LGBTQ COMMUNITIES IN INDIA: BARRIERS IN ACCESSING HEALTH CARE FACILITIES

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ABSTRACT

Background: The global experience of LGBTQ populations with respect to health and healthcare services is fraught with disparities and barriers. The stigma and discrimination against these communities stems from their experience of violence against them from various social groups. Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) community prefer to remain outside the mainstream health services and this can be because of the stigmatization by the healthcare providers. **Aim:** The objective of this paper is to identify the stigmatization, barriers to health care and particular health issues and health risks experienced by these groups. **Methods and Materials:** The study is a qualitative study that has examined the available literature in India to identify the challenges faced by transgender individuals and substantiated the findings with some in-depth case studies representing the various identities of LGBTQ communities. **Conclusion**: The study reveals that the main obstacles faced are stigma, limited sexual health knowledge, concerns about confidentiality, fatalistic attitudes and structural barriers. The suggestions that developed from this study were inclusive clinics, improved doctor patient interaction, sensitive data collection, cultural awareness, Staff training and education.

Keywords: LGBTQIA groups, health care, barriers, challenges, inclusive

INTRODUCTION

Social stratification in Indian society has been multifarious - along the lines of class, religion, language, education, that transect with sexuality and further add to oppressions. In India, the discriminatory attitudes and actions against gender variant persons is antagonistic and have been reaffirmed on the pretext of these groups being anti-religious, anti-social or simply anti-tradition. This ostracisation and hostility is an infringement of their fundamental rights. Sexual minorities in the Indian society have found cultural acceptance throughout history – popularly the *Hijras* - and have existed in the peripheries at other times shrouded in invisibility and silence but these have been replaced by a culture of stigma and oppression.

Queer has often been the overarching term for those persons who identify as gay, lesbian, transgender and/or bi-sexual. According to Queer theory, identities of individuals, especially their sexual identities, are not stable and unambiguous as the socially given identities sometimes do not match the self-identities constructed by the grown-up agencies. Queer identity focuses on mismatches between sex, gender and desire. Queerness has been associated with bisexual,

lesbian and gay, and its analytic framework and includes topics like cross-dressing, intersex bodies, gender ambiguity and gender confirmation surgery. Queer theory posits that individual sexuality is fluid, fragmented and a dynamic collectivity of possible sexualities which may vary at different points in one's life time (Jagose & Genschel, 1996). Queer theory is not a singular or systematic conceptual or methodological framework, but a collection of intellectual engagements with the relations between sex, gender and sexual desire (Spargo, 1999).

LGBTQ studies as a form of discourse has challenged the dominant notion of sexuality, i.e., heterosexuality. When a specific category is termed as "nor0mal", it inevitably designates the opposite to be "deviant". The practices relating to deviant category are marked by less prejudice and these practices are liable to different forms of social condemnation and punishment. "Queer theory emerges from gay/lesbian studies' attention to the social construction of categories of normative and deviant sexual behavior. But while gay/lesbian studies focused largely on the questions relating to homosexuality, queer theory expands its realm of investigation to a wider field. Queer theory looks at, and studies, and offers a political critique of anything that falls into normative and deviant categories" (Harris, 2005).

REVIEW OF LITERATURE

Existing literature on LGBTQ health has been exclusively focused on HIV and the susceptibility of these groups to sexually transmitted diseases and HIV/AIDS.

There are various risks and associated stress related to the sexual life and practices of homosexual men. Chakrapani, Babu and Ebenezer (2004) through their work point to the dependence of *Hijras* on free medical care because of their low socio-economic status. They also pointed out that discrimination against transgenders starts right from the registration desk at the medical centre, and continue as insensitive treatment from care givers and doctors. This discrimination and insensitivity deter them from seeking proper medical help. Often, health care providers fail to comprehend these sexual diversities and lack adequate knowledge about their health issues and needed health services. Thus, these "sexual minorities" who follow alternate sexualities counter unique barriers in the pursuit of public or private health services. Their presumed/real occupation leads them to anonymous multiple sex partners and is an effective strategy to camouflage their identity. But their exposure to a wide range of penetrative and non-penetrative sexual behaviour is often a precursor to multiple types of sexually transmitted diseases specifically HIV. The transgenders have also well documented the hurdles they face with regards to access to HIV testing, anti-retroviral treatment and other sexual health services. The various discriminations that the transgender/Hijra communities come across in the health care settings are: the deliberate use of gendered pronouns in addressing *Hijras*; registering transwomen as 'male', to getting them admitted in male wards; the humiliation of standing in the male queue; along with verbal provocation by co-patients and lack of sensitive healthcare providers and trained professional on providing treatment/ care to transgender people and even denial of medical services. Discrimination could be attributed to their visible gender status, history of sex work or HIV status or a combination of these. The existence of the homosexuality law is another stumbling block that prevents transgender and men who have sex with men from coming forward to test for HIV/AIDS. It also frustrates social workers for not being able to provide information regarding treatment, monitoring and

counseling to the homosexuals (Agoramoorthy and Hsu).

A key study in this domain, concerning HIV protection, human rights and social exclusion of Hijras/transgender women, has been prepared in India by Chakrapani in 2010 under UNDP. The study has reviewed published researches in different context of India using the human rights and exclusion framework. The findings of the study mainly stresses on the need of sexual health service based on specific gender role of transgender groups that also draws attention to the interrelationship between social exclusion and vulnerability to HIV and other health risks (Chakrapani, 2010).

A study by Indian Council for Medical Research in 2013 by Chakrapani, Samuels, Shunmugam and Sivasubramanian titled Modelling the Impact of Stigma on Depression and Sexual Risk Behaviours of Men who have Sex with Men and *Hijras* or Transgender people in India: Implications for HIV and Sexual Health Programs' has been crucial in charting the relationship between the discriminations faced by these sexual minorities and mental health ailments. The key finding of the study were that same-sex orientation was realised by individuals at an early stage or sometimes highly delayed. In between the realization and self-acceptance MSM and Transgender participants expressed a transition from guilt to self-pity. It was found that stigma and discrimination lead to chronic stress that adversely affected the mental health of Transgender youth. Disclosure of one's sexual identity and orientation also acted as stressor for them. Discrimination among MSM/Transgender communities was found to be based on economic status, HIV status or engagement in sex work in existing absence of familial support often lead to unremitting depression and self-apathy. Sexual violence also impacts the mental health of transgender communities—deflating their self-esteem and consequently resulting in Post-Traumatic Stress Disorder (PTSD) or depression.

"Problems Faced by Hijras (Male to Female Transgenders) in Mumbai with Reference to Their Health and Harassment by the Police" a study by Anitha Chettiar attempts to highlight the socio economic conditions of the Hijra community in and around Mumbai and understand the problems faced by them with detailed reference to their health and the police atrocities they face by using data from sixty-three *Hijras* across multiple districts in the state of Maharashtra, India. The content analysis undertaken to analyze the problems narrated by the *Hijras* revealed that the majority of them (87.5%) acknowledged widespread police atrocities (both railway and traffic) for begging and soliciting clients for sex work. Reports of *Hijra* respondents being raped and even gang raped by the police was found out. A section of the *Hijras* complained about inhuman and disrespectful treatment especially during healthcare access in the Government hospitals at the hands of the doctors and nurses

PROBLEMS OF THIS COMMUNITY

The medical system functions on the binary of men and women. This completely negates the presence of Transgender Groups (TG). Gender non-conforming individuals and transgender people often experience discrimination while accessing health care; these were as trivial as disrespect and harassment to as extreme as violence and outright denial of service. Transgender groups have put forth concerns about barriers they face in getting proper health care. These barriers range from issues in pursuing preventive medicine, unawareness in routine and emergency care, or ambiguity in services for transgenders. These realities and issues, combined with predominant ignorance of the

medical service providers around the health care needs of transgenders and gender non-conforming people, discourage them from seeking and receiving quality health care. Transgender people not only lack services but they also face discrimination in diverse ways in the Indian health care system. It has been noted that their transgender status, presumed/real occupation (sex work) or HIV status/fear of HIV transmission is a primary cause of rampant discrimination against them. A crucial reason as well as consequence of the exclusion is the lack of (or ambiguity in) legal recognition of the gender status of *Hijras* and other transgender people. Discriminations start in the family, occur in educational institutes, persist in employment opportunities and even encroach on certain basic civil rights such as marriage and parenthood. They remain socially marginalized and are usually apprehensive about expressing their identities in public sphere due to the fear of ostracisation. In the Indian family an individual is required to create a false sense of self because disclosure of an alternate sexual identity is met with violent denial or negative reaction from the family. The family either disowns or coerces the individual to undergo psychiatric treatment in a futile attempt to revert them back to heterosexuality. Society at large ridicules gender-variant people for being 'different' and treats them with hostility. Studies undertaken on *hijra* communities in various parts of India agree that, in addition to earning their livelihood as performers, most *Hijras* in contemporary India engage themselves in sexual activity with men for money or for satisfying their own homosexual desires, as long as they are physically attractive or capable of doing so. Most *Hijras* seem to engage in casual prostitution by offering sexual favors to men in exchange for money (Nag, 1995). Very few work sectors have opportunities for the transgender population. The transgender community claimed inability of getting a mainstream job due to lack of education, 'unusual' non-conforming lifestyle unacceptable for the working environment.

People's Union for Civil Liberties-Karnataka (PUCL) has presented a report that highlights the unusual, yet persistent violence and stigma that gender minorities face. The report aims to conceptualize these inflictions and violations by the state (through the laws and police) and by civil society (through the family, media, popular culture, workspaces, and household spaces). The report deducts the specific nature of the violations from state and civil society, how this gender group is understated, and the little-understanding to which these "sexual minorities" are subjected to (PUCL, 2001). Violations against different LGBTQIA communities include extortion, harassment, abuse, illegal detention, and sexual assault; all of these have been perpetrated by the police under the cover of legitimacy provided by the criminal law framework. This kind of violence has been further supported by the established societal norms of intolerance towards alternate sexualities. In the absence of any other viable alternative, many gender alternate individuals join the "*Hijra*" (eunuch) community and undergo illegal, secret and crude castration operations that are risky in terms of their health. Anecdotal evidence locates the number of castration deaths at 50% of those operated upon by untrained Dai, sham doctors and "surgeons" with dubious credentials.

'Life of a Eunuch'(Saxena, 2009) proceeds to look at the different aspects of transformation from one gender to another, the complexity of the medical procedures involved as well as the socio economic ramifications of such gender transformations. This book highlights the need for investigation, diagnosis and counseling before resorting to reconstructive surgery for changing the body. The legal status of sex change surgery in India is

ambiguous, it needs to be clarified and this surgery should be offered in government hospitals so that members of the LGBTQ groups can afford it and not be forced to go to unqualified medical practitioners for having their sexual organs removed. This can prevent complications resulting from bad surgical procedures by quacks.

The research gap that could be identified from the available literature was a lack in terms of clarity about the barriers that different LGBTQ subgroups face while accessing healthcare services.

OBJECTIVES

♦ Analyse the existing discriminations in the society against the LGBTQ communities in India with special reference to health and healthcare access.

♦ Comprehend the challenges that these groups face in accessing medical facilities with special reference to different sub-groups in the LGBTQ community.

METHODOLOGY

The research methodology used for this paper is primarily qualitative and draws from both primary and secondary sources. The invisibility of the LGBTQ community has been a deterrent in reaching out and gathering substantial data that is necessary to maintain academic objectivity. This study has used 6 case studies to understand the lives and explore the experiences of the LGBTQ communities in India. Case study is a data collection method that presents detailed information about a particular participant or small group, frequently including the accounts of the respondents themselves. Extensive in-depth personal interviews were undertaken from the major categorical divisions in the LGBTQ community.

A number of existing studies and recent policy level documents on Transgender issues were analyzed to locate the challenges in integrating the Transgender groups into a socially inclusive society.

RESULTS

The Transgender community prefers to stay away from the mainstream health services. The reason for staying away is the stigmatization faced by them in the hands of the health service providers. The stigmatization is double for Men who have Sex with Men (MSM) and transwomen. This community also feels that the health care providers specially the doctors are not oriented about the health issues faced by the community. The disparity in health care for the sexual minorities exists in all societies. For example, transgender groups often have no permission to seek health service inside hospitals and do not have separate ward earmarked for in-patient care. Their access to health care needs to be ensured because they are at a high-risk for various physical and mental illnesses. Case studies of different individuals highlight the basic problems they face in accessing healthcare facilities.

(CASE 1)

K* a *Hijra* originally from a distant village in Malda district of West Bengal ran away from home at the age of fifteen. Her family did not like her dressing up as women and playing with girls. She initially moved to Kolkata and started begging at railway stations. It was here that she met a group of Hijras who were begging in trains. She befriended a Hijra and moved in with her. "I was slim and had no facial or body hair like men, when I dressed in women's clothing a lot of people mistook me for a young girl. I also started engaging in sex work. With admiration from other Hijras and my male customers, I was eager to the

(CASE 2)

N* a Kothi shared her story –she spoke about her childhood, her life then, likes, dislikes, love and struggles. N* started her narration talking of her early recollections of gender and sexuality: "*It is evident that I have a mind of a woman with a body of a man. That is why my story will be different from the story of other men. I belong to a lower middle class family. My Baba (father) doesn't earn much. I have an elder sister and a younger sister. Being the only son in the family everyone had high expectations from me. But since childhood I was girly as you are seeing me now. I used to like dressing up like women, wear sari, do my hair - these were my fascinations*". As N* grew up these effeminate characteristics became evident to everybody else around him. She dropped out of school in the 8th standard because of harassment and bullying in school. It was at this time that N* had her first sexual encounter with an elder boy from the locality. She then started travelling to Kolkata to work as a prostitute. It was during these escapades that she came in contact with a Hijra and moved in with her as a chela. She has had various STDs and had taken treatment from government hospitals. N* prefers to be identified as a woman and would like to go in for Sexual Reassignment Surgery later when she can muster that kind of confidence in such procedures.

(CASE 3)

B*, a 32 year old Trans woman from Kolkata has been a Launda dancer for a few seasons during her twenties. Originally from Kolkata, she lives with her mother and is associated with an organization working on Transgender issues. B* first realized her sexuality when he had a major crush on a school mate in class 5. By 12 he had identified *kothis* near his locality and started hanging out with them. He grew his hair, started wearing women's jeans and explored with complete cross dressing in private. B* is not comfortable undergoing a complete sexual reassignment surgery which is why he prefers to dress up as a woman. He is a MSM and has multiple sexual partners. Early on when he started sex-work, he was young and naïve. He had multiple sexually transmitted diseases early on and an exposure to NGOs working on HIV/AIDS and other STDs he started using condoms. According to B* "*I like to look and feel like a woman but I do not like the idea of mutilating my body. I had a steady partner who is also a transgender and he used to treat me like a wife at home and in bed*". His partner was an alcoholic who used to beat him as well as had multiple sexual partners. B* is also an alcoholic and is undergoing counseling for depression and self-destructive behavior like wrist slashing and using drugs.

(CASE 4)

S* a 35 year old bisexual cross dresser also from the outskirts of Kolkata has a wife and an 8 year old son. He is identified as a Hijra and begs in trains and stations. He also works as a Launda dancer during the wedding seasons. He is comfortable dressing as a woman and his family has accepted this as they are dependent on his income. According to him " I am not a Hijra, I did not undergo castration but I have a guru who has accepted me as a chela. I perform Launda dance during wedding seasons and rest of the year I indulge in begging and sex work". He also admitted to having multiple male sexual partners. He is associated with a NGO that has regular medical checkups and he is dependent on this as he does not like spending time trying to avail government medical facilities which he feels is useless.

(CASE 5)

V* a homosexual man first realized his sexual orientation was different when he felt aroused at the sight of his male friends changing in a locker room after their basketball match in school. He was only 14 and had just hit puberty. According to him, "For a year I tried to dismiss these feelings as curiosity. It was only a few years later that I had my first sexual encounter with a boy in school. I went through a phase of substance abuse during college but as I had not come out of the closet I had a normal medical process for dealing with deaddiction. Even now I do not disclose my sexual orientation during healthcare procedures unless specifically asked. I am in the media and being gay is accepted at my workplace". V* is in his mid-30s and has a steady partner. For him homosexual roles are unlike traditional marriage role and he prefers mutually reciprocated sexual activity with his partner. He seeks healthcare at private nursing homes and chooses this over Government institutions both because of ease of access, quality of healthcare and time. His job gives him the confidence and economic freedom to access private healthcare.

(CASE 6)

R* is a lesbian woman living and working in Delhi. She has been sexually active with both sexes from college and only recently declared herself a lesbian to her friends. According to her, "in my earlier hetero normative relationships I felt connected to men emotionally, but I soon realized that I was attracted to women physically, emotionally and mentally. Relationships with women gave me a sense of completeness and identity. Being a lesbian has no repercussions on my health or health seeking behavior. I regularly visit my gynecologist who is well aware of my sexual orientation and my sexual practices". A major difference in attitude she feels can be attributed to the sensitivity and awareness of the doctor in a private metropolitan setting. R* belongs to a middle class Bengali family from Durgapur and till date her parents have no idea about her sexual preferences as they are still trying to set up matrimonial matches for her. Coming out has not been possible and that has caused some amount of mental health issues for her.

DISCUSSION

India has traditionally been a patriarchal society, wherein the decision-making power often rests with male members of the family. This has created a social environment where alternate sexualities and gender identities are not readily accepted.The National Family Planning program initiated in 1952 primarily focused on controlling birth rates and population growth. While this program aimed to address population concerns, it did not adequately address the needs and rights of marginalized communities, including transgender individuals.

LGBTQ communities in India have historically faced social exclusion, discrimination, and stigma. This community fringes on the margins of society, which have severe consequences for their self-esteem and sense of belonging. This social exclusion also hampers their ability to fulfill their social responsibilities. Gender dysphoria and mental stress are common experiences for many transgender individuals. The realization of being different from the established societal norms often occurs during adolescence, leading to significant challenges in terms of identity and mental well-being.

Recognizing the importance of addressing these mental health challenges, it is crucial to provide adequate support to transgender individuals. Counseling and psychiatric therapy can play a significant role in assisting

transgender individuals battling depression and other psychological traumas. It is essential to recognize the necessity of such mental health care services and make them accessible in government hospitals.

In recent years, there have been positive developments in India in context of transgender rights. The Transgender Persons (Protection of Rights) Act has been passed in 2019, aiming to protect and empower transgender individuals and provide them with equal opportunities and social inclusion. However, there is a considerable gap in terms of implementing and effectively addressing the various challenges faced by the transgender community.

Overall, promoting acceptance, equality, and inclusivity for transgender individuals is crucial in challenging the deeply ingrained societal attitudes and creating a more supportive environment. This requires collective efforts from society, the government, healthcare systems, and various other stakeholders to ensure the well-being and rights of transgender individuals are protected and respected.

The findings of the paper "Social Integration and Health: Community Involvement, Stigmatized Identities, and Sexual Risk in Latino Sexual Minorities" a major study by Valles et al. indicates that community involvement has been recognized as a potentially effective intervention attributed to dealing with stigma of homosexuality among Latin American origin or descent. Sexually risky behavior stems from the groups alienation from the mainstream society. This study offers alternatives to improve HIV prevention efforts among sexual minorities. Similar to the findings of the afore mentioned study, community involvement and participation has been identified as a potential pathway to address issues of substance abuse and risky behaviour among the transgender community in India. By creating opportunities for transgender individuals to actively engage in organizations, advocacy, and support networks, their overall well-being and access to resources could improve, leading to better health outcomes and reduced risks of substance use and sexual risk behaviors.

Although studies have shown that gender exists on a spectrum and encompasses diverse identities and expressions, the medical field often simplifies it to a binary concept of male or female and further confines gender roles to a linear binary as well: men are expected to be masculine, while women are expected to be feminine. As a result, individuals who do not conform to this binary understanding, such as cross dressers and Kothis, may feel discouraged from seeking healthcare services from institutionalized healthcare institutions. Transgenders shared that medical staff do not recognize their gender identity or rights; their focus is only the biological body. In Government hospitals, transgender individuals are often confused about what line to stand in – the queue for male or female – and apprehensive about reporting their sex in the form. Another confusion regarding what ward they can be admitted in is also present. Since their biological identity is not in congruence to their expressed gender identity, they are forced to get admission to the ward for the opposite gender, this is a harrowing and deprecating experience as expressed by K*, a transwoman.

Health problems arising from alcohol and substance abuse are a raging issue among Transgender communities. While it is difficult to determine the exact proportion of TG individuals who consume alcohol, it is crucial to approach this topic with sensitivity and recognize the complex factors that may contribute to these behaviors. The reasons provided by gender variant individuals for their

alcohol consumption can vary greatly and often include attempts to cope with stress, depression, or difficult life circumstances. These reasons can encompass a range of factors such as lack of family support, feelings of isolation or neglect, discrimination, or the challenges associated with sex work. These individuals may use alcohol as a means to temporarily alleviate distress or to cope with the emotional burdens they face. Although attributed to the pathology of homosexuality or variant gender identity in the past, higher prevalence of substance abuse and mental health disorders among LGBT individuals can be attributed to a concept known as "minority stress." According to which real or expected prejudicial experiences lead to internalized homophobia, depression, and anxiety (UNDP, 2010)

Sexual minority groups are vulnerable to developing sexually transmitted diseases (STDs) and HIV/AIDS. The reason that they are a high risk group is because of their propensity to reuse needles and indulge in unsafe sexual intercourse during commercial sex work both in heterosexual and homosexual relationships. The social customs in India constrain individuals from communicating explicitly about problems associated with sex, especially menstruation, sexual health and reproductive health. Multiple studies have cited reluctance to talk explicitly, including between spouses, about sex and sexual behavior as the biggest social obstacle to the control of HIV transmission and promotion of sexual health (Solomon et al. 1998, Sethi 2002).

Inequality in the access of health care by LGBTQ community members exists across societies. For instance, transgender groups still lack a separate ward in any hospital or have designated beds set aside for them. They are often restricted entry inside hospitals and do not have separate ward reserved for in-patient care. *Hijras* and *kothi*s avoid these institutions because they are accommodated in male wards which are in deference to their practiced gender. Healthcare social work is the practice of social work that deals with the aspects of general health. Social workers have to ensure that LGBTQ communities have adequate access to health care needs as they are at a high-risk for various physical and mental illnesses. These basic facilities must be in place for all people irrespective of any differences.

Gender variant patients are often mocked and ridiculed by hospital staff and kept waiting longer than other patients. Previous instances where both male and female doctors have refused to examine them have been reported. Those seeking treatment for a Sexually Transmitted Infection in hospitals have faced admonition or advice to change their sexual behaviour rather than receiving treatment. As a result, they do not like to go to hospitals even for general health issues; they prefer to go to the chemist shop instead. Providers should adopt a formal policy of non-discrimination and respect for each patient's gender identity.

Transgender groups (TG) specifically face a risk of developing emotional disorders because of the widespread stigma and discrimination they face in all spheres of the society. Suicide risks among same sex partners are higher than the other groups. Transgender youth are often forced out of their homes or choose to leave home because of parental rejection or fear of societal rejection, increasing their risk of homelessness, poverty, and associated negative consequences. These results in greater psychiatric morbidity risk among sexual minorities. Necessary codes and guidelines need to be formulated regarding Sex Reassignment Surgery (SRS) and other

procedures that Transgenders usually seek, namely mammoplasty (breast implants), vaginoplasty, facial hair removal, scalp hair growth, hormonal supplements and changing of voice.

CONCLUSION

The global disease and health problems of transgender populations remain under researched, particularly in relation to the effects of stigma, discrimination, social, and structural factors that affect the health of this underserved population (Reisner et al, 2016). In the Indian context in identifying the transgender groups as a third gender, the Supreme Court passed this unique judgment in April 2014 stating one's sexual orientation as the integral part of personality, dignity and freedom. Gender identity is at the core of one's personal identity, gender expression and presentation and therefore, it will have to be protected under Article 19(1) (a) of the Constitution. A transgender personality could be expressed by the behaviour and presentation of a transgender. State cannot prohibit, restrict or interfere with a transgender person's expression of such personality, which reflects that inherent personality. In conclusion, "sexual minorities" experience lapses in health care that can be eliminated only if health care providers and clinicians educe information about alternative sexual orientation and gender identities from their patients.

According to available studies it has been found that access to safe and effective healthcare services for LGBTQ and gender variant people is a crucial requirement for achieving their human rights. Globally it has been found that these particular groups are highly susceptible to the human immunodeficiency virus (HIV) and other sexually transmitted diseases. Through critical evaluation of qualitative papers addressing barriers to accessing sexual healthcare services for LGBTQIA groups, five themes were identified. Stigma as a barrier has been further sub-divided into stigma associated with sexuality, gender identity, HIV status, sex worker status and internalized stigma. The other barriers highlighted are lack of sexual health literacy, confidentiality issues, fatalism and structural barriers.

This paper incorporates information about the LGBTQ individuals through thoughtful, non-judgmental discussion and analysis of case histories. The need for awareness among medical professionals about the needs and concerns of "sexual minorities" is the foremost apprehension and in spite of increasing social acceptance, there is a long history of anti-LGBT bias in health care which continues to shape health-seeking behaviour and access to care for LGBT individuals. Although there are no LGBT-specific diseases, medical practitioners must be informed about LGBT health because of numerous health disparities which affect members of this population. Individual level intervention may be ineffective due to the absence of a holistic positive change at the health care system level. Access to information and education relating to sexuality and sexual health is essential to enable people to protect their health and make informed decisions about their sexual and reproductive lives. To become more responsive to the needs of the LGBTQ community and sexual minorities in general the suggestions that arise are building inclusive clinical environment, setting a standard for doctor-patient communication, sensitive collection and documentation of data with respect to sexual orientation, encouraging cultural awareness, comprehensive staff training, and awareness generation on health issues for these communities. Investment on research initiatives in this area and inclusion of issues on sexual minority in the medical curriculum is of the utmost importance. This is crucial

for health professionals and medical social workers in improving their response to health disparities and become sensitive to the needs of the LGBTQ community.

Although social acceptance of lesbian, gay, bisexual, transgender and queer (LGBTQ) people in India has been improving during the last decade, LGBTQ individuals continue to face stigma and discrimination. These negative experiences, combined with a lack of access to culturally-affirming and informed health care, result in multiple health disparities for LGBT populations. Social workers can play a crucial role in changing the existing conditions. They can advocate for inclusive policies and practices within the healthcare system, provide support to LGBTQ individuals, and contribute to creating a more equitable society.

REFERENCES

Agoramoorthy, G., & Hsu, J. M. (2007). India's homosexual discrimination and health consequences. Rev Saúde Pública, 41(4), 657-660.

Ard, K. L., & Makadon, H. J. (n.d.). Improving the health care of lesbian, gay, bisexual and transgender (LGBT) people: Understanding and eliminating health disparities. The National LGBT Health Education Center. The Fenway Institute.

Babbar, S. K. (May, 2016). Vulnerabilities of Transgender Community: A Case Study approach with special reference to HIV/AIDS. IOSR Journal of Humanities and Social Science (IOSR-JHSS), 21(5), Ver. 4, 4-6. E-ISSN: 2279-0837, p-ISSN: 2279-0845.

www.iosrjournals.org.

Bada Math, S., & Seshadri, S. (2013). The invisible ones: Sexual minorities. Indian Journal of Medical Research, 137(1), 4-6.

Bhagabati, K. (2012). Vulnerabilities of Transgender Community: A Case Study approach with special reference to HIV/AIDS. Dissertation submitted in partial fulfilment of Masters Degree in Department of Social Work, University of Delhi: Delhi.

Chakrapani, V., Newman, P. A., Mhaprolkar, H., & Kavi, A. R. (2007). Sexual and social networks of men who have sex with men (MSM) and Hijras in India: A qualitative study. Humsafar Trust, Mumbai: India. http://www.indianlgbthealth.info/Authors/Downloads/Report_SxlNeworks_MSM_Hijras_Apr_07.

Chakrapani, V., PriyaBabu, Ebenezer, T. (June 2004). Hijras in sex work face discrimination in the Indian health-care system. Research for Sex Work, 12-14.

Chakrapani, V., Samuel, M., Shunmugam, M., & Sivasubramanian, S. (2013). Modelling the Impact of Stigma on Depression and Sexual Risk Behaviour of Men who have Sex with Men and Hijras/Transgender people in India: Implications for HIV and Sexual Health Programs. Jointly published by Madras Christian College, the Humsafar Trust and C-SHaRP with support from ICMR.

Chettiar, A. (2015). Problems faced by Hijras (male to Female Transgenders) in Mumbai with reference to their Health and Harassment by the Police. International Journal of Social Science and Humanity, 5(9).

Harris, S. (2005). Don't Say Gay: Why States Are Erasing LGBTQ Students, and How They Have the Power to Change It.

Jagose, A., & Genschel, C. (1996). Queer theory. Melbourne: Melbourne University Press.

Nag, M. (1995). Sexual behaviour in India with risk of HIV/AIDS transmission. Health Transition Review, Supplement

to Volume 5, 1995, 293-305.

Nanda, S. (1999). Neither man nor woman: The Hijras of India. Toronto: Wadsworth Publishing Company.

People's Union of Civil Liberties-Karnataka. (2003). Human Rights Violations Against the Transgender Community: A Study of Kothi and Hijra Sex Workers in Bangalore, India. People's Union of Civil Liberties-Karnataka.

Reisner, S. L., et al. (2016). Global health burden and needs of transgender populations: A review. Lancet, 388(10042), 412-436.

Saxena, P. (2011). Life of a Eunuch. Shanta Publishing. ISBN 8192026388.

Sethi, G. (2002). AIDS in India: the government's response. Living with the AIDS virus—the epidemic and the response in India. New Delhi: Sage Publications.

Singh, S., Dasgupta, S., Pattankar, P., & Sinha, M. (2013). A people stronger: The collectivization of MSM and TG groups in India. Sage Publications: New Delhi.

Solomon, S., Kumarasamy, N., Ganesh, A. K., & Amalraj, R. E. (1998). Prevalence and risk factors of HIV-1 and HIV-2 infection in urban and rural areas in Tamil Nadu, India. International journal of STD & AIDS, 9(2), 98-103.

Spargo, T. (1999). Foucault and Queer Theory. Totem Books.

Thappa, D. M., Singh, N., & Kaimal, S. (2008). Homosexuality in India. Indian Journal of Sexually Transmitted Diseases, 29, 59-62. Doi:10.4103/0253-7184.448725

United Nations Development Programme (UNDP) India. (2010). Hijras/ Transgender Women in India: HIV, Human Rights and Social Exclusion. Accessed at: http://www.undp.org/content/dam/india/docs/

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