

Reproductive Justice Beyond the Binary: A Comparative Review of Transgender People Across Two State Contexts

Kamalaveni

Associate Professor, Center for Women's Studies,
Pondicherry University, Puducherry
and

Singamala Neeladri

Research scholar, Centre for Women's Studies,
Pondicherry University, Puducherry

Abstract

The recognition of reproductive rights as human rights dates to the 1994 International Conference on Population and Development. The ICPD conference was a catalyst for shifts in both the health of developing nations and gender equity (UNFPA, 1995). Yet understanding, scholarship, and legal protections for reproductive justice of trans people in clinical and legal systems remain underexplored. Through a transnational analysis of Tamil Nadu, India, and Oregon, US, we offer an in-depth examination of claims-making around transgender reproductive health rights and justice. The paper discusses the application of the theory of reproductive justice, intersectionality, and critiques of cisnormativity within medical and legal institutions. This paper draws from a diverse array of interdisciplinary scholarship on fertility, contraception, abortion, pregnancy, and family building for transgender individuals. The finding indicates that though Oregon has adopted a rights-based model and service-based model for inclusion, as it is a welfare-based approach, Tamil Nadu still falls short; they are taking away the right to reproductive freedom of transgender individuals. In the present article, we argue that affirming legal rights without extending to reproductive inclusivity is an ongoing driver of systemic disengagement. The proposed research uses a mixed methodology that aims to look at the reproductive rights of transgender people in Tamil Nadu and Oregon. It calls for all-inclusive changes in health care education, laws, and policy to achieve true reproductive justice for transgender communities throughout diverse states.

Key Words: Transgender, Reproductive rights, Tamilnadu, and Oregon

Introduction

Transgender individuals whose gender identity does not align with their sex assigned at birth experience vastly higher levels of sexual violence, health problems, and discrimination from institutions. A survey of the world's most restrictive laws around reproductive health reveals that most continue to focus on cisgender women. This means that transgender women, transgender men, and nonbinary people are frequently shut out of services such as abortion, fertility preservation, pregnancy care, and adoption. (Sharanya Chowdury, 2022). This is

apparent in India's Medical Termination of Pregnancy Act of 1971, which explicitly uses the phrase "Women"; leaving out transgender individuals who might also require abortions. This paper will consider the reproductive health rights of transgender people in Tamil Nadu and Oregon as part of a comparison of how laws, healthcare structures, and public attitudes shape battles for reproductive justice. (Shalev, 1998).

Reproductive health should not be seen merely as a medical concern; it is about dignity, autonomy, and justice. The 1994 International Conference on Population and Development (ICPD) brought about a global revolution in the approach to reproductive rights. This was no longer just about medical care; it was about the freedom to choose when (or if) to have children, obtaining contraception and safe abortion, fertility treatments, and accurate information. (UNFPA, 1995). This was a door that opened for all women. They gained control, choices, and clarity. However, what about transgender individuals? Their needs are invisible in further laws, clinics and research. The underlying assumption is that reproductive capacity has to do with "women" only. This presents a large problem: Transgender women, transgender men, and nonbinary people — especially those with reproductive organs or who wish to have biological children — are excluded. The current system does not see or address their realities. Recent studies uniformly show transgender people experiencing higher levels of sexual violence, engagement in risky sexual behavior (STIs), reproductive coercion, and having a variety of barriers to fertility services. But their reproductive health care is still scattered and intermittent, trapped between permissive laws in some places, medical gatekeeping in others, and social stigma across the region. (Callander, 2019). This article advocates for transgender reproductive health and justice in two contexts: Tamil Nadu, India, and Oregon, USA. These sites provide a genuine point of comparison, as Tamil Nadu does so through state-sponsored welfare programmes within the context of a developing country and Oregon via rights-based legal protections in the context of Western liberal democracy. In contrasting the two, we can see how government obligations, medical authority, and cultural norms either enable or restrict reproductive autonomy for transgender people.

Methodology

The proposed research uses mixed methodology that aims to look at the reproductive rights of transgender people in Tamil Nadu and Oregon.

Objectives

- To study transgender reproductive health and rights within the framework of reproductive justice.
- To understand the role of cisnormativity in shaping medical, legal, and institutional practices affecting transgender individuals
- To compare transgender people's reproductive healthcare systems in Tamil Nadu (India) and Oregon (USA).
- To identify structural barriers in access to fertility, contraception, abortion, and family-building services among transgender people through interviews.

- To evaluate the effectiveness of welfare-based versus rights-based approaches in ensuring reproductive justice and suggest policy and institutional reforms for inclusive reproductive healthcare systems.

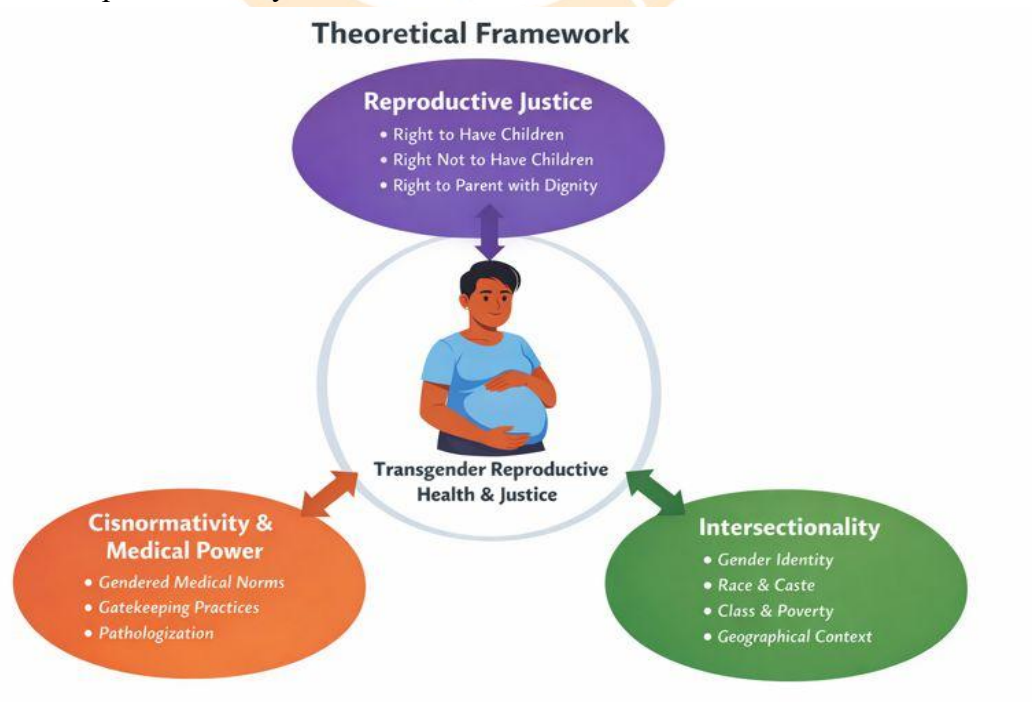
Theoretical Framework:

Reproductive Justice

This analysis is informed by reproductive justice theory. Not just of choice, but of reproductive health rights, investigating the social, political, and economic factors that mould genuine reproductive freedom. At its base, reproductive justice encompasses the right to have children, the right not to have children, and the right to parent in safe and sustainable communities (Eggers-Barison & Hayes, 2020)).

For transgender people, this perspective elucidates a crucial point: reproductive exclusion is not merely a medical issue. It’s about the right to make decisions over one’s own body, to receive gender-affirming and reproductive health care, and to create families instead of experiencing pressure or stigma. (Marinho, 2021). This work tells us that fertility, family planning and reproductive decision-making matter to transgender people. They also refute obsolete medical conceptions of transgender people as asexual or unable to parent. (Rodriguez-Wallberg, 2022). Weight of international evidence indicates that a large proportion of transgender people express the desire to begin or build their families, and most aspire for parenthood in later life despite significant obstacles (von Doussa 2015).

Figure 1. Conceptual Framework for Transgender Reproductive Health and ustice. Created using OpenAI’s DALL·E 3 (via ChatGPT), generated on [31/12/2025], and reviewed by the author for conceptual accuracy.



Cisnormativity and Medical Power

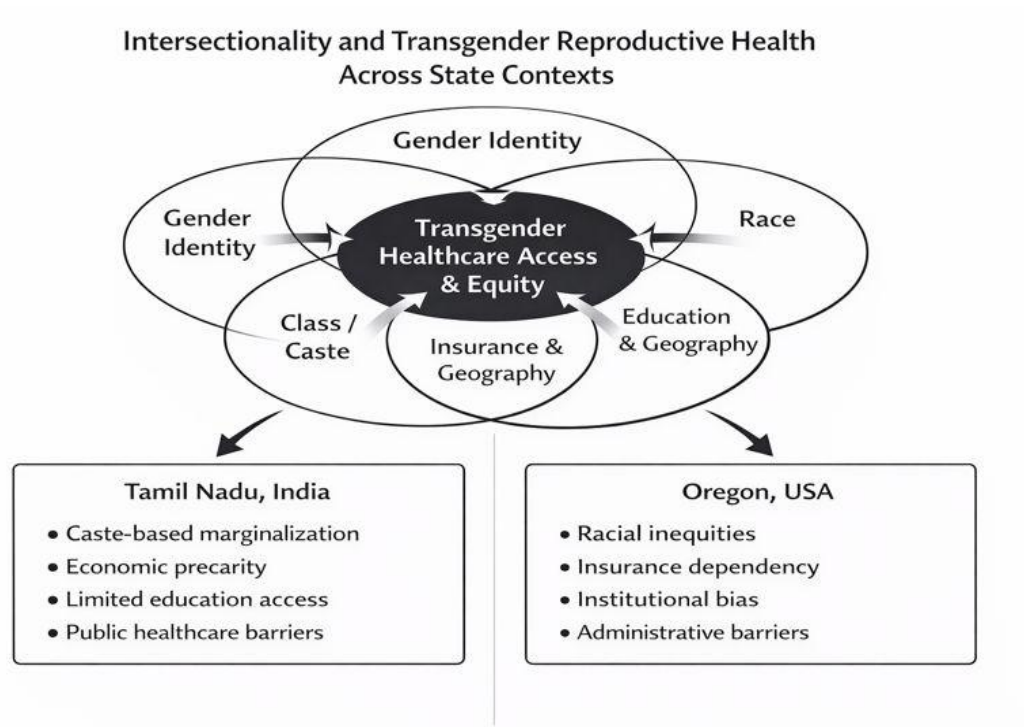
Cisnormativity codifies healthcare, and it affirms the body that is closest to binary sex categories, while reducing everyone else to the margins. The fundamentals of medical training, the treatments clinicians choose, and even how they go about diagnosing patients rely upon this idea that gender identity follows naturally from reproductive anatomy. To transgender people, this translates into bodies that are dismissed or viewed as problems to fix. Feminist scholars' discourse on Gender norms reveals that “let institutions regulate bodies, rob transgender people of reproductive autonomy and reduce them to biology,” (Theo Erbenius, 2018).

Intersectionality

The intersectionality of reproduction and gender is a major concern in transgender research. There are various research studies conducted on challenges and issues faced by transgender people in day-to-day life. Intersectionality is key to understanding transgender reproductive health. To understand transgender reproductive health, one needs to talk about all the intersecting parts. Human experience is not isolated: Our experiences are born of and mediated by a complex set of conditions that include gender identity but aren't limited to it (including class, caste, education, race, and even location). In Tamil Nadu, caste and class intersect with gender identity, so that poor transgender people are not only poorer compared to rich ones but also lack access to health care. For example, ten interviews were conducted with transgender individuals in Coimbatore in February 2023, which revealed some important findings. The transgender people interviewed belong to the socially and economically weaker class, and their education was up to schooling. The research showed that most of the transgender people end up in sex work due to social stigma and a lack of employment. Even to undertake surgeries, they end up taking jobs in the unorganized sector or sex work. The problem is that they don't get a job even in the unorganized sector when they reveal their gender identity. So they are pushed into sex work to meet the needs of their livelihoods. Amidst of this condition, all the transpeople interviewed like to have family and children of their own. Only three out of ten have undergone transition surgery, and those who underwent the transition surgery did not even know the information on their reproductive rights. Others were working and saving money to take up the surgery. They also revealed that in the whole of Coimbatore, there was only one doctor who performs transition surgery (Kamalaveni personal communication, February 2023). So, in Tamil Nadu, caste and class intersect with gender identity, so that poor transgender people are not only poorer compared to rich ones but also lack access to health care.

Oregon seems to have disparate legalisms. But that's not the end of it. Race, insurance, and systemic biases still dictate who can access proper reproductive health care. Look at the chart below that shows how many of these same things come together in shaping Transgender reproductive health in both Tamil Nadu and Oregon.

Fig 2: *Source: Author’s Own Conceptualisation; Figure Generated using AI-assisted Tools and refined by the Author*



Transgender Reproductive Health: Global Evidence

Transgender people around the world can experience serious challenges in accessing reproductive health. Evidence suggests there are many discrepancies in access to fertility preservation, contraception counselling, pregnancy care, and lactation support. For example, transgender men may feel invisible or isolated when they become pregnant; pregnancy care tends to be a very gendered service, not designed for them. This is a deeply painful experience. Meanwhile, transgender women have two of their own obstacles to overcome. Many are unable to access fertility preservation prior to beginning gender affirming treatment and face impossible barriers at this critical time. Australian research shows that transgender women are more likely to contract STIs than cisgender heterosexual groups (Sari L Reisner Jaclyn M White, 2014). Although there are similar health concerns that transgender men face, they have a harder time getting the screening that they need (Callander, 2019). This pattern is replicated in Europe and North America, where transgender men often experience invisibility and discrimination in pregnancy and perinatal care, as a result of the medical clinics and hospitals are organized along fixed, cisnormative lines of gender (MacLean, 2021). If the assumption made by most clinicians is that every patient is cisgender, transgender patients may not seek care at all, or if they do, may be discouraged to wait until they are in a greater level of distress. (Theo Erbenius, 2018). Health professionals see this, and many acknowledge that there is not sufficient education and institutional support for transgender patients. Many gynaecologists are willing to be of assistance, but most do not know how to provide the necessary cancer and

reproductive health screenings for transgender men. The holes are structural, and the time for change is now. (Unger, 2015).

Transgender Reproductive Health Evidence in India

The landmark NALSA judgement in 2014, recognising transgender people's rights, was the turning point in Indian society. The Transgender Persons (Protection of Rights) Act, 2019 was passed and was the first comprehensive law addressing transgender people's rights. This Act prohibits discrimination against a transgender person in areas such as access to education, employment, and healthcare. Tamil Nadu deserves a special mention in this regard, as it has proclaimed the creation of the Transgender Welfare Board and banned non-consensual surgeries on intersex infants. Yet laws around reproduction have fallen short. Even the Medical Termination of Pregnancy Act, 1971, still uses strictly gendered language. It restricts abortion access for "women," which would erase transgender men and non-binary individuals altogether.

The situation exposed in a study done in Tamil Nadu is terrifying. Transgender populations face serious social and economic challenges, including unemployment, homelessness, and participation in informal or highly stigmatized sectors of work, such as sex work. Reproductive rights are elusive, accurate information is hard to come by; medically-trained professionals are scarce, and public health institutions carry a deeply ingrained stigma. A part in which even gender-affirming surgeries, frequently labelled portentous of progression, can be difficult to access due to a lack of surgeons who possess the necessary skills. Transgender people in Tamil Nadu are generally regarded as beneficiaries of welfare policies rather than citizens with rights. Reproductive health is seldom talked about, and not infrequently folded in under general health care or surgical transition, which means that fertility preservation, contraception, pregnancy care, and family building remain incomplete. Critics say the act itself is a medical check. The certification process often regulates bodies and does not necessarily empower people. In the backdrop of Tamil Nadu leading the way with its Transgender Welfare Board, funding sex reassignment surgery, and banning non-consensual procedures for intersex children, a certain amount of the ongoing struggles cannot be swept under the carpet. (Knight, 2019). Studies and community stories show that joblessness, homelessness, and reliance on sex work persist because of relentless stigma. (Shalev, 1998). Access to reproductive health care remains extremely restricted, gender sensitive doctors are in short supply, fertility counselling before transition-related surgeries is not available, and community members are outside the framework of adoption or surrogacy. National policies and laws regarding adoption and surrogacy, such as the Central Adoption Resource Authority (CARA) and Surrogacy (Regulation) Act, still frame eligibility in only cisgender and heterosexual terms. This specifically excludes transgender people from legal pathways to parenthood. (Mukhuty, 2022).

Oregon, United States: Rights-Based Inclusion and Its Limits

Oregon, as a USA State implemented trans healthcare based on rights, not medicine. Oregon has a right to have gender-affirming care, contraception, and abortion; health insurance provides access to it (and more) if health plans must cover these services – insurance rules

ensure access to those specific services by double-requirements on health practitioners and related institutions (Rush, 2023). Most recently, lawmakers have taken this several steps further by requiring public universities and community colleges to provide emergency contraceptives and medical abortion at their student health centres. This is the state asserting itself, being proactive and changing the practical reality of what it means to access reproductive health (Brown, 2022). In the USA, academic research has made real progress in having clinical guidelines acknowledge transgender reproductive health through inclusion of fertility preservation, contraception, and pregnancy care for transgender men (Alexis Light, 2018). However, many of the obstacles remain as transgender people are still discriminated against in implicit ways, healthcare providers are not prepared, and thick bureaucratic barriers to access are presented to them when they attempt to access health services (Besse, 2020). These persistent barriers underscore the importance of an intersectional approach. So Oregon illustrates what happens when legal structures underwrite rights with actual practices. While change is possible, the reproductive work that remains far from over (Morison 2021). “We’re hopeful it will be an effort that will need to continue, but we see the progress going in the right direction,” Nudo said. Ultimately, institutions still have a long way to go in dismantling those deeply embedded cisnormative practices if inclusive health care is truly going to be achieved.

Comparative Analysis: State Responsibility and Reproductive Justice

Comparing Tamil Nadu and Oregon gives us two alternative faces of government. Tamil Nadu is welfarist, but with medically restrictive recognition and social protection without reproductive recognition? Oregon has a rights-based, service-focused methodology that links reproductive health with other gender-justice issues. However, both places face many of the same challenges, and medical education is still cisnormative, while their inclusive laws on reproduction and the transgender reproductive experience remain unvoiced (Liam Gary Arnull, 2021). Legal recognition or some welfare allowances aren’t enough to ensure reproductive justice. Healthcare delivery reform, legal language, and professional education are necessary (Seiger et al., 2024). In both sites, cisnormativity is a barrier for transgender individuals. Today, medical schools still teach almost exclusively about bodies that can be classified male or female, and most people tend to think of reproductive health as an issue relevant only to those who were assigned female at birth. (Julia D Sbragia, 2020)

There is a large experiential gap in the experiences of transgender people, particularly outside the West, and addressing that gap only happens when one opens people’s real lives, which in turn leads to better policy development (Rob Stephenson, 2017). Without the availability of transgender- inclusive curriculum, people don't seek out care and do not access healthcare at all. The absence of good data, policies, and research relegates transgender lives to the periphery (Gatos, 2018).

Discussion

Although there is an increasing body of scholarship, relatively little is known about the lived reproductive experiences of transgender individuals, especially in the global south (Lunde et al 2021). The majority of research is centred on sexual health risk as opposed to reproductive

aspirations, family building, and parenting experiences (von Doussa, 2015). Community-driven, qualitative, and intersectional research is urgently needed to support socially inclusive policy and practice (Rob Stephenson, 2017). This demonstrates that TRRE is a structurally inevitable consequence of the way in which states think about gender, reproductive rights, and citizenship. Gendered legal language and a welfare-oriented approach restrict reproductive rights in Tamil Nadu. In Oregon, while legal rights to reproductive justice exist, institutional hardening and cultural norms complicate its achievement.

Conclusion and Policy Implications

Transgender persons should be considered full reproductive beings, not bodies to be disciplined and corrected as such. Realizing reproductive justice will be dependent on non-discriminatory legislation, trans-specific clinical guidelines, widespread provider education, and extensive community participation in the development of policies. This article discusses how reproductive justice for trans people is not simply a matter of recognition but of structural change in healthcare, law, and education. Comparison with other studies from Tamil Nadu and Oregon allows us to consider the role rights-based strategies, gender-affirming health care practices and legal definitions of family and reproductive health play in shaping this context. Centring the voices of transgender people in research and policy is important to moving reproductive justice from a concept to a lived experience.

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