Hegarty *et al. BMC Medical Ethics* (2025) 26:3
https://doi.org/10.1186/s12910-024-01134-9

BMC Medical Ethics

RESEARCH **Open Access**

Healthcare practitioners as accomplices: a qualitative study of gender affirmation in a context of ambiguous regulation in Indonesia

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Abstract

Background The World Professional Association for Transgender Health guidelines Standards of Care 8 draw on ethical arguments based on individual autonomy, to argue that healthcare and other professionals should be advocates for trans people. Such guidelines presume the presence of medical services for trans people and a degree of consensus on medical ethics. Very little is known, however, about the ethical challenges associated with both providing and accessing trans healthcare, including gender affirmation, in the Global South. In light of the challenges associated with medical and legal gender affirmation in Indonesia, we conducted a qualitative study to understand the views of trans people, healthcare providers, and legal practitioners.

Methods In this qualitative study, we drew on a participatory methodology to conduct 46 semi-structured interviews between October and December 2023, with trans people (10 trans feminine people and 10 trans masculine people, each interviewed twice) and key informants (three healthcare providers and three lawyers and paralegals). Trans people were a central part of the research team from inception through to analysis and writing. Participants were recruited via community-led sampling. Data analysis of interview data took place through an immersion/crystallisation technique and preliminary inductive coding which highlighted key quotes. We focused on an inductive analysis using participant narratives to identify key concepts in the ethics of gender affirmation in Indonesia.

Results We characterize the ethics of supportive healthcare workers, community members, and family members, as that akin to "accomplices," a concept of ethics used in theories of racial justice which evaluate a willingness to support people to navigate laws and regulations which perpetuate injustices and violence. Overall, both trans people and key informants shared an understanding that the legal status of gender-affirming medical care was particularly ambiguous in Indonesia due to a lack of clarity in both laws and regulations. For trans participants, ethical arguments for the validity of legal and medical gender affirmation was premised on evidence that their gender identity and expression was already recognized within society, even if limited to immediate friends and family. Given that all participants expressed a desire for gender affirmation, but such services were widely unavailable, accomplices played a crucial role in supporting trans people to access healthcare.

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Conclusions An empirical study based on an "ethics from below" helps to show that arguments grounded in autonomy, or based on biomedical evidence, are unlikely to alter unjust laws or facilitate a change to pathologizing guidelines governing understanding of trans people's healthcare and legal needs in Indonesia. We provide an analysis that is sensitive to the ethics of facilitating gender affirmation in a context where that process is inherently social, and often articulated in relation to a prevailing religious morality.

Keywords Gender affirmation, Ethics, Indonesia, Transgender people, Hormones, Surgery

Background

Over the past decade, scholars have documented the broad inequalities in health outcomes experienced by trans people, particularly trans feminine people in the Global South and in relation to HIV [1, 2]. Recent research has demonstrated positive health benefits associated with legal and medical gender affirmation for diverse populations [3–5]. Gender affirmation includes a range of medical, legal, social, and psychological services accessed by trans people to facilitate comfort in recognition of their gender identity [6]. Despite the historical codification of "gender identity disorder" as a diagnosis in the Global North and subsequent depathologization [7], in many parts of the world, trans people face ambiguous regulations and criminalization of practices associated with gender affirmation [8]. Although clinicians outside of the Global North may draw on international guidelines and national standards of care where they exist, in settings where access to healthcare is limited and national guidelines do not exist, healthcare providers and trans people are required to navigate significant ethical challenges to facilitate access to gender affirming services. These ethical challenges highlight the connection between the ordinary, everyday ways that people attempt to negotiate access to healthcare and broader forms of injustice, including state violence, neglect, and poverty [9, 10].

In recognition that trans is a "product of normal human variability" [11], ethicists have argued for gender affirming care based on the right to live with integrity [12] and the right to autonomy [13]. These arguments emerge from a historical backdrop in which medical professions have addressed trans people as requiring psychiatric assessment and treatment to ensure the validity of their claims [14]. As a result, recent approaches to trans health are guided by a commitment to *depathologization*, one goal of which is to reduce the need for a diagnosis to facilitate gender affirmation [15]. This view is reflected in the absence of a requirement for a psychiatric diagnosis according to the most recent World Professional Association for Transgender Health (WPATH) Standards of Care, 8th Edition (SoC 8) [7]. Nevertheless, diagnostic categories have been retained because they serve a practical need of facilitating access to medical care and insurance [15]. "Gender dysphoria" is a category that requires clinically significant distress or impairment related to "gender incongruence" [16], which is an experience of incongruence between gender and assigned sex exacerbated in disapproving social settings [17]. According to current clinical guidelines, neither of these diagnostic categories are intended to reflect a pathology that is inherent to a person.

These shifts have been reflected in changes to medical practitioners' role in gender affirmation, from that of a gatekeeper to the role of a facilitator. Such a model is reflected in "informed consent" guidelines for gender-affirming care, which emphasizes that trans people should be the primary decision-makers with respect to the treatment that they would like to access [18, 19]. WPATH SoC 8 guidelines now include a broader recommendation that healthcare providers and others involved in gender affirmation, "support and advocate for clients within their families and communities (schools, workplaces, and other settings) where appropriate" [7]. Under such conditions, WPATH guidelines suggest that clinicians take the role of advocates and supportive allies who respect peoples' self-knowledge about their gender, assisting patients and carers to make decisions in their best interests.

As this brief overview of the field of transgender health suggests, understandings of gender affirmation are overwhelmingly based on data about trans people in and debated by scholars and activists in the Global North. This remains the case, particularly in the ethics of gender affirmation, despite calls to "decolonize transgender" [20], which echoes longstanding anthropological research about the limitations of the use of the category transgender in a universalizing way [21–23]. Decolonization is a critical component of advancing trans health equity, given that pathologizing psychiatric and medical models originally developed in the United States of America were imported into many Global South settings as "best practice" [24]. This historical legacy of the pathologization of trans people within medicine and the law in the Global North, partially spread through processes of colonization, makes it difficult for many trans people in the Global South to access medical and legal gender affirmation [11, 25, 26]. For this and other reasons, the evolving ethics of gender-affirmation in the Global North are frequently not aligned with realities for trans people within the Global South [8].[1]

This article describes ethical challenges related to gender affirmation for trans people and healthcare providers in Indonesia as a way to understand the broader possibilities of research on the ethics of gender affirmation in the Global South. Studies conducted in the Global North have largely focused on ethical arguments in terms of autonomy [28], often neglecting structural concerns [29]. As Black and Indigenous trans scholars have highlighted [30], trans health equity, including gender affirmation, must also investigate inequality on the basis of race, class, ability, and citizenship status [31]. We draw on the results of a qualitative study conducted in Indonesia to develop an ethics of gender affirmation "from below" [10]. This approach builds on dialogic forms of empirical ethics [32], which aim to stimulate input and exchange on ethics from perspectives often marginalized from the decision-making process [33]. Based on this evidence, we identify how clinicians and legal practitioners act with an ethical disposition as accomplices, aiding people to negotiate ambiguous regulations and criminalization, to access gender affirmation.

We develop this argument based on a qualitative study of the experiences of trans people's access to medical and legal gender affirmation in Indonesia. When referring to our participants, we have used the terms trans feminine (assigned male at birth, who identified and expressed themselves as trans woman, *transpuan*, or woman) and trans masculine (*trans laki-laki*, *transpria*, trans man, or man). Trans terminology in Indonesia is complex and subject to change, but referring to participants using the broad categories *trans masculine* and *trans feminine* allows for us to preserve important differences that were expressed by participants recruited to the study. While we did not deliberately use the terms trans masculine and trans feminine at the recruitment or data collection phrase, it also reflects the limitation that no people who identified as non-binary were recruited to the study. In Indonesia, legal and medical gender affirmation for trans people is made difficult by vague and inconsistently applied regulations [34]. In this paper, we include the voices of both trans people and clinicians. The study aims to contribute to (1) a better understanding of the ethics of legal and medical gender affirmation in the Global South, (2) record how trans people and healthcare providers navigate ethical challenges in the provision of gender affirming care where regulations are ambiguous, (3) understand barriers to gender affirming care in light of shifting global guidelines [7, 35] and, (4) reflect the role for medical practitioners in gender-affirming care under such conditions.

Study policy and cultural context

Throughout Indonesia, regulations and guidelines pertaining to accessing medical and legal gender affirmation are highly ambiguous. A court case is required for the most common forms of gender affirmation sought by trans people, including name alteration and change of sex marker [34]. Present Indonesian medical guidelines, established in the 1970s with reference to the clinical management of what was then referred to as transsexuality, have since the 1990s been reinterpreted as relevant only to intersex people [36]. However, the ambiguity of these guidelines means that trans people can access hormone replacement therapy following a diagnosis similar to gender dysphoria in a limited number of major tertiary hospitals [24]. The Indonesian Psychiatric Association has previously stated that its position is that a diagnosis of "transsexuality" equates to a mental illness, adopting a stigmatizing definition of trans identity and gender affirmation that has been criticized by both the American Psychiatric Society [37] and Indonesian trans activists, for the reasons that it both pathologizes trans people and restricts access to important health and legal services [23].

In August 2023, the Indonesian government passed a new Health Law (*Undang-Undang Kesehatan Number 17 2023*), which includes passages which appear to be designed to limit access to gender-affirming care. Although trans people are not mentioned explicitly in the Health Law, Article 87, Section 2 includes a passage which restricts plastic and reconstructive surgery related to changing appearances in any way (described in terms of preventing fraud), including procedures which are intended to change a person's sex [38]. Gender affirmation through the legal system (i.e. change of name or sex marker on identity documents) is routinely sought, but whether or not it is granted depends on the judge in a particular case, and trans people face routine forms of discrimination [34]. Conservative religious groups in Indonesia have opposed the expansion of Lesbian, Gay, Bisexual and Transgender (LGBT) rights over the past decade, one consequence of which has been growing opposition to the legal or social recognition of trans people [23]. The majority of trans people in Indonesia live without accessing medical or legal gender affirmation through formal state institutions, reflecting forms of social recognition that have developed in the context of the historical acceptance of trans people [39, 40].

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[1] Global North and Global South are categories used to generalize power imbalances in the production of knowledge and in equitable access to health [27], relevant to understanding the economic and political dominance of the United States of America, the United Kingdom, Canada, and Australia, including in the field of trans health [8].

Methods

We conducted a qualitative, interview-based study which explored the experiences of accessing legal and medical gender affirmation among trans people and accomplices who supported them to do so (supplementary file 1, 2). We decided on an interview-based qualitative methodology, given the paucity of information about the Indonesian setting and community-based forms of knowledge in a context of criminalization and ambiguous regulation. This facilitated a depth of insight into populations which are often hidden and hard to reach, and allowed us to value community knowledge by involving participants in discussions about the problems that affected them [41].

Design

We conducted this study in Jakarta, the capital city of Indonesia with an estimated population of approximately 11 million people. Jakarta was selected as it is Indonesia's largest city, a location where trans people migrate to within Indonesia, and reflects a context where access to gender and legal gender affirmation is widespread. The study used a participatory, qualitative methodology, and included trans researchers and community members at all stages, from study design to analysis and dissemination. The inclusion of trans members of the research team was crucial to the analytical insights revealed [42]. The study was conducted in collaboration with a national transgender network, which nominated a community researcher to be included as an investigator on the research team. To avoid reproducing unequal power dynamics between community and researchers in participatory research [43], the community researcher was paid at the rate of a qualified Indonesian researcher, and participated in all aspects of the research process, from research design onwards. Ethics approval was received from Atma Jaya Catholic University (0007 W/III/PPPE. PM.10.05/08/2023) and UNSW Sydney (HC230454), and ethics approval and a research permit for the lead Australian investigator was obtained from BRIN, the Indonesian National Research and Innovation Agency (613/SIP/IV/FR/10/2023).

An Indonesian-language interview schedule was designed by the research team, with two interviews conducted with each trans participant ($n = 20$). This method of interviewing each trans participant twice allowed time for the person to reflect on the first interview, and offered an opportunity to invite participants to elaborate further on key points of interest [44]. It also facilitated rapport, crucial to in-depth, quality insights in qualitative research [45]. One interview was conducted with each key informant ($n = 6$). We conducted all interviews in Indonesian using Zoom videoconferencing software, and were recorded, transcribed and deidentified. Analysis was conducted by members of the research team who are fluent in Indonesian language, with only key quotes translated into English for this article. Members of the research team who were native Indonesian language speakers checked the English-language translations for accuracy and nuance. Following this, a summary document was created and presented to all trans interview participants at a face-to-face workshop, who provided feedback and guidance on the preliminary analysis and presentation of results. A summary of the research in Indonesian was sent to all participants, who provided input which helped to guide the analysis and interpretation of data.

Participants

For this study, we drew on a purposive method to recruit participants [46]. Participants recruited were (1) trans people (trans masculine and trans feminine people), and (2) healthcare practitioners and legal practitioners involved in the provision of gender-affirming services. Purposive sampling method was used in which trans members of the research team drafted an initial list of participants, and were sent information about the study. Prospective participants who expressed interest were sent a participant information sheet and informed consent form for their consideration. Trans participants were invited to identify their gender identity in an open field along with sex assigned at birth, in line with the two-step procedure [47], as well as in recognition of the wide range of categories used in Indonesia (Table 1). We conducted 40 interviews with 20 trans participants (i.e. two interviews with each) (*unpublished interview data*, *interview schedules available as* supplementary file 1, supplementary file 2). Broadly, we recruited two groups of participants: (1) $n = 10$ *trans feminine participants*, who identified as *transpuan* or *transgender perempuan* (Indonesian: woman), *woman*, *transgender woman* or *trans woman*, and; (2) $n = 10$ *trans masculine participants* who identified as *male*, *transpria*, *trans laki-laki*, (Indonesian: man) *transman*, *or transgender man*. No participants identified explicitly as non-binary. The age of trans participants was between 21 and 38 years, all but six had graduated from university, and all but two participants earned more than 4.9 million Indonesian rupiah (US$310) per month. In addition to trans participants, we also recruited key informants, with whom we conducted a one-off interview to better understand the processes associated with medical and legal gender affirmation. Using purposive sampling, drawing on the research team's networks, we recruited three healthcare providers and three people with experience providing support for legal gender affirmation ($n = 6$) (Table 2).

Analysis

Anonymized data included interview and workshop transcript and notes taken by one member of the research

Table 1 Demographic details of trans participants. Table of demographic details collected from transgender participants as part of the interview process. Results of the demographic survey from all trans participants, conducted at the beginning of the first interview, included in order to show participant characteristics.

Demographic detail	Number
Age	
20—24 years	4
25—29 years	4
30—35 years	10
Above 35 years	2
Sex assigned at birth	
Female	10
Male	10
Gender identity (open field)	
Trans feminine	
Transgender perempuan	6
Transpuan	1
Woman	1
Transgender woman	1
Transwoman	1
Trans masculine	
Man	1
Transpria	5
Transgender man	2
Transman	1
Translaki-laki	1
Education level	
Graduated from high school	6
Graduated from technical college	4
Graduated from undergraduate degree	8
Other (postgraduate degree)	2
Income	
Under 4.9 million Indonesian rupiah (IDR) (the Jakarta minimum wage in 2023 was 4.9 million IDR)	2
Above 4.9 million to less than 7 million IDR	8
Above 7 million to less than 9 million IDR	4
Above 9 million to less than 11 million IDR	2
Above 11 million IDR	4
Status of sex as listed on identity documents	
Changed	6
Plan to change	9
Unable to change	4
Do not want to change	1
Status of name as listed on identity documents	
Changed	6
Plan to change	9
Unable to change	2
Do not want to change	3
Access gender-affirming care in health facilities	
Yes	15
No	5
Access gender affirming care by self-administration	
Yes	16
No	4
Insurance	
Government health insurance	11
Private health insurance	1
Government and private health insurance	4
No health insurance	4

team immediately following interviews. We analyzed transcripts using a thematic analytic approach and immersion/crystallisation technique [48]. This involved all of the members of the research team who conducted the interviews reading back over the transcripts and interview notes, and discussing them in a series of online meetings to ensure immersion in the data. We created a flow chart of the processes involved in accessing gender affirmation in order to help guide this phase of the analysis. All data was uploaded to Dedoose 9.2.7 (Socio-Cultural Research) and coded according to an inductive coding schema, which preserved participants' own words and interpretations.

Ethical considerations

The participatory design of the project helped to address the primary ethical concern raised by this project: engaging trans people in meaningful discussion in a volatile and potentially hostile context. In line with important critiques of research about trans people that does not include trans people [49], including that which highlights the analytical strength of drawing on trans people's own lived experiences [42], the research was developed, designed, conducted and written with one trans investigator alongside non-transgender researchers with experience working with Indonesian trans communities. The recruitment of an additional trans community researcher in partnership with an Indonesian trans community organization without formal training further helped address the project's ethical questions. The guidance offered by participants conveyed that the research and dissemination of results abide by the principle of non-maleficence. As a result, we adjusted the ethics of "informed consent" in the project to extend to the ability to contribute to the way in which data was interpreted and analyzed; we achieved this by conducting a workshop and summary of findings to all transgender participants, and by providing the means by which they could address potentially harmful material uncovered in the findings.

Results

Both healthcare providers and trans people described a complex negotiation of ethical considerations. Among the clinicians who spoke to us, the decisions and wishes of trans patients were largely respected without question. This is likely due to a self-selection bias, in which those who are supportive of trans people are more likely

Table 2 Demographic details of key informants. Table of demographic details collected from key informants as part of the interview process. Results of a demographic survey from key informants, conducted at the beginning of the first interview, included in order to show participant characteristics. Includes data on age, gender identity, and occupation.

Demographic detail	Number
Age	
25—35 years	1
36—45 years	4
Above 46 years	1
Sex assigned at birth	
Female	2
Male	4
Gender identity (open field)	
Woman	2
Man	3
Feminine	1
Occupation	
Lawyer	3
Midwife	1
Doctor	2

to participate in a study about gender affirmation. In several cases, doctors described their role as facilitators, working with trans people to achieve their desired wishes with respect to their gender. A coding schema was developed and used to organise material into key domains in response to these questions, which can be characterized as follows: (1) *the impact of legal ambiguity and ethical concerns among clinicians on gender-affirming medical treatment*; (2) *legal ambiguity does not restrict healthcare providers and others to support trans people accessing gender-affirming care*; (3) *the ethics of requiring gender-affirming medical procedures to access name change and change of sex marker*. These domains arose in the context of ambiguous regulation and absence of clear guidelines for (1) clinical guidelines for the provision of affirming care for trans patients, and (2) legal certainty regarding gender affirmation, including name and sex marker listed on identity documents.

Within the trans participant group, there were also important distinctions between those who we identified as trans feminine and trans masculine participants. For trans masculine participants, it appeared to be easier to navigate access to hormone replacement therapy within the medical system, in more traditional pathways that typically started with a diagnosis of gender dysphoria from a psychiatrist. For reasons that were not entirely clear, this was not the case for trans feminine participants, the majority of whom purchased and administered hormones beyond the medical system. Both trans masculine and trans feminine participants spoke of the possibility of negotiating access to hormone replacement therapy and surgery through private healthcare providers, including overseas. For all participants, a key concern was cost, with economic class shaping both access and quality.

Ethical concerns among clinicians to provide gender-affirming medical care

Trans participants described challenges associated with finding clinicians willing to provide gender affirming medical care, including hormone replacement therapy and surgery. The main barrier to gender-affirming care was unclear regulations, with clinicians concerned about the risk of liability if they performed surgery or dispensed hormone replacement therapy. Several described how fear of litigation overshadowed patient wellbeing. One trans masculine participant who wished to have a hysterectomy, explained that their doctor sought advice from the hospital ethics committee:

> *At that time, [the doctor's] concern was legal, because they were afraid they would be sued by the family of patients … the doctor was between a yes and a no, they were waiting for confirmation from the legal team, but the … ethics committee [said no].* Lucky, man (trans masculine), interview 2.

Lucky explained that the requirement that he provide parental consent was because he was not married. In Indonesia, ethical arguments for gender affirmation grounded in individual autonomy are overshadowed by the wishes of family, but particularly parents, even when the trans person is an adult, and a fear of liability among clinicians.

Given a lack of clear referral pathways and the willingness of doctors, a psychiatric and psychological assessment was no guarantee of access to gender-affirming care. Joni noted that he experienced discrimination from a psychologist when seeking a referral to an endocrinologist to start hormone replacement therapy. The discrimination that he experienced meant that he was unable to obtain a referral. As a result, Joni purchased his own hormones, although this was not his first preference:

> *I asked a lot of friends online … [it is like] a support system [where] we shared information, so I said I wanted to access hormones, but I didn't know at all how to, and then they gave me advice, like a support system … Because it wasn't possible for me to go to a clinician … so in the end someone let me know, there are hormones sold freely for bodybuilding, they [bodybuilders] all use testosterone, in the end they let me know [what hormones to purchase].* Joni trans laki-laki (trans masculine), interview 1.

Joni explained that he had initially self-administered hormone replacement therapy and sought out laboratory tests required to check hormone levels through peer network or what he called a community "support system." Yet, Joni was not entirely satisfied with this, and eventually sought out gender-affirming medical treatment despite his previous experience of discrimination. Rather than a linear process tied to a diagnosis, several participants understood that consulting a psychiatrist and an endocrinologist or andrologist served the role of minimizing risks of harm associated with accessing hormone replacement therapy.

Other participants echoed Joni's sentiment that highlighted how even pathologizing forms of medical oversight provided some reassurance to trans people. Bambang explained that he had gone to a hospital, leading to moments of recognition and validation of their desires: "that time, I was scared, but then the admin person, they clocked it immediately that I wanted to transition to male … and then I was immediately directed to … a psychiatrist" (*Bambang, man (trans masculine), interview 2*). Wulan described how she felt that a psychiatric assessment could ensure that she was completely prepared and that she would not regret the surgery later (*Wulan, woman (trans feminine), interview 1*).

Some healthcare providers willing to provide gender-affirming care despite ambiguity

A lack of recognition of the autonomy of trans people and a fear of liability among clinicians made accessing gender-affirming care through the medical system challenging. Although the processes accessed by trans masculine and trans feminine participants differed in significant ways, hormone replacement therapy was frequently accessed via relationships with community networks and support:

> *Now, I … access hormone replacement therapy in clinics … in Jakarta there are actually clinics, not specialist clinics [for gender affirming care], but a clinic or a local health clinic, where they are willing to inject birth control for us, or want to inject hormones that friends have bought in Bangkok.* Rara, transpuan (trans feminine), interview 1.

Clinicians articulated a range of reasons justifying the provision of gender-affirming care. For one doctor, an ethical decision to provide hormone replacement therapy — with or without a psychiatric assessment — was described in terms of respect for patient autonomy. Edi asserted that gender dysphoria was not an illness, and so he was guided by the desires of his patients:

> *If it is concerning an illness, it will be different, if it is an illness I will be strict. [I will make] no compromises … you have to follow my orders. But if it is concerning everyday behavior that impacts your quality of life, we can talk about it [gender identity], now that is my experience … I look at a person as they are, I can help them as they are, whoever they are, whatever the origins …. I am just there to help, and I don't have a right to change it … after all, the patient already wants it.* Edi, doctor.

In order to support people's autonomy in a context where access was difficult, clinicians supported trans people to independently manage gender affirmation. One trans masculine person, Dony, explained the support he received from a doctor who taught him to purchase and inject his own hormone replacement therapy:

> *On the advice of Dr [name removed] actually, I must be able to do it myself. They said, this is something you will do your whole life, you can't depend on me, so they are the ones who taught me … That meant that, once I'm able to do it on my own, I can change the hormones that I use, I don't use the same medicine anymore. That's because, Dr [x] said, 'that medicine isn't available in Indonesia, so we have to … look online.'* Dony, trans laki-laki (trans masculine), interview 1.

In other cases, parents or friends — some of whom were trained medical professionals — helped trans people to inject hormones. The desire for this support complicated a straightforward understanding of ethical decisions that were based on individual autonomy or informed consent:

> *It [testosterone] is an intramuscular injection, right, so it is like a whole vial that needs to be injected into my muscle … in fact … my mother is a nurse, so … right at the beginning, I asked for her help, [and] after about four months I could inject myself … at the beginning she was still tentative [about it], sometimes she would do it, sometimes she wouldn't, but now she fully supports me. I didn't say much, just 'can you help me?' What was important was that she helped me.* Joni, trans laki laki (trans masculine), interview 1.

While not all trans people desired surgery, for some it was an important component of their gender affirmation. Given the lack of guidelines, for plastic surgeons and others supporting gender-affirming surgery, ethical decisions were driven by a need to obtain the trust and safety of the patient. Some healthcare practitioners facilitated access to the insurance system, by matching codes for trans patients with surgeries commonly accessed by non-trans people.

Role of social and religious authority in court cases seeking change of name and/or sex marker

While a majority of participants either had changed their sex marker ($n = 6$) or wished to do so ($n = 9$), others reported that they were unable ($n = 4$) or did not wish to do so ($n = 1$). This was similar for name change, with a greater number of participants reporting that they had changed ($n = 6$), or wished to change ($n = 9$), relative to those who were unable to change ($n = 2$) or did not wish to change it ($n = 1$). Some trans masculine participants described that their decision to undergo sugery, and particularly a hysterectomy, was guided by a wish to improve their chances of success when changing their legal sex marker. As Bambang explained: "one reason [is] for my health, but it [the hysterectomy] is also to provide additional evidence for the court" (*Bambang, man (trans masculine), interview 2*). Even though hormone replacement therapy was not required for a change of name, for example, trans people described that being on hormone replacement therapy did make it easier to convince a judge that they had made a demonstrable effort that was "worthy" of legal recognition.

In many cases, judges placed less weight on biomedical evidence than on the social recognition of an individual's gender. For example, this meant that judges often called upon figures with social authority, particularly religious experts, or at times ethical justifications grounded in their own social and religious beliefs, to assess trans participants requests for legal gender affirmation. One trans masculine person speculated that his petition to change his name and sex marker was refused due to the religious beliefs of the judge who had heard his case. As Lucky explained:

> *I went to the court to change my name and my sex marker, so two things, two separate things, but the court could hear them together … we went to the court in my area of residence … well I was assigned a very Christian judge, so the trial was all about Jesus, and in the end I was refused … and it was supposed to be the two … name and sex marker … in the end they didn't ask about my name.* Lucky, man (trans masculine), interview 2.

The participant recounted that the judge had conveyed that her decision was guided by her spirituality, and expressed that she had consulted a priest while deliberating on the case. The ethics of her decision were not, therefore, grounded in either respect for autonomy or medical evidence, but in her own religious beliefs.

In such cases, expert opinion held little meaning in the face of religious beliefs, which were considered more important in building an ethical argument to not provide legal gender affirmation. In this case, although the change of name should have been straightforward, it was denied on ethical grounds stemming from the judge's religious beliefs. The impact on Lucky's life was significant: given the importance of identity documents in securing housing or employment, they continued to face discrimination due to the disjuncture between appearances and their name and sex maker on identity documents.

Discussion

This qualitative study investigated the ethical challenges faced by trans people and healthcare providers in accessing gender affirmation in Indonesia. Based on the results of the study, we asked two questions: (1) *how do trans patients and clinicians articulate the ethics of gender affirmation where access is limited, and regulation is ambiguous?* (2) *where diagnosis is not available, what do trans people have to produce evidence of to achieve legal gender affirmation?* We described how these ethical challenges and understandings arise in a context where access to gender affirmation is difficult for reasons of inequality, ambiguous regulation, and emerging patterns of criminalization.

The ethics of being an accomplice has been discussed in arguments for racial justice, to characterize people who are characterized by their "refusal to cooperate with unjust laws" [50]. Based on the results of this study, we found that accomplices played a critical role in aiding trans people to access gender affirmation in Indonesia. The trans participants in our study overwhelmingly wanted to access legal and medical gender affirmation regardless of its regulatory or legal status. The many difficulties in accessing a diagnosis of gender dysphoria, and of accessing hormone replacement therapy and surgery through the medical system, resulted in a range of mostly informal and community assisted strategies to access gender affirmation. In the case of hormones, participants most often used self-administered hormones, as has been observed among trans masculine people in Peru [51] and among trans women in other parts of Asia [52].

Many discussions of the ethics of gender affirmation rest on the assumption of the primacy of individual autonomy to decide on appropriate froms of healthcare [6, 19, 53]. One such view of gender affirmation for trans people argues that, it is a "*vital … confirmation of their sense of self, a confirmation that they are being seen for who they are and are being treated as they wish to be treated*" [6]. However, both WPATH SoC 8 guidelines and informed consent are models of gender-affirming care that are unavailable to the majority of trans people globally, many of whom have very limited access to any form of healthcare at all [8]. Under such conditions, we argue that ethical arguments for gender affirmation can be guided by moral and ethical norms within a given society alongside available guidelines [54]. We suggest that limiting the focus on gender affirmation to a "sense of self" — common in the ethics of gender affirmation derived from Western contexts — marginalizes how gender affirmation is linked to concrete forms of social recognition [55]. These forms of social recognition have less to do with affirming a sense of self than they do affirming that self in the contexts where gender affirmation matters [3], which is particularly important in cases of acute vulnerability [26].

In Indonesia, trans people face extensive barriers to accessing medical and legal forms of gender affirmation. Our findings echo research elsewhere, that improved access to gender affirming care results in lower rates of suicidal ideation [56], that legal gender affirmation leads to an improved emotional state [3], and that gender-affirming HIV care results in improved testing and treatment outcomes [57]. In part, barriers to gender-affirming services are tied to the pathologization of treatment which can be traced to the importation of psychiatric and medical models of diagnosing and treating gender dysphoria developed in the United States of America and adopted in Indonesia in the 1970s [24]. Discussions about the ethics of gender affirmation in Indonesia are limited, taking place in a setting where national guidelines, laws, and regulations are ambiguous and access to even existing pathologizing models are being eroded [38]. These shifts do not stand alone, but are linked to a broader erosion of reproductive and sexual health and rights, particularly for women and young people [58, 59]. In Indonesia, ethical arguments for criminalizing trans people's access to gender-affirming care — similar to arguments for removing access to sexual and reproductive healthcare — are guided by morality linked to forms of Islamic and Christian religious authority.

Our data highlights that Indonesian trans people over eighteen years of age are usually required to produce evidence of parental consent to change their name or sex marker, or to undergo surgeries. In part this reflects the fact that the majority of trans people are unable to get married, in a context where marriage marks adult status in both social and legal terms. In the case of legal gender affirmation, routine requests for name change were routinely denied by judges. Ethical justifications provided to prohibit and restrict gender affirmation are similar to those used to justify limiting or criminalizing reproductive, sexual health, and abortion services, with significant health impacts on unmarried pregnant women and people [58, 59]. As is the case with reproductive and sexual health, this means that the ethics of gender affirmation are often ceded to the most conservative moral arguments, which generates significant health risks. Qualitative approaches to an "ethics from below" [10] can help to guide a discussion of the ethics of gender affirmation aligned with the Indonesian context. Like Nussbaum [60], supportive clinicians, judges, and family members all articulated that the desire for available forms of gender affirmation was worthy of respect, and that it had the potential to enhance trans people's dignity as they navigated social life. Trans participants also narrated that supportive clinicians and judges held the view, articulated in different ways, that gender affirmation would help trans people to live with integrity [12].

Under conditions of ambiguous regulation, clinicians were able to uphold an ethics of integrity by acting as "accomplices" to trans patients. For example, doctors working in state clinics leveraged the ambiguity of definitions of intersex and transsexuality as contained in Indonesian regulations, using it to facilitate access to hormone replacement therapy. Healthcare workers facilitated access to insurance payments by mapping surgeries onto those commonly accessed by non-transgender people. One participant described how a doctor had provided guidance on purchasing and injecting their own hormones. In some cases, parents also acted as accomplices, supporting their trans children to access gender affirmation in an unjust system. Echoing other understandings which argue that ethically guided forms of gender affirmation should incorporate counselling for the parents of transgender youth [61], there is an important need to understand the ethics of gender affirmation, which move beyond the individual as the locus of care. Understanding the ethics of clinicians and family members as accomplices, rather than only as advocates and allies [7], helps to understand the ethics of operating under the conditions of pathologization and discrimination experienced by increasing numbers of trans people around the world.

Limitations

This study has several limitations. First, the community-based sampling used by the researchers was essential to locating participants who had experience of gender affirmation in a context where such practices are stigmatized. Our participant group was made up of trans participants who identified in a range of ways, who we categorized broadly as trans masculine and trans feminine identities in dialogue with our participant group and trans researchers on the team.

Notably, although our research design allowed participants to select any gender identity they wished, none identified themselves as having a non-binary identity. Future studies could incorporate more explicit opportunities for understanding non-binary identities in the Indonesian context, including this population's experience of gender affirmation. The community-driven recruitment and sample size mean that the findings should be therefore interpreted carefully, as reflecting the characteristics of a small group of trans people. They should also be understood as biased towards the research team and local community organization's networks. Similarly, key informants were self-selecting, and therefore tended to reflect the ethical standpoint of those who supported the provision of gender-affirming care.

Second, the findings of this paper provide an in-depth view of highly variable conditions of gender affirmation in Indonesia, the majority of which take place outside of the medical system. Complementary studies are needed which focus specifically on several areas identified as important by this study, each of which follows a different set of ethical principles and challenges. This includes gender affirmation through state-run clinical settings, private clinics, clinics abroad, and self-administered hormones, including those that take place through community networks.

Conclusion

For a majority of trans people globally, gender affirming care as described in WPATH SoC 8 [7] is inaccessible, in that it is either unavailable or unaffordable. Even in the United States of America, diagnostic uncertainty surrounding "gender dysphoria" pervades clinical decision-making [62], and new laws introduced in several states seek to restrict social and medical gender affirmation on the basis of ethical arguments related to dignity, privacy, and parental rights [63]. Ethical arguments for gender affirmation, developed and debated in the Global North, have tended to emphasize the importance of authenticity and self-actualization as central to gender affirmation. An "ethics from below" reveals that such arguments hold little relevance when, "poverty, racism, and gender inequality come to constrain agency, the ability to make choices" [10]. Such constraints are compounded in the context of increasing hostility and emerging patterns of criminalization. Moreover, ethical arguments tend to focus squarely on secular philosophical concepts or scientific evidence, neglecting the central role of religious ethics to trans health in many parts of the world [22, 64]. Ethics that draws on qualitative data to develop theories aligned with the legal and social contexts that trans people live in, can serve as a useful guide for arguments for medical and legal gender-affirming care in the Global South.

Even as the Indonesian trans participants in our study did have constrained agency, they were also capable of articulating a desire for gender affirmation to live with dignity in society [60]. They desired social recognition and often sought it in a hostile legal and medical system. We found that trans people navigated available systems to affirm their gender, yet these were rarely articulated in terms of the realization of an individual self. Trans participants instead emphasized that legal and medical gender affirmation was important because it allowed them to be recognized by others. We also highlight that an "ethics from below" also encompasses healthcare providers and others who support those with constrained agency to navigate unjust systems. The ethics of gender affirmation under such conditions may take many forms, including being an accomplice, which means working within unjust systems to facilitate ways for trans people to live with dignity. This requires moving beyond diagnosis, but also decentering the role of the disciplines of medicine and the law in ethical decision-making. An ethics from below attentive to how gender affirmation is possible through recognition by others, can provide a perspective on the ethics of gender affirmation. An ethics of accomplices is particularly crucial in settings where trans people face unjust laws, and cannot be expected to act alone to access forms of gender affirmation, which are critical to living with dignity and integrity.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12910-024-01134-9.

Supplementary Material 1

Supplementary Material 2

Acknowledgements

We would like to gratefully acknowledge funding received from the 2023 Australian Human Rights Institute seed funding grant, and a 2023 Kirby Institute, UNSW Emerging Investigator Award. We would also like to thank the Indonesian National Transgender Network and most of all the participants in this study for sharing their valuable insights.

Author contributions

B.H. led the research, performed the initial analysis, and wrote the manuscript text. A.W., A.P.H. and K.M. contributed to research design and assisted with data collection, supported analysis, and provided comments on the first draft. A.P.H. prepared the tables. J.N., D.O., I.P. and A.K.H. provided assistance with research design, and provided comments on the first draft of the paper. All authors reviewed the final draft manuscript prior to submission.

Funding

Funding for this paper was received from the Australian Human Rights Institute's 2023 seed funding round.

Data availability

As qualitative data, as per research ethics approval received and the sensitive nature of the material, this research is not to be made available publicly. We have included the interview schedules (including all questions) as supplementary files to the manuscript.

Declarations

Ethics approval and consent to participate

This study was approved by the ethics committee of Atma Jaya Catholic University, Jakarta (0007 W/III/PPPE.PM.10.05/08/2023), the University of New South Wales Sydney (HC230454), and issued a National Research and Innovation Agency (BRIN) research permit (513/SIP/IV/FR/10/2023). After approval, the researcher sent these details to the Indonesian National Transgender Network, which shared these details internally for discussion, and a member of the organization nominated as the community researcher. In line with respondent-based sampling, prospective participants were nominated by the community researcher, who were then contacted by a research assistant. If participants expressed interest, informed consent guidelines and participant information sheet were shared. At the time of interview, these details were shared once more, and written voluntary informed consent for participation obtained. The research was carried out in accordance with relevant national and international guidelines for research involving human subjects.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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Received: 22 July 2024 / Accepted: 5 November 2024

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