Queer-Affirmative Healthcare

Queering the Law: Beyond Supriyo

VIDHI Centre for Legal Policy

This is an independent, non-commissioned piece of work by the Vidhi Centre for Legal Policy, an independent think-tank doing legal research to help make better laws.

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Contents

Queering the Law: Beyond Supriyo

ABOUT THE SERIES

Introduction

On October 17, 2023, the Supreme Court of India ('Court') delivered its judgment in the landmark case of *Supriyo alias Supriya Chakraborty vs. Union of India* ('Supriyo'). While the Court recognised that it was the legislature's prerogative to enable marriage equality, it also noted the discrimination faced by queer persons in various realms of life. Consequently, it directed the Union Government to set up a High-Powered Committee ('Committee') to set out the scope of benefits that will accrue to queer couples and outline key areas that require State intervention to realise the constitutional rights of the queer community, including the right against discrimination.

In September 2024, the Committee issued a press release outlining the steps taken by the Union Government to address the discrimination queer persons face, such as inclusion for the purposes of opening a joint bank account or a ration card. The Committee also invited comments from the public in relation to measures that may be taken to ensure queer inclusion. In pursuance of this, the Vidhi Centre for Legal Policy ('Vidhi') and the Keshav Suri Foundation ('KSF') collaborated to make joint submissions to the Committee.

This set of four policy briefs, namely, 'Queering the Law: Beyond Supriyo' ('Beyond Supriyo') follows Vidhi's 2019 project, 'Queering the Law: Making Indian Laws LGBT+ Inclusive' ('2019 Project'). The 2019 Project, which was the outcome of several rounds of consultations held at the Vidhi office, identified how laws excluded queer persons across four areas: identity, violence, family, and employment. Beyond Supriyo is a continuation of this initiative and prescribes how laws and policies may be modified to be made queer inclusive. It provides for measures that may be pursued by the Union and State governments to address and redress the discrimination queer persons and persons in queer relations are subject to on account of a legal system that does not recognise them at par with cis-gendered and heterosexual persons.

In light of the Court's judgment in *Supriyo*, the onus of queer inclusion in laws now largely lies with the legislature. We hope this work will inform and assist queer civil society in carrying out advocacy towards more queer inclusive law reform.

Pan-India Consultations

The recommendations put forth in this series of policy briefs, and those presented before the Committee, have been informed by three public hybrid consultations conducted by Vidhi and the KSF in New Delhi, Bombay and Jaipur. These consultations were attended by around 150 stakeholders including members of the queer community, lawyers, civil society organisations, activists, and other interested stakeholders. The consultations were aimed at understanding the lived experiences and demands of the queer community in relation to law and policy reform. They were organised around five broad themes: (a) recognition of queer relationships, (b) queer parenthood, (c) access to goods and services, (d) violence, and (e) healthcare.

The plurality of views expressed across the consultations guided our approach to various policy questions and enabled us to make holistic recommendations. The detailed minutes of each consultation are annexed to the comprehensive recommendations submitted by KSF and Vidhi to the Committee.

About the Series

Beyond Supriyo comprises four policy briefs covering the following themes: queer relationships, discrimination, healthcare, and violence. These themes are informed by the observations and directions issued by the judges in Supriyo and the inputs received at the consultations. The Court in Supriyo broadly identified family law, access to goods and services, welfare benefits, financial benefits, labour benefits, healthcare and involuntary treatments, transgender rights and violence as areas that require State intervention.

While the policy briefs follow an accessible and actionable format to aid queer civil society and other interested stakeholders in their law reform advocacy, for a holistic view of the nature and form of measures that may be pursued by the State, one can refer to the comprehensive recommendations submitted by Vidhi and KSF to the Committee.

The series comprises of the following briefs:

1. Recognition of Queer Relationships and Family:

This policy brief addresses the need for legal recognition of queer families and relationships. Part A focuses on relationships between parties and recognition of a variety of family structures in law. Part B on parent-child relations, recommends amendments to the secular law on adoption to make them queer inclusive and suggests targeted measures for reform of laws governing parenthood to make them modern and inclusive of atypical families.

2. Discrimination in Access to Goods and Services:

This policy brief makes recommendations to address the discrimination queer persons face. Part A recommends general measures such as a comprehensive anti-discrimination law and reforms to the Transgender Persons (Protection of Rights) Act, 2019. Part B recommends sector specific recommendations across four sectors: financial services, employment, education, and housing. Recommendations are directed towards both prohibition of discrimination as well as affirmative measures to address systemic exclusion.

3. Queer-Affirmative Healthcare:

This policy brief captures wide-ranging recommendations spanning combatting existing discriminatory practices in healthcare, introducing affirmative healthcare, and affecting systemic measures. The removal of existing discrimination includes banning conversion therapy and medically unnecessary intersex surgeries, and ensuring compliance with the law on anti-discrimination against persons living with HIV-AIDS. Recommended affirmative measures include the provision of gender-affirming treatment, affordable mental health support, queer-inclusive health research, and provision for nomination of healthcare representatives of choice. Systemic measures include making health laws queer-inclusive, and increasing the presence of queer-affirmative healthcare workers through improved training and modified curricula, as well as horizontal reservations in public healthcare.

4. Prohibition of and Rehabilitation from Violence:

This policy brief addresses violence propagated by the State and society at large, by the natal family, and domestic and sexual violence. It recommends reforms in law enforcement including police sensitisation, amended police rules and binding directions. Proposed affirmative measures for rehabilitation from violence include shelter homes and emergency helplines. Legislative changes have been suggested to protect queer persons and persons in queer relationships from sexual, domestic and intimate partner violence as well as workplace harassment.

Principles

1. Non-Discrimination:

Queer persons must receive healthcare free from stigma, refusal to provide healthcare, or invasive practices.

Examples:

* Recommends banning conversion therapy and medically unnecessary intersex surgeries.
* Calls for removal of HIV-related exclusions in insurance and enforcement of non-discrimination under the HIV Act.

2. Affirmative Action and Positive Obligations:

Healthcare systems must actively provide gender-affirming, inclusive, and community-sensitive care.

Examples:

* Proposes expansion of government insurance schemes to cover gender-affirming care.
* Suggests modifying mental health programs like Rashtriya Kishor Swasthya Karyakram ('RKSK') to be queer-affirmative.

3. Recognition of Diverse Family Structures:

Queer persons' caregivers and chosen families must be legally recognised in treatment and end-of-life care.

Examples:

* Recommends enabling nomination of surrogate decision-makers for medical decisions.
* Urges hospitals to include non-normative family structures in end-of-life policies.

4. Gender-Inclusive and Queer-Inclusive Language:

Medical laws and policies must reflect diverse identities and avoid binary or pathologizing terms.

Examples:

* Calls for modification of medical curricula to include queer-specific health concerns.
* Proposes training healthcare workers in queer-affirmative care and communication.

5. Participation and Voice of Queer Communities:

Healthcare reforms must centre queer-led advocacy and lived experiences.

Examples:

* Guidelines for intersex care and mental health were shaped by consultation-based inputs.
* Emphasises community collaboration in health research and clinical training.

Queer-Affirmative Healthcare

INTRODUCTION

Queer persons in India continue to face significant barriers in accessing equitable and affirming healthcare, stemming from structural discrimination and institutional neglect. The challenges largely result in lack of access to proper care, which violates the autonomy and dignity of an individual.

In certain cases, healthcare itself becomes a site for violence. This is especially true when it comes to conversion therapy and medically unnecessary intersex surgeries, where the lack of regulation has led to continuation of unnecessary, unethical, and discredited practices. In addition, there is discrimination in access care for queer persons. This ranges from an explicit exclusion, bias, and discrimination to exclusion due to lack of appropriate infrastructure and training.

The Supreme Court in Supriyo drew attention to issues faced by queer persons in healthcare and issued the following directions to the Union, State, and Union Territory Governments:

* suitable steps to ensure that queer and/or transgender persons are not subject to any involuntary medical or surgical treatments;
* steps to sensitise the public about queer identity, including that it is not a mental disorder;
* ensuring that “treatments” offered by doctors or other persons which aim to change gender identity or sexual orientation are ceased with immediate effect;
* ensuring that intersex children are not forced to undergo operations with regard to their sex, especially at an age where they are unable to comprehend and consent to such operations fully;
* ensuring that no person should be forced to undergo hormonal therapy or sterilisation or any other medical procedure either as a condition or prerequisite to grant legal recognition to their gender identity;
* medical professionals to consult family, next of kin, and next friend in case a person is terminally ill and does not have an Advance Directive.

The Court has also directed that the appropriate government under the Mental Healthcare Act, 2017, must design and implement programmes to promote mental health in the country and implement public health programmes to reduce queer suicides in India.

ISSUE

Queer persons in India have been historically excluded from affirmative healthcare owing to wide-ranging issues such as non-inclusive laws written in strictly binary language, discriminatory and violent practices by healthcare professionals, exclusion as equal participants in providing healthcare, negligence towards health issues disproportionately affecting queer persons, non-implementation of their health rights, and lack of sensitisation and training.

APPROACH

In this brief, we have highlighted some pertinent executive and legislative steps to address discrimination, violations of the right to dignity, privacy, and autonomy, and inadequate access to healthcare. We have also envisaged a prominent role for professional guidelines and regulations, which in many cases has a more meaningful and immediate impact on the quality and inclusivity of healthcare.

POLICY RECOMMENDATIONS

I. DISCRIMINATORY PRACTICES IN HEALTHCARE

A. Banning of Conversion Therapies

Nodal Authority:
Ministry of Social Justice & Empowerment ('MOSJE') Ministry of Women and Child Development ('MWCD'); Ministry of Health & Family Welfare ('MoHFW'); State Health Departments; and National Medical Commission ('NMC')

These therapies are globally regarded as unethical, unscientific and harmful. In the garb of 'cure', in reality, these take forms of mental, emotional, physical, and sexual abuse. The therapies also lead to long-term effects, such as low self-esteem, anxiety, depression, and an increased risk of suicide.

"Prohibit any attempts to medically "cure" or change the sexual orientation of LGBTIQA+ people to heterosexual or the gender identity of transgender people to cisgender. To take action against the concerned professional involving themselves in any form or method of conversion "therapy", including withdrawal of license to practice."
—N Anand Venkatesh, J., S Sushma and Anr v. Director General of Police and Ors, High Court of Judicature at Madras

Prohibition of conversion therapies:

Introduce a law that explicitly prohibits all forms of conversion therapy, including medical, psychological, and religious practices. The law should define such practices as unlawful and introduce punitive measures for the practitioners as well as advertisers or promoters of such therapies.

Introduce as 'magic remedy':

Conversion therapies have an expansive definition, and can fit within the definition of 'magic remedy' under Section 2(c) of the Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954. Under the Act, a new provision banning advertisements of conversion therapies must be introduced as well.

"National Medical Commission, New Delhi, has issued notification ... to all State Medical Councils, to incorporate "conversion therapy of LGBTQIA+ community group" as professional misconduct under the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulation, 2002.."
—N Anand Venkatesh, J. W.P.No.7284 of 2021, High Court of Judicature at Madras

Declare as professional misconduct:

Using the power conferred under the National Medical Commission Act, 2019 ('NMC Act'), the NMC must declare conversion therapy practices as professional misconduct. Further, executive orders and guidelines must be released for all healthcare professionals directing them to comply with the ban on conversion therapy.

Mental Health Authorities must issue clarificatory orders specifying that conversion therapies are in violation of Section 3 (Determination of mental illness), 95 (Prohibited procedures), 96 (restriction on psychosurgery for persons with mental illness), and 97 (restraints and seclusions) of the Mental Healthcare Act, 2017 ('MHA').

* Mental health institutions and de-addiction centres (and the mental health professionals performing conversion therapies) violate section 3 of the MHA when they diagnose queerness as an illness that needs to be cured. This is against current medical and professional standards, and queer persons are diagnosed with an illness solely because they do not conform to dominant social, cultural, or religious norms.
* If procedures banned or regulated under sections 95, 96, and 97 of the MHA (including electro-convulsive therapy, restraints, seclusion, etc.) are performed to "cure" or "convert" queerness, there is clear violation of these provisions.
* There is violation of the precondition of informed consent for admission and treatment, under the MHA as well as regulations under it like the Minimum Standards of Care for Centres Providing Substance Use Disorder Treatment and Rehabilitation, 2018.

B. Ban on Medically Unnecessary Intersex Surgeries

Nodal Authority:
MoHFW, State Health Departments; Indian Council for Medical Research ('ICMR'), National Council of Clinical Establishments ('NCCE'), professional medical associations, and NMC

Intersex surgeries are procedures that aim to change the genital appearance or reproductive autonomy of an individual with intersex variations. Some forms of intersex surgery may be life-saving or otherwise medically necessary for urination or other essential bodily functions. However, in many cases, they are done to make the genital appearance conform with social norms. This violates intersex persons' bodily autonomy, especially since many such surgeries are done to infants/minors, and artificially enforces gender binaries. They may also lead to complications like infertility, chronic pain, sexual dysfunction, and gender dysphoria.

"The Government after careful examination of all the above points and based on the opinions of the experts as forwarded by the Director of Medical Education, have decided to ban sex reassignment surgeries on intersex infants and children except on life-threatening situations and ordered accordingly.
—Order G. O. (Ms) No. 355 dated 13.08.2019, Health and Family Welfare (M-2) Department, Government of Tamil Nadu

"In fact, the Hon'ble Supreme Court in NLSA case categorically stated that no one shall be forced to undergo medical procedures, including SRS, sterilisation or hormonal therapy, as a requirement for legal recognition of their gender identity. But, what is happening in reality is more in breach of this judgement given by the Hon'ble Supreme Court. Article 39(f) of the Constitution of India...."
—G. R. Swaminathan, J., Arunkumar and Anr. v. Inspector General of Registrations and Ors., High Court of Judicature at Madras

Ban unnecessary and non-consensual intersex surgeries:

All forms of medically unnecessary intersex surgeries should be banned, unless done with valid and informed consent from the intersex person. This ban can be put in place in two ways:

* Executive orders from the nodal government authorities to all clinical establishments and healthcare professionals
* Terming unnecessary intersex surgery as professional misconduct as per the Indian Medical Council (Professional Conduct, Etiquette, and Ethics) Regulations, 2002. Misconduct under these regulations would invite action from professional bodies like state medical councils and help in supporting claims of medical negligence.

"After careful deliberations, the Commission is of the considered opinion that the Government of Delhi should declare a ban on medically unnecessary, sex-selective surgeries on intersex infants and children except in cases of life-threatening situations and advises the government accordingly."
—Order No.F/DCPCR/20-21/Health & Nutrition/Project File-VIII/1329495 dated 13/01/2021, Delhi Commission for Protection of Child Rights

Issue guidelines on medically necessary intersex surgeries:

The NMC and professional bodies of medical professionals, in consultation with intersex persons and queer rights organisations, should issue comprehensive guidelines on:

* The meaning and types of medically necessary intersex surgeries - and conversely, medically unnecessary intersex surgeries;
* How to understand and ensure consent from intersex persons to conduct these surgeries;
* How to communicate the meaning of intersex variations, the need for necessary surgeries, and the issues associated with unnecessary or non-consensual surgeries - to families or others accompanying the intersex person in question.

C. Remove the Blanket Ban on Blood Donations

Nodal Authority:
National Blood Transfusion Council ('NTBC'); National Aids Control Organization ('NACO') and MoHFW

The 2017 Guidelines on Blood Donor Selection and Blood Donor Referral ('Guidelines') put a blanket ban on '*transgender persons, men who have sex with men, and female sex workers*' to donate blood. While all donated blood is supposed to be tested for HIV, this ban assumes these categories to be HIV-positive based on one's gender identity, sexual orientation, and occupation.

"What is worrying me is, are we going to brand all transgenders as risky and thus indirectly stigmatize these communities? Unless you can show with some medical evidence that there is some kind of link between transgenders and these diseases. You can't [say] all transgenders are involved in those kinds of activities, even normal persons engage in such activities..."
—Surya Kant and N Kotiswar Singh, JJ., Thangjam Santa Singh @ Santa Khurai v. Union of India, Supreme Court of India

Amend to remove arbitrariness:

To align with the fundamental rights guaranteed under Article 14 and 21 of the Constitution of India, the Guidelines must be amended as follows -

* **Removal of discriminatory clauses -**
Clause 51 (At risk for HIV Infection) which highlights the categories assuming these to be HIV-affected and Clause 12 'Risk Behavior' which highlights the categories and leaves the decision up to the medical officer deciding fitness. The categories must be omitted from these sections.
* **Revision of Blood Donor Questionnaire-**
Update Annexure 1 of the Guidelines by - Removing reference to 'engage in male to male sexual activity' from question 10.2 and replacing 'sex' with 'gender' in the personal information section.

D. Address Discriminatory Practices Against PLHIV

Nodal Authority:
MoHFW, Department of Health of State Governments, and Insurance Regulatory and Development Authority of India

Historically, owing to stigma and systemic issues in access to healthcare, the queer community has been disproportionately affected by HIV-AIDS and its impact. This has been exacerbated by the following:

* **Discrimination in healthcare:**
Multiple healthcare professionals continue to operate on the assumption that persons living with HIV ('PLHIV') deserve their fate. Healthcare institutions are also known to deny admission or treat PLHIVs, with issues like involuntary testing of HIV, segregation of hospital wards, and early discharge without explanation, among others. Discrimination in healthcare settings remains a major obstacle to ending the AIDS epidemic as a public health threat by 2030, as it undermines the ability to reach people with testing, treatment, and other necessary services.

* **Discrimination in insurance policies:**
While the inherent nature of private insurance implies that persons with certain health conditions may have to pay higher premiums or be excluded from certain benefits, having blanket terms for persons living with HIV/AIDS is discriminatory. Most healthcare policies in India cover family members. Given that the determination of family members is dependent largely on the heteronormative structure, members of the queer communityn lack proper access to insurance.

Non-Discrimination against PLHIV:

Persons living with HIV face significant structural discrimination, and this is worse for persons from the queer community. This double marginalisation is worsened by stigma entrenched stigma, often embedded within healthcare systems and perpetuated by healthcare providers. Insurance policies also exclude or limit coverage for PLHIV. These barriers hinder positive health-seeking behaviour and worsen health outcomes. This structural discrimination must be addressed.

Implementation of the HIV-AIDS Act:

Directions on enforcing the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 ('HIV-AIDS Act'), e.g. provisions on nondiscrimination in healthcare, informed consent for HIV testing, etc.

Amendment to terms and conditions of insurance:

Directions to private insurance companies to amend their schemes and terms and conditions such that persons with HIV/AIDS are not automatically excluded from insurance benefits or made to pay higher premiums.

II. QUEER-INCLUSIVE HEALTHCARE

A. Provision of Gender-Affirming Care

Nodal Authority:
MoHFW; Department of Health of State Governments and the NMC

The Transgender Persons (Protection of Rights) Act, 2019 ('Trans Act') directs the Central and the State government to provide healthcare facilities for transgender persons. However, the obligation has not translated into practice.

* **Gender-affirming healthcare facilities:**
Executive orders must be issued to appropriate governments to ensure compliance with Section 15 of the Transgender Persons Act. These provide for requirements such as the setting up of HIV sero-surveillance centres, facilitate access to care for transgender persons in hospitals and healthcare institutions or centers. These guidelines must define detailed timelines and reporting requirements to aid the implementation of the Act.

* **Inclusion in government insurance:**
Various forms of gender-affirming care should be included in benefit packages of health insurance schemes at the central and state levels. This should be accompanied with provision for temporary stays within or near the hospital campus - especially since many queer persons may not have the requisite support or community to continue treatment while facing homelessness or wage loss.

* **Release of professional guidelines:**
The NMC must release professional guidelines on what entails gender-affirming care and its diverse forms. This could include genitalia surgery, hormone therapies, and other procedures that work towards affirming the gender of a transgender person. These should be developed in consultation with the community and medical professionals.

B. Provision of Queer-Friendly Mental Healthcare

Nodal Authority:
MoHFW; Departments of Health of State Governments

The societal marginalisation and non-recognition is likely to lead to mental health challenges such as anxiety and depression. However, these issues remain unaddressed, considering mental health professionals are not trained to be queer-affirmative and do not have a grasp on the realities of queer intimacies and experiences.

Develop queer-affirmative mental health guidelines:

The MoHFW, in collaboration with experts in mental health, queer rights organizations, and members of the LGBTQIA+ community, should develop comprehensive queer-affirmative clinical guidelines. These should outline best practices for supporting queer and trans persons, address issues such as gender dysphoria, minority stress, identity affirmation, queer-affirmative language, and tackle harmful and unethical practices like conversion therapy.

"... individuals belonging to the LGBTQIA+ community encounter difficulties in obtaining mental healthcare as a result of various pressures exerted upon them. Findings revealed that societal influences in the perception of stigma about sexuality, gender, and mental health....

Participants hold mistrust about mental health providers as a result of unfavourable encounters, underlying bias, and apprehension towards adverse treatments. Additional factors such as inadequate parental support, socio-economic instability, and religious beliefs were identified as determinants of limited accessibility to mental healthcare."

—Surya Kant and N Kotiswar Singh, JJ., Thangjam Santa Singh @ Santa Khurai v. Union of India, Supreme Court of India

Mandatory sensitisation and training programs:

Post the development of the guidelines, structured sensitisation and training programs must be developed and implemented. These must be made mandatory for all persons providing mental healthcare in India and registered under the Mental Healthcare Act, 2017.

Inclusive Adolescent Friendly Health Clinics ('AFHCs'):

To ensure access of queer-affirmative mental health care to adolescent populations, guidelines should be developed for the functioning of counsellors at these centres. Programmes under the National Mental Health Programme such as the 'RKSK' should be examined and modified to make sex education and counselling services at AFHCs queer-inclusive and queer-affirmative.

C. Access to HIV/AIDS Care

Nodal Authority:
MoHFW and Departments of Health of State Government

Despite dedicated programmes on HIV/AIDS under the National Health Mission, access to healthcare, including prophylactic drugs and therapeutic care, remains limited. Apart from issues of access and availability, stigma and discrimination further alienate queer persons from HIV/AIDS care.

* **Audits of Healthcare Systems:**
Directions should be issued for regular audits of healthcare establishments, including primary and community health centres, regarding the availability of preventive and curative care for HIV/AIDS.

* **Targeted Sensitisation:**
Sensitisation and training programmes for all healthcare workers regarding sensitive and nondiscriminatory handling of persons living with HIV/AIDS.

* **Including the Community for Outreach:**
Directions should be issued for collaborations among Civil Society Organisations ('CSOs') and frontline workers to ensure awareness and outreach programmes.

D. Nomination for Healthcare Decision-Making

Nodal Authority:
MoHFW and Department of Health of State Governments

In India, supported decision-making, i.e. decisions made on behalf of a person who does not have decision-making capacity by a nominee/representative chosen by that person, finds a place in law in limited contexts. A nominee, representative, or surrogate decision-maker can be chosen only in the case of persons with disabilities, mental health decisions, or end-of-life care decisions. For general healthcare decisions, in practice, treating teams defer to the opinions of persons related by blood or marriage. This may not be ideal in all scenarios, especially if a person has strained relationships with their family or they do not know or share their values and choices. This is particularly pertinent for queer persons, many of whom face violence or alienation from their families and/or may want to choose non-married partners or chosen family members for taking decisions on their behalf.

Comprehensive Legislation on Mental Capacity:

This legislation should provide for nominating any person of choice as a surrogate decision-maker for healthcare decisions (as well as for other kinds of decisions) - preferably with options to nominate different people for different kinds of decisions. Healthcare power of attorney laws, similar to those in place in the United States of America, can also be considered.

Directions to Broaden Understanding of 'Kin' or 'Family':

Issue directions to all healthcare establishments and medical practitioners to include non-normative families within their understanding of 'family' or 'kin'.

Inclusive end-of-life care policies:

Issue directions to healthcare establishments to put in place end-of-life care policies that are inclusive of non-normative partners and family/ friends, in line with the AIIMS, Delhi Guidelines for End of Life Care.

"In Aruna Shanbaug, this Court has observed that autonomy means the right to self-determination where the informed patient has a right to choose the manner of his treatment. To be autonomous the patient should be competent to make decisions and choices. In the event that he is incompetent to make choices, his wishes expressed in advance in the form of a Living Will, or the wishes of surrogates acting on his behalf... are to be respected. The surrogate is expected to represent what the patient may have decided had he/she been competent or to act in the patient's best interest."

—A. K. Sikri, CJ., Common Cause (A Regd. Society) vs Union Of India, Supreme Court of India

E. Queer-Inclusive Health Research

Nodal Authority:
MoHFW; Departments of Health of State Governments and ICMR

Research and development in healthcare has historically been restricted to the concerns of privileged demographics, mostly cisgendered men of a certain class. This ends up excluding health concerns and experiences of other categories of persons, leading to their neglect in the healthcare ecosystem.

* **Amendment to research and grant guidelines:**
Research guidelines of organisations such as ICMR should incorporate further focus on the health of queer persons. This can include incentivising research on issues disproportionately concerning queer persons, including diverse queer experiences in tests and trials, etc.

* **Reorienting the relationship of queer persons with health research:**
Medical professionals should be oriented towards important queer-centric issues without unscientific pathologisation of their identities, while including queer persons as equal participants in such research.

F. Making Laws Queer-Inclusive

Nodal Authority:
MoHFW and Department of Health of State Governments

Health laws in India are entrenched in traditional gender binaries. Among other issues, this reduces persons to essentialist perceptions of sex and gender - for example, transgender persons are either misgendered or find it difficult to access healthcare or rights pertaining to ovo-uterine systems.

Clarifying terms to make them inclusive:
Executive direction to clarify that references to 'woman' in these Acts would include any person who identifies as one, and 'pregnancy' and other terms pertinent to conception, pregnancy, or termination would apply to anyone who is medically able to be pregnant.

[This recommendation should be read in conjunction with the proposed action on parenthood in Queering the Law: Beyond Supriyo: Recognition of queer relationships and families]

III. DIGNITY AND PRIVACY

A. Protection of Healthcare-Related Data

Nodal Authority:
Ministry of Electronics and Information Technology

The Digital Personal Data Protection Act, 2023 ('DPDP Act') does not adequately protect the personal data of queer persons. Although it establishes the importance of consent, it does not recognise information on HIV status or queer identities as a specific class of 'sensitive' personal data, which requires additional protection. Further, it does not accord a special degree of protection to health information. As a result, data about one's sexual orientation and gender identity is vulnerable to breaches, increasing risks of being outed or targeted harassment or violence.

The Information Technology Act, 2000 ('IT Act') and the Information Technology (Intermediary Guidelines and Digital Media Ethics Code) Rules, 2021 ('IT Rules') do not specifically recognise hate speech or discrimination based on sexual orientation or gender identity under categories of prohibited content, including material that is 'harmful', 'harassing' or 'discriminatory'. As a result, platforms can interpret these terms narrowly, leaving out queer-phobic content unless it explicitly incites violence. Moreover, the grievance redressal mechanisms under the IT Rules are ill-equipped to handle queerspecific issues. Grievance officers often lack training on LGBTQIA+ rights and are unable to identify subtle or coded forms of queerphobia, such as derogatory memes, misgendering, or microaggressions.

Amendment to the DPDP Act:

The DPDP Act and rules/regulations under the law should be amended to protect categories of health or HIV data that can increase vulnerability for queer persons. The law should also mandate audits at organisations to assess if the processing of personal data has led to discriminatory conduct based on these grounds.

Amendment to IT Rules:

The following amendments should be made:

* Specific references to discrimination or hate speech against individuals or groups based on their sexual orientation and gender identity in categories of prohibited content.
* Broadening the definition of 'harmful' and 'harassing' to include subtle forms of queerphobia, such as misgendering or derogatory content.

Queer-friendly grievance processes:

Mandatory training of grievance officers on LGBTQIA+ rights and sensitisation to identify queer-phobic content, including coded and indirect hate speech. Specialised LGBTQIA+ liaisons or consultants can also be introduced within grievance redress systems.

IV. SYSTEMIC MEASURES IN HEALTHCARE

A. Institutionalise Queer-Inclusive Infrastructure

Nodal Authority:
MoFHW, Department of Health of State Governments, Clinical Establishments, National Accreditation Board for Hospitals and Healthcare Providers

Healthcare establishments are heavily catered towards hetersexual identities. Queer identities and bodies do not find representation anywhere from admission forms to the wards.

* **Prohibit discrimination:**
  Amend the Clinical Establishments (Registration and Regulation) Act, 2010 ('CE Act') to explicitly prohibit discrimination based on gender identity and sexual orientation in admissions, patient care, and treatment.

* **Renew accreditation standards:**
  The National Council performing the power granted to it under The CE Act should have grounds for inclusive infrastructure, such as inclusive forms, washrooms, wards, changing rooms as necessary conditions for licenses and accreditation. Similar accreditation guidelines must be issued by Indian Public Health Standards Guidelines.

B. Queer-Affirmative Workforce

Nodal Authority:
MoFHW, Department of Health of State Governments, NMC; Under-Graduate Medical Education Board and the Post- Graduate Medical Education Board

Healthcare workers at private or government hospitals are not trained to interact with queer persons. There is prevalent use of derogatory language, instances of discrimination, or even refusal of admission while dealing with queer healthcare users. This stems from existing biases as well as non-training on queer bodies. The result of these practices is poor health-seeking behaviour.

Horizontal reservation:

Horizontal reservation to ensure transgender representation among medical/nursing students and healthcare workers in the public sector, in compliance with the NALSA judgement.

"We direct the Centre and the State Governments to take steps to treat them as socially and educationally backward classes of citizens and extend all kinds of reservation in cases of admission in educational institutions and for public appointments."
—A.K.Sikri, J. NALSA v. UoI, Supreme Court of India

Modify medical curricula:

An expert committee consisting of queer and queer-affirmative medical professionals and educators should be set up to comprehensively analyse medical curricula followed in this country to address instances of stigmatisation, unnecessary pathologization, or inadequate emphasis pertaining to identities and healthcare of queer persons.

Sensitisation and training:

To ensure use of queer-affirmative language and practices for daily interactions, mandatory training and sensitisation sessions must be conducted regularly. These sessions must be led by queer folk to highlight lived experiences, and should be targeted at all hospital workers and community health workers. Other than focusing on queer-sensitive behaviour with patients, it should also focus on interactions and their families/friends/partners.

Key Takeaways

Discriminatory Practices In Healthcare

* Ban on different forms of conversion therapy through:
—separate law or
—under laws such as The Drugs and Magic Remedies (Objectionable Advertisements) Act, 1954 and The Mental Healthcare Act, 2016
* Making conversion therapy by healthcare workers part of professional misconduct as per the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002
* Orders banning medically unnecessary and non-consensual intersex surgery, along with guidelines on what constitutes 'medically necessary' or 'life-saving intersex surgeries'
* Terming unnecessary intersex surgery as professional misconduct as per the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002
* Ban on medically unnecessary intersex surgeries
* Removing the blanket ban on blood donations for transgender persons, men who have sex with men, and female sex workers
* Directions for enforcing the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017
* Directions to private insurance companies to amend their schemes and terms and conditions such that persons with HIV/AIDS are not automatically excluded from insurance benefits or made to pay higher premiums

Queer-inclusive healthcare

* Executive orders to all appropriate governments to comply with Section 15 of the Transgender Persons (Protection of Rights) Act, 2019
* Specific guidelines on and facilities for queer-affirmative care
* Expansion of benefits under central and state-level health insurance schemes to include forms of gender-affirming care
* Enabling nomination of representative of choice for healthcare decisions
* Modification of programmes under the National Mental Health Programme such as the RKSK to make sex education and counselling services at AFHCs queer-inclusive and queer-affirmative
* Directions to all healthcare establishments and medical practitioners to:
—include non-normative families within their understanding of 'family' or 'kin',
—put in place end-of-life care policies that are inclusive of non- normative partners and family/friends
* Queer-affirmative guidelines and sensitisation programs for mental health
* Focus on the health of queer persons in research guidelines of organisations such as ICMR

Dignity and privacy

* Training of grievance officers under the Information Technology (Intermediary Guidelines and Digital Media Ethics Code) Rules, 2021 on queer rights and identification of queerphobic content including hate speech
* Detailed investigation to explore possible harms to queer persons as a result of the existing scheme of the Digital Personal Data Protection Act 2023; exploring the need for measures to ensure privacy of queer persons

Systemic Measures in Healthcare

* Building queer-inclusive healthcare establishments to ensure easy access to healthcare at all levels
* Ensuring healthcare workers are queer-affirmative
* Modifying medical curricula to make it queer inclusive
* Clarifications regarding laws like the Medical Termination of Pregnancy Act, 1971 and the Assisted Reproductive Technology (Regulation) Act, 2021, and others to read them in a queer-inclusive manner

Glossary

Term	Definition
ASEXUAL PERSONS	A person with a complete or partial lack of sexual attraction or interest in sexual activity with others. Asexuality exists on a spectrum.
BINARY GENDER	The false concept that there are only two genders, namely man and woman.
BISEXUAL	A person emotionally, romantically or sexually attracted to more than one gender, though not necessarily simultaneously, or in the same way or to the same degree.
CIS-GENDER PERSON	A person whose gender identity corresponds with the sex assigned to them at birth.
CIS-NORMATIVE	The idea that everyone is cis-gender.
CIVIL UNION	A legally recognised union with rights similar to that of marriage.
GAY	A person who is emotionally, romantically or sexually attracted to members of the same gender.
GENDER	The socially constructed norms, behaviours and roles associated with being a woman, man, girl or boy, as well as relationships with each other. The law currently recognised three genders: man, woman, transgender.
GENDER AFFIRMING CARE	A range of social, psychological, behavioural or medical (including hormonal treatment or surgery) interventions designed to support and affirm an individual's gender identity.
GENDER IDENTITY	A person's subjective sense of their gender. This exists on a spectrum.

Term	Definition
HETERONORMATIVE	The idea that everyone is heterosexual.
HORIZONTAL RESERVATION	Derived from Article 15(3) of the Constitution, these are equal opportunities provided to other categories of beneficiaries, including women, transpersons, persons with disabilities, and cuts through vertical categories.
INTERSEX PERSONS	Persons who have innate sex characteristics that do not fit medical and social norms for female or male bodies.
LESBIAN	A person who experiences same-sex emotional, romantic or sexual attraction to non cis-male people.
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and other other allies that are not heterosexual or cis-gender.
QUEER	An umbrella term that includes persons who are not cis-gender or heterosexual. Queer & LGBTQIA+ have been used interchangeably in this series.
SEX	This is the biological difference on the basis of genetics, hormones, and genitalia. Traditionally, it has been assumed to be male and female, but also includes intersex persons.
SEXUAL ORIENTATION	A person's enduring physical, romantic and/or emotional attraction to members of particular sexes or genders.
SEX REASSIGNMENT SURGERY	A surgical procedure to align a person's physical characteristics with their identified gender.
TRANSGENDER PERSON	A person whose gender identity does not correspond with the sex assigned to them at birth.

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