preventive or even urgent medical care, deferring treatment for chronic conditions, infections, and injuries.

Studies on transgender persons' healthcare access in India note that anticipated discrimination, fear of mistreatment, and lack of financial resources are major reasons for postponing or avoiding care. When economic exploitation and impostor misuse of hijra identities are added to this mix, the resulting structural violence becomes even more complex and deeply entrenched, requiring policy responses that both protect communities from fraud and strengthen their economic and health security.

Methodology

This paper is based on a literature-driven, multidisciplinary review that integrates empirical research, policy documents, and cultural narratives to examine healthcare barriers and stigma affecting transgender populations, with a focus on the Indian

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hijra context. The review followed a modified PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) framework suitable for qualitative and mixed-methods synthesis.

Academic databases such as PubMed, JSTOR, and Google Scholar were searched using combinations of keywords including “transgender health India,” “hijra healthcare access,” “transgender WASH,” “transgender stigma in clinics,” and “transgender economic marginalization.” Policy briefs and reports were identified through organizational websites, such as the Strategic Policy and Research Foundation (SPRF), as well as government and non-governmental sources focusing on sanitation, health equity, and human rights. Cultural texts, including *I Am Vidya*, *The Truth About Me*, and *Me Hijra, Me Laxmi*, were included for their rich first-person accounts that illuminate how structural factors are experienced at the individual level.

In total, roughly 80–90 relevant sources from the period 2010–2025 were identified, including peer-reviewed articles, policy documents, and major autobiographical works. Themes were derived through iterative reading and coding, concentrating on four broad domains: interpersonal stigma in healthcare settings; infrastructural barriers, particularly sanitation; economic exploitation and impostors; and policy responses and gaps. While this review does not employ statistical meta-analysis, it aims for conceptual integration of findings across disciplines, highlighting convergences between clinical studies, social-science research, and lived-experience narratives.

Findings and Discussion

Stigma across Families, Communities, and Clinics

The collected literature and narratives consistently show that transgender individuals encounter stigma at multiple levels: within families, in public spaces, and in healthcare settings. Family rejection often appears early in life in the form of emotional abuse, physical violence, or expulsion from home, leading many transgender youth to leave school and community networks, thereby losing access to social protection and health information. Once in urban environments, hijra communities can provide kinship and identity affirmation, but they also operate within constrained economic choices dominated by begging and sex work because of broader labor-market exclusion.

In healthcare environments, stigma manifests as misgendering, invasive questioning, denial of services, lack of confidentiality, and moral judgment about transgender bodies and livelihoods. Narrative accounts show how repeated negative encounters create a sense of dread around medical institutions, which becomes a powerful deterrent even in serious illness. Empirical research supports this pattern, indicating high levels of healthcare avoidance or delayed care among transgender persons due to anticipated discrimination and prior bad experiences. The result is a cycle where untreated health problems worsen over time, reinforcing stereotypes that transgender bodies are inherently “problematic” while masking the structural origins of their vulnerability.

Sanitation and Public Infrastructure as Health Determinants

The evidence on sanitation underscores that WASH infrastructure plays a much larger role in transgender health than is often assumed. For many transgender persons, navigating public toilets is an everyday ordeal involving risk assessment, strategic timing, and bodily self-denial. Fear of harassment or assault in male restrooms, combined with potential expulsion from female restrooms, leaves few safe options, so some individuals delay urination, avoid drinking water in public, or restrict travel. These coping strategies can lead to urinary and kidney problems, headaches, and reduced concentration, which in turn may affect work performance or school attendance.

In healthcare facilities themselves, inadequate sanitation design can exacerbate barriers. Transgender patients may fear using hospital toilets, particularly when clinics are crowded and offer no privacy or gender-neutral facilities. This makes it difficult to endure long waits or multi-hour procedures. When considered alongside stigma from staff and other patients, the absence of safe restrooms turns hospitals into symbolically and materially hostile environments, further discouraging care-seeking.

Economic Exploitation, Impostors, and Health

The literature and media reports on impostors posing as hijras reveal a dense intersection of gender, class, and crime. As non-transgender men imitate hijra dress and performance to aggressively demand money, genuine hijra communities suffer both economically and reputationally. With incomes from traditional

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blessings and ceremonies decreasing, many hijras fall deeper into poverty, reducing their ability to afford consultations, medications, and gender-affirming treatments. Policymakers and the general public often focus on public order and nuisance aspects, rather than addressing underlying economic exclusion and the need for sustainable livelihood opportunities for transgender persons.

Economic vulnerability functions as a health barrier in at least two ways. First, inadequate income limits the ability to pay for transportation, consultations, tests, and medicines, particularly for specialized services like hormone therapy or surgeries that are often not fully covered by insurance schemes. Second, when daily survival requires long hours of street work, begging, or sex work, there is little time or energy left for proactive health management, including keeping appointments or adhering to treatment regimens. These factors help explain why health disparities persist even when legal recognition improves.

Conclusion and Policy Recommendations

The evidence reviewed shows that addressing healthcare barriers and stigma in transgender populations requires a multidimensional approach that goes far beyond individual clinical encounters. Stigma is produced and reinforced through family dynamics, school and workplace environments, public infrastructure, cultural representation, and economic structures. Autobiographical texts and films reveal how these forces are felt in intimate, everyday experiences of humiliation, exclusion, and resilience, while empirical studies quantify their impact on healthcare access, mental health, and physical morbidity.

The Indian context illustrates both unique cultural patterns and broader global challenges. Hijra communities have long played ritual roles in society, yet continue to be marginalised in education, employment, and housing. New pressures, such as impostors exploiting hijra identities and slow implementation of transgender-inclusive policies, mean that many individuals remain stuck in precarious livelihoods and environments that make healthcare a low priority. Sanitation barriers and the absence of safe WASH facilities further undermine their capacity to move freely and use services even when available.

Suggested Key Recommendations

In light of these findings, several interlinked strategies could be considered to improve healthcare access and reduce stigma for transgender populations:

- Integrating cultural narratives such as *The Truth About Me* and *I Am Vidya* into medical, nursing, and social work curricula may help future professionals understand the lived experience of stigma and marginalization, thereby building empathy and reducing discriminatory behaviors in clinical practice.
- Developing and implementing transgender-inclusive WASH infrastructure—such as gender-neutral or third-space toilets—across schools, colleges, workplaces, and healthcare settings could address a major source of daily anxiety, improve safety, and support sustained engagement with education and employment, which are themselves key determinants of health.
- Considering targeted measures to distinguish between genuine hijra communities and impostor groups, such as working with community leaders, civil society organizations, and law enforcement, could help reduce fraudulent extortion while protecting hijras from blanket criminalization and harassment. Coupling such measures with livelihood programs, skill training, and inclusion in social protection schemes may reduce dependence on begging and increase the capacity to invest in health.
- Strengthening healthcare policies and insurance schemes to ensure coverage of gender-affirming care, including hormone therapy and surgeries, as well as mental health services, may encourage earlier and safer access to treatment, reducing the harms of informal or unsafe procedures documented in narratives and studies. Involving transgender community representatives in designing and monitoring these programs can help align services with actual needs and improve trust.

Together, these suggestions point towards a comprehensive, multidisciplinary approach that combines legal and policy reforms with infrastructural improvements, economic support, and cultural change. Rather than treating transgender health as a niche or specialized issue, such an approach recognizes it as central to broader goals of human rights, social justice, and public health.

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Acknowledgements

The authors gratefully acknowledge that the funding for this publication was provided by the Rashtriya Uchchatar Shiksha Abhiyaan (RUSA) Project sanctioned to them.

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