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TRANSGENDER PERSON'S RIGHT TO HEALTHCARE

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Abstract:

Transgender community in India has been a subject of systematic discrimination for centuries and because of this discrimination, the access to right to health of the community has been in a chokehold. The Supreme Court through its judgment in NALSA paved the way for progressive and affirmative rights for the community and there were a lot of expectations from the Transgender person Act, 2019 but the Act has simply failed to deliver. Especially in the healthcare front, the policies in India have been inadequate to say the least. This article explores how in India there is no systematic right to health and hence, it is essential that there must be a law that confers it and in case of the transgender persons, this legislative intervention becomes imperative. Another facet of this article is the possible justifications for the State to provide gender affirmative healthcare services. I build upon the already existing principles such as autonomy and medical necessity.

Keywords: Transgender, Gender, LGBTQ, Constitutional law, Affirmative action, Right to health.

Introduction:

It is unfortunate that in a country like ours where transgender people had a special place in the community have to face systematic oppression, harassment and marginalization. One of the main concerns is the health of the transgender community and how little attention it has received on the policy front. Healthcare for transgender people is rife with stigma. Their bodies are considered deviant. One of the main reasons for that lack of knowledge and social stigma. Access to healthcare which is a basic human right is jeopardized in their case. Gender reaffirmative surgery is a facet

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which does not even get attention but is vital for most transgender people[1]. In the first part of this paper I locate the effects of colonial encounter on the transgender identity. In the second part, I delve into whether in India there is a systematic right to health. Then I delve into justifications for State to provide gender affirmative healthcare services to the members of the transgender community and in the last part, I delve into the steps taken by government to further healthcare services for transgender community and analyze the adequacy of theses.

Effects of Colonial Encounter on Trans-gender Identity

The story of the marginalization of the transgender community is deeply connected with the colonial displacement. In particular to the socio-political context, the social exclusion started with rigid dichotomous gender identities under the influence of patriarchal policies adopted by the British.[2]In the pre-colonial era, the Hijras played a significant role. The 18th century Maratha State granted certain rights such as special cash and land grants in favor of the hijra community for their welfare and they were also appointed at respectable positions in royal courts.[3] The Sanskrit language also acknowledged the third gender as "*tṛitīyā prakṛti"*. By analogy with Vedic and Sanskrit language, three genders were recognized, male (puns), female (strī) and neuter (*napuňsaka)*. Those who were neither male nor female were considered neuter gender.[4] During the colonial rule, the British translated several Hindu texts to British English to aid judges and maintain uniformity amongst courts. Through the acquisition of the cultural and historical knowledge, the British wanted to use that to their advantage so as to ease the administration.[5] Several problems arose while the text was being translated. In some cases, the pandits that worked with British to translate the text made errors. In the process of translation, the words in the texts had to pass through a British social, political and moral filter. The British social lens influences translation of a wide variety of Sanskrit and Pali terms for persons deviating from the British mode of masculinity.[6] One of such word was "eunuch" which subsumed several social groups. British society assumed that an un-masculine man was impotent and therefore a "eunuch". The translation process allowed homogenization of all the diverse groups and put them together in the same bracket: Eunuch[7]. Further, Criminal Tribes Act, 1871 was passed which declared everyone belonging to a certain caste or tribe to be born with criminal tendencies. The Act, by amendment in 1897 created the category "eunuch" which referred to many gender non-conforming communities in India such as Hijras, khwajasarais, and kotis. The very fact of membership of such tribes was

[1] TK Devasia, "Why Kerala's free sex-change surgeries will offer a new lifeline for the transgender community", The Scroll, March 19, 2016
https://scroll.in/article/804496/why-keralas-free-sex-change-surgeries-will-offer-a-new-lifeline-for-the-transgender-community (Last visited on 8th May, 2021)
The article says that in Kerala as much as 81% of the transgender population wanted to change their gender identity.
[2] Asad Ullah Khan, Gendered Justice: Constitutions, Trans-Genders and Equality, 3 LUMS L.J. 69 (2016).
[3] Lawrence W. Preston, 'A Right to Exist: Eunuchs and the State in Nineteenth-Century India' (1987) 21 (2) Modem Asian Studies 371, 372
[4] Renate Syed "Hijras: India's Third Gender and 2500 years of discrimination and exclusion" Routledge India 2019
[5] Dipika Jain, Shifting Subjects of State Legibility: Gender Minorities and the Law in India, 32 BERKELEY J. GENDER L. & Just. 39 (2017).
[6] Id,
[7] Id,

sufficient to implicate a person under this Act.[8] The Criminal Tribes Act, 1871 was repealed in 1952 and was replaced by Habitual Offenders Act, 1952. The Act had no mention of the word "eunuch" however, since the Act applied to habitual offenders with previous criminal records, in effect, it continued to apply to "eunuchs"[9] The story of oppression didn't end there. Hijras were especially considered to be those who engaged in "carnal intercourse against the order of the nature" which was an offence under the infamous Section 377 of the Indian Penal Code, 1860. In the case of Khairati[10], the person was arrested merely on the fact that "…was found singing dressed as a woman among the women of a certain family."[11] The State sponsored oppression of the transgender community is not only in the history books rather even as early as 2011, The State of Karnataka amended its Police Act to "control undesirable activities of eunuchs."[12] The Act required "maintenance of a register of the names ... of all eunuchs residing in the area ... reasonably suspected of kidnapping or emasculating boys or of committing unnatural offences,"[13] In 2017, Karnataka Sexual Minorities Forum filed a writ petition that challenged the provision and the government of Karnataka responded by informing the High court that the word "eunuch" has been replaced by the word "person"[14] By imposing laws aimed at control and invasion of the privacy of the members of the transgender community, they were marginalized. All these laws based upon ill-founded views on morality had huge repercussions on the hijras way of life and their status within the society. Such policing stigmatized the community to the extent that we can still see the debris of it even after the Suresh Kumar Koushal and NALSA judgments. Considered outsiders to the society and civilized Indian culture, they struggle to access healthcare amongst other facilities.

Status of systematic right to health in India

Madhav Khosla in his work[15] argues that the socio-economic rights adjudication in India is based upon conditional social rights model and not upon systematic social rights model. It is important here to differentiate between the two. A useful point of differentiation was presented in the case of Olga Tellis.[16] In this case, the petitioners had migrated to Bombay in search of employment and had no option but to reside on the pavements. They relied upon Article 21 and 19(1)(e) to contend that eviction would deprive them of livelihood and employment[17]. Court held that the right to life would include right to livelihood. However, such right is not absolute. The real issue in this case was whether there is a right to shelter. Upon analysis, it can be seen that the case provides no individualized right to shelter as well as no right that State must take steps to provide

[8] Criminal Tribes Act (CTA), 1871 (as amended in 1897), available at https://perma.cc/HG8XHZXH (last visited on May 8th, 2021)
[9] Supra at 5.
[10] Queen Empress v. Khairati (Allahabad H. C.), ILR 6 All 204 (1884)
[11] Id,
[12] Karnataka Police Act Sec. 36A (1963), available at https://perma.cc/CH4X-NSN6 (last visited on May 8th, 2021)
[13] Id,
[14] "Govt to HC: word 'eunuch' removed from Police Act," Deccan Herald, available at https://perma.cc/E5J3-L69E (last visited on May 8th, 2021)
[15] Madhav Khosla, Making Social Rights Conditional: Lessons from India, 8 International Journal of Constitutional Law (2010).
[16] Olga Tellis v. Bombay Municipal Corporation, (1985) 3 S.C.C. 545.
[17] Id,

shelter. The focus was on ensuring that a proper procedure for eviction is followed.[18] Yet the court in this case did require the State to provide one set of petitioners accommodation before their eviction. In 1976, State had decided to provide certain land for slum dwellers and a census had been conducted and slum dwellers were given identity cards. The court held that these slum dwellers must be provided accommodation.[19]

The distinction in the remedy provided clearly sets out the distinction between systematic and conditional social rights approaches. In this case, the court only granted shelter to those who were promised the same under State scheme. The court's remedy did not flow from systematic right to shelter rather State's failure to follow through on its own decision.[20] Therefore, resorting to conditional social rights model. Similarly, In Rakesh Chandra Narayan[21] a letter was written to the Chief Justice of India about condition of a mental health hospital. The hospital was under-staffed, there was water shortage, toilets were not in working condition, doctors were unavailable and so on. Court directed State of Bihar to improve matters. Even then State failed to oblige. Court then constituted committee of management and developed guidelines on how they are to be appointed and their task.[22] The court in this case didn't scrutinize State's effort to construct hospitals or its budgetary allocation towards healthcare. The decision only suggests that once the State has decided to spend certain amount on healthcare or built a hospital then it is the constitutional obligation of the State to fulfill that obligation.[23]

Likewise, in the case of Paschim Banga Khet Mazdoor Samity[24] Where the petitioner fell from a train and received head injuries and was taken to one government hospital to another where at every instance he was refused treatment. He finally went to private hospital and incurred certain medical expenses. He approached the Supreme Court alleging that it has violated his Article 21. The court formed a committee to look into the matter and committee reported that there were several administrative failures because of which treatment was refused.[25] In analyzing this case, it would be appropriate to distinguish between two scenarios, in one, where petitioner went to several hospitals but couldn't receive treatment because of unavailability of bed/treatment etc but the hospital was working perfectly. In second, where the petitioner approached several government hospitals but couldn't get treatment due to failure on the part of hospital authorities such as informing that the requisite facility is not available when in fact it does. The second one is evident in the present case. The focus on this case, like that in Rakesh Chandra Narayan, is on State's inability to effectively run a hospital rather than on creating new hospital or new facilities.[26]

[18] Supra at 15.
[19] Id,
[20] Id,
[21] Rakesh Chandra Narayan v. State of Bihar, A.I.R. 1989 SC 348.
[22] Id at 18.
[23] Id,
[24] Paschim Banga Khet Mazdoor Samity v. State of W. B., (1996) 4 S.C.C. 37.
[25] Supra at 15.
[26] Id,

The soul of the argument is this: The remedy in case of violation of a social right in India would only be provided if State had promised to take an action regarding it. If State had taken an obligation to build a hospital or provide medical facilities to a certain group of communities and the State fails to secure it then there is a remedy in courts and court can hold the State accountable and pass orders. However, in India, there is no systematic right to health by which the court has the power to pass orders requiring executive to build hospitals wherever there is a shortage. Therefore, it becomes important that any legislation that comes in for the welfare of the transgender community has to necessarily have positive obligations on the State to provide comprehensive healthcare facility. The current legislation which is the Transgender Persons(Protection of Rights)Act, 2019 and the Draft rules do not provide a comprehensive healthcare plan.

Justification for State to provide gender affirmative healthcare services to transgender community

The Supreme Court's judgment in National Legal Services Authority v. Union of India[27] recognized the right to self-determine one's gender identity. This also put an obligation on the State to provide for the rights and welfare measures to be adopted for the members of the transgender community. One of the most important of the welfare measure is the affordable health care. In the context of health, gender affirmative healthcare include surgical and non-surgical processes which helps a person assert their internally felt gender identity. Some of these are sex reassignment surgery ('SRS'), hormonal therapy and counseling[28]. The issue is far more complex than it appears to be. SRS is considered to be a cosmetic procedure and one that does not need intervention. The transgender community on the other hand, argues that gender affirmative healthcare services are medical necessity. They are integral for bodily self-acceptance and identity as well as acceptance within the society. Taking into account the integral nature of such surgeries for self-identity and social acceptance, terming them as 'cosmetic' does not do justice to the transgender community.[29]
The two very famous principles or justification for state sponsored SRS surgery are "medical necessity" and "autonomy principle." The idea of medical necessity was first developed with the establishment of Harry Benjamin International Gender Dysphoria Association ('HBIGDA') in 1979[30] HBIGDA established the transsexual Standards of Care ('SOC') which laid down the criteria for diagnosis, management and surgery of transgenders. HBIGDA is now known as World Professional Association for Transgender Health ('WPATH'). WPATH Guidelines deals with the treatment of gender dysphoria, which is the discomfort that a person goes through when there is a discrepancy between the person's gender identity and sex assigned at birth[31]. Many members of transgender community describe it as being trapped in the wrong body. This discomfort can cause

[27] National Legal Services Authority v. Union of India, (2014) 5 SCC 438
[28] Diksha D. Sanyal, Locating a Moral Justification for State Funded Gender Affirmative Health Care, 10 NUJS L. REV. 822 (2017).
[29] Dean Spade, Resisting Medicine and Remodelling Gender, 18 Berkeley Women's Law Journal (2003).
[30] Id at 28.
[31] Id,

mental distress too[32]. The WPATH guidelines is used and recognized internationally as useful starting point to determine what kind of medical care is required by the member of the transgender community. However, relying completely on them comes with their own set of drawbacks. Many transgender do not wish their identity to be pathologized as a disorder. Also, emphasizing the importance of these guidelines has led to a medical approach in which medical necessity has to be proved conclusively in order to be eligible for SRS[33]. The problem is that the opinions of the medical expert are also subjective. What case falls under medical necessity for one expert may not be such for another. The courts in such cases also not well-equipped to make that decision and they too then have to rely on the medical expert. This shows that analyzing the claim of SRS purely from the point of view of medical necessity has its own dangers[34].

As far as autonomy principle is concerned, the argument that all human beings should be free to choose their versions of good life and there isn't any standard to determine one conception of good life from someone else's* conception of good life also has several problems. The language of autonomy, personal development and self-determination surely has a nice tune to it but it is open to be challenged from point of view of subjective satisfaction. There may be claims that are based on autonomy and personal development which will be placed at an equal footing to that of some other claims which have lesser legitimacy to those claims.[35] One of the examples is demand for breast augmentation surgery by a cis-gender women and a transgender person. If autonomy, choice and personal development is looked at then both must have the benefit of State's resources for such surgeries but that is not possible in countries which have limited resources like India.[36] One argument that improves on both the above mentioned principles is the "quality of life" argument. WHO defines 'quality of life' as "an individual's perception of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns"[37]. The quality of life argument has strong parallel to Amartya Sen's Capability framework upon which Martha Nassbaum supplemented. Capability theory appeared as not only a critique of the various theories of justice but also a comparative tool to see how well people are doing in their lives across various cultures, communities and nations[38]. In order to understand this theory, one needs to differentiate between functioning and capabilities. As per Sen, 'functioning' is 'being and doing', that is, the ability to 'be' certain things such as educated and well-nourished as well as to 'do' certain things such as start a family, work or travel. Functioning are things that one can achieve. On the other hand, capabilities are the freedom to be able to make these choices. For instance, if one wants to watch a football match, one will have the capacity only when one has money to buy the ticket, mode of transportation to reach there and basic

[32] R. Gupta & A. Murarka, Treating Transsexuals in India: History, Prerequisites for Surgery and Legal Issue, 42(2) Indian Journal of Plastic Surgery (2009), available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2845370/ (Last visited on May 10, 2021).
[33] Supra at 32.
[34] Supra at 28.
[35] Id,
[36] Id,
[37] The WHOQOL Group, The World Health Organization Quality of Life Assessment: Position Paper from the World Health Organization, 41 Social Science and Medicine (1995).
[38] Id at 34.

senses like seeing to enjoy the match. Whether one exercises this choice is the measure of functioning[39]. The strength of this approach lies in its recognition of difference between different human beings in converting certain set of resources in valuable functioning[40]. Amartya Sen kept his theory open-ended as he didn't specify which aggregate of capabilities constituted "good-life". This is where Nassbaum steps in and supplements the theory by giving a list of capabilities which must be part of every country's constitution. As per Nassbaum, denial of any of this on the list is denial of human dignity itself. Nussbaum suggested ten important capabilities. These include life, bodily health, bodily integrity, senses, imagination and thought, emotions, affiliation, practical reason, other species, play and control over one's environment.[41]

The argument here is that gender affirmative healthcare services including SRS, hormonal treatment and counseling have significant impact on quality of life of an individual. Such health care services have a positive outcome relating to sexual life, health and family of transgender person.[42] From the context of capability approach, this improves capacity of bodily integrity, emotion, practical reason and affiliation. By denying access to healthcare service, the State is interfering with transgender person's capability to their personal and intimate decisions as per their own perception of what is good. It has been found that those who undergo such surgery report post-operative satisfaction with the way their body looks and also greater psychological stability[43].

Adequacy of steps taken by government for extending the healthcare services for the community

NALSA judgment allowed transgender people to identify as male, female or a third gender irrespective of any medical sex reassignment. The court also gave the following directions related to the health of transgenders in their order-

(4) The Centre and State Governments are directed to operate separate HIV serosurveillance centres since [H]ijras/[T]ransgenders face several sexual health issues[44].

(5) The Centre and State Governments should seriously address the problems being faced by [Hijras/[T]ransgenders such as fear, shame, gender dysphoria, social pressure, depression, suicidal tendencies, social stigma, etc. and any insistence for SRS for declaring one's gender is immoral and illegal[45].

(6) The Centre and State Governments should take proper measures to provide medical care to Transgender in the hospitals and also provide them separate public toilets and other facilities[46].

It seemed at that time as a very progressive step but on ground, very little has changed. Despite government campaigns, the doctors still lack awareness as to the physical anatomy of the

[39] Supra at 28.
[40] Id,
[41] Id,
[42] Constanza Bartolucci, Esther Gomez, Manel Salamero et al., Sexual Quality ofLife in Gender Dysphoric Adults Before Genital Sex Reassignment Surgery, 12 Journal of Sexual Medicine 180 (2015)
[43] Id at 39.
[44] Supra at 27.
[45] Id,
[46] Id,

transgender body[47]. Both trans-patients as well as doctors exist within an unaffordable and ill-equipped health care system. Even though the government hospital does offer cheap health care, they are unaware on how to deal with a trans-patient. The only worth-while healthcare service is HIV prevention and sexual health. Those who seek sex reassignment surgery are often forced to consult private hospitals where the cost is too high[48].

The latest Transgender Persons (Protection of Rights) Act, 2019 states that a person who is recognized as 'transgender' shall have the right to 'self- perceive' their gender identity. Once a person identifies as transgender, they may apply for a Certificate of Identity issued by a District Magistrate. Such a certificate will be proof of their identity as 'transgender' and confer rights and benefits under the Act[49]. However, it is totally against the NALSA judgment as it conferred a person with the power to self-identify. When it comes to sex reassignment surgery, the first step is documenting consent. It means that the person has to sign an affidavit self-declaring them as transgender and present it to magistrate. It is unnecessary that a magistrate decides such a thing.

The Draft Transgender Persons (Protection of Rights) Rules, 2020 provides for obtaining report from psychologist as well as the hospital if they have undergone a sex reassignment surgery. The rules in this regard are unclear[50]. Rule 10 of the Draft Transgender Persons Rules, 2020 provides that the Appropriate Government in the span of 2 years must ensure the building of- Rehabilitation centres, HIV surveillance centres, separate hospital wards, separate washrooms in establishments for transgender persons[51].

The argument here is not that there must not be psychological evaluations or medical tests to determine the distinct need of each individual rather the proposed framework must be made less onerous. Since these are welfare provisions, they must be for their benefit based upon the autonomy and informed consent. The role of the State in such cases must not be to be the gatekeepers of identities. While the NALSA judgment and some provisions of the Transgender Persons(Protection of Rights)Act, 2019 seem progressive, the ground reality is far from it. The current legal framework hardly does anything to improve the ground reality. Even the Transgender Persons Act, 2019 does not talk about positive obligation on the State to provide gender affirmative healthcare services. There is also a lack of clarity on many of the provisions.

Conclusion:

Healthcare services are one of the most important demands of the transgender community. In this article I've tried to argue that India does not have a systematic right to health which means that only when the executive branch promises health care to transgender community only then can the court follow it up with orders enforcing them in case of any lapses. Therefore, it's important that there is a healthcare plan for the trans community. I also provide the justification for State

[47] Rajvi Desai, "What a Transgender-Friendly Health Care System Would Look Like", The swaddle, Oct 5th 2019 https://theswaddle.com/what-a-transgender-friendly-health-care-system-would-look-like/ (last visited on 11th May 2021)
[48] Id,
[49] The Transgender Persons (Protection of Rights) Act, 2019.
[50] Draft Transgender Persons (Protection of Rights) Rules 2020 https://egazette.nic.in/WriteReadData/2020/220497.pdf (last visited on 11th May 2021)
[51] Id,

sponsored gender affirmative healthcare services by locating it into the capabilities framework in the work of Amartya Sen and Martha Nassbaum. In the end I analyze if the present healthcare schemes are in any way adequate and find that there is a serious gap between the expectation and the latest legislative framework.

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