DEMYSTIFYING TRANSGENDER HEALTHCARE: ADDRESSING THE FELT NEED

Editorial Team

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ATHI in Collaboration with
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व पृथ्वी विज्ञान मंत्री, भारत सरकार
Union Minister for Health & Family Welfare, Science & Technology and Earth Sciences Government of India

MESSAGE

I am pleased to know that Jamia Hamdard in collaboration with Association for Transgender Health in India is organizing the first International Conference on Transgender Healthcare with the theme "Demystifying Transgender Healthcare: Addressing the felt need" from 1st to 2nd November 2019 at New Delhi.

2. I applaud Jamia for having taken the lead to fill the gaps and formalize the primary, secondary and tertiary aspects of Transgender Healthcare in the country by collaborating with the Association for Transgender Health. I am sure this conference will help in kick-starting the much needed debate and providing an opportunity for the professionals from various specialties, working in the field of Transgender Health, to not only interact with each other, but also communicate with members of the community, caregivers, students and scholars to assess their needs. I am certain that the deliberations on the existing protocols and prevalent standards of care, in the backdrop of the Indian culture shall lay the foundation for formulation of first "Indian Standards of Care in Transgender Health" and provide the benchmark for delivery of Transgender Healthcare to be emulated by others.

3. I congratulate the organizers and the participants of the Conference and extend my best wishes for its success.

(Dr. Harsh Vardhan)

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Vice Chancellor

October 22, 2019

MESSAGE

It gives me immense pleasure that Jamia Hamdard has taken the lead to fill the gaps and formalize the primary, secondary and tertiary aspects of Transgender Healthcare in the country by collaborating with the "Association for Transgender Health in India". The hosting of the first International conference on Transgender Healthcare with the theme of "Demystifying Transgender Healthcare: Addressing the felt need" on 1st and 2nd November 2019 will be the step in this direction. This conference will be the first of its kind in the country, kickstarting the much needed debate and providing an opportunity for the professionals from various specialties, working in the field of Transgender Health, to not only interact with each other, but also communicate with members of the community, caregivers, students and scholars to assess their felt needs.

I commend the organisers for adopting a holistic approach. I am pleased to note that the organizers while planning the sessions have ensured that not only are the medical aspects covered, but the social and legal experts area also given a platform to express their view by sharing their professional experiences through presentation of scientific papers, poster presentations and panel discussions. I am certain that the deliberations on the existing protocols and prevalent standards of care in the backdrop of the Indian culture shall lay the foundation for formulation of the first "Indian Standards of Care in Transgender Health" and provide the benchmark for delivery of Transgender Healthcare to be emulated by others.

I wish the organizers all the best in their endeavour.

Seyed E. Hasnain

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22nd October 2019

MESSAGE

I am very pleased to know that the Department of Healthcare Management under the School of Management and Business Studies (SMBS) and Hamdard Institute of Medical Sciences and Research (HIMSR) in collaboration with Association for Transgender Health in India is hosting the first International Conference on Transgender Healthcare with the theme of "*Demystifying Transgender Healthcare: Addressing the Felt Need*" on 1st and 2nd November, 2019. This conference will be the first of its kind in the country, kick-starting the much needed debate and providing an opportunity for the professionals from various specialties, working in the field of Transgender Health, to not only interact with each other, but also communicate with members of the community, caregivers, students and scholars to assess their felt needs.

I am pleased to note that this two days conference not only covers the medical aspects but also the social and legal requirements. The experts in these fields have also been provided a platform to express their view by sharing their professional experiences in the form of scientific papers, poster presentations and panel discussions.

I wish the organizers all the best in their endeavours.

(Dr. Ahmed Kamal)

Preface

There can be no pain greater than the ache of knowing that your child, your bundle of joy, hope, aspiration and desire, is unhappy, scared and driven to a point where they no longer perceive home to be a place synonymous with comfort, warmth and love. They doubt, that you, their parent, would unlike the ones they have been hearing about, comprehend and accept their reality. That you, the parent, would choose to stand rock solid by their sides and not abandon them, buckling under the pressures of a prejudiced society denying them a life of dignity. That they, would not suffer the same fate, as that of the similar less privileged children, who are ostracized and consigned to abuse. Well, though this narrative began as a personal journey of bringing up a Transgender child, it is not about the courage exhibited by a person trying to come to terms with establishing their gender identity in the face of adversity. It is about the need to address the gaps present in 'care' for a marginalized subset of society. It is about reinstatement of rights and privileges as bestowed to every citizen by the constitution. It is about ensuring that no child or parent is ever in a situation wherein they need to undergo this pain. It is about providing a nurturing environment to every human form enabling them to achieve their full potential and become productive citizens of the Nation.

'Gender Incongruence' has been introduced as a condition under 'Conditions related to Sexual Health' in the latest International Classification of Diseases, ICD-11, releasedby the World Health Organization on 18th June 2018. This step, which undoubtedly reflects the progressive mindset of the Medical Fraternity, will

go down in the annals of history of Modern Medicine as the turning point whence forth the existence of the Gender Spectrum has been validated and a platform prepared for addressing the issues arising out of nonconformity to the populist binary view of gender held by the society at large without the attached stigma of Mental Illness. Though a debate on the appropriateness of the label of Gender Incongruence continues to rage among the academicians and a number of other wrinkles also need to be ironed out, it is nevertheless a positive step towards delivery of Healthcare to this marginalized and oft neglected subset of society. Another significant step is the complete removal of Homosexuality from the ICD 11 which validates the current scientific stand that 'Sexual orientation' is a matter of personal choice and not a medical issue.

'Gender' is the pedestal on which the construct of 'I' or 'Self' stands. It is the foundation of 'Identity', what one sees oneself as and what one desires to project to the environment irrespective of the genotype inherited or phenotype exhibited. Gender and Sexuality are recognised as separate entities and are definitely not binary. Gender, we now know with certainty, is hardwired. It is a multifaceted spectrum manifested by the self- assigned role and expression which cannot be limited to Male or Female.

Gender identification is not only the stepping stone for psychosocial development but also serves as the basis for sexual orientation. Gender recognition, though starting very early in childhood, may remain fluid through a large portion of the growing years before gender affirmation finally crystallizes. This fluidity in some cases may extend right through adolescence into adulthood. A conflict arising as a result of incongruity between assigned sex and desired gender leads to dysphoria and non-resolution may distort psychosocial development, thereby manifesting as deviant behaviour, delinquency, mental ill-health, high risk behaviour and conditions related to sexual health. This is further compounded by the insensitive callous attitude of the cisgender majority looking at them through the narrow prism of their own preconceived notions, perpetuating an environment of mistrust and intolerance

and threat of ostracization, thus forcing the gender incongruent child/adolescent to solicit advice through the unmonitored electronic media exposing themselves to further harm at the hands of unscrupulous professionals who peddle street hormones and offer unscientific 'quick fix' treatments as cures for their malady. Abandonment by family and society forces them into fostering abusive relationships and associations.

It has been documented that early recognition of gender incongruity, provisioning of a gender sensitive environment for psychosocial development and early access to Healthcare services when coupled with social support, especially acceptance by parents, markedly reduces dysphoria, incidence of mental illness, risk taking behaviour and sexual health issues. Hence it is of paramount importance that a multipronged proactive approach be adopted for the management of gender incongruence. The stakeholders need to acquire and share knowledge, facilitate delivery of multispecialty Healthcare, empower through advocacy and implement strong legislation for getting these outliers of society into the mainstream.

Primary care givers, especially Paediatricians, who already had the onerous task of wearing the hats of first responders, guide and confidants for parents and care givers alike, in light of the current scientific evidence legitimized by the ICD 11, now need to step into the shoes of leader and coordinator of the multi professional team required for effective management ofgender incongruence by becoming partners in execution of a task which till date had been the exclusive responsibility of the mental health professionals. In the current scenario the Primary care providers not only need to be well versant with the current Standards of Care(SOC-7) published by the World Professional Association for Transgender Health (WPATH) but also actively participate in the ongoing efforts being made for revision of the standards and formulation of SOC-8 by WPATH.

The changing social environment and diffusion of cultural boundaries, dictates that more India centric studies are undertaken in order to ensure that our children get the maximum benefit of

global best practices in vogue. A thorough knowledge of the normal Gender development and the 'Red Flags' coupled with an clear understanding of the varied aspects of the spectrum of gender identity and sexual orientation are prerequisites for accurately recording and monitoring the psychosocial development encompassing issues related to both gender and sexuality, along with the motor, sensory and social development during each routine well baby clinic visit.

The onus of educating the parent and tactfully garnering social support lies with the first responder who more often than not is either an aware paediatrician or a trained school teacher. School teachers especially pre-primary and primary school teachers need to be gender sensitive and be trained to identify the child under her care who is struggling with issues arising out of nonconformity to assigned sex. Often these children are bullied and may either become withdrawn or express aggression as a result of not being able to fit in or show desire to participate in the perceived gender appropriate activities. Poor scholastic achievement may be wrongly ascribed to learning disability instead of gender incongruence. The converse situation of ignoring the Red Flags simply because the child may be performing very well academically will be more damaging as the shining report cards may mask the turmoil of the child.

Teachers especiallypre-primary and primary need to talk about psychosocial milestones in addition to the academic performance during parent teacher interactions. The parent should be provided resources for bringing up a Transgender child.The school counsellor should ensure that the school administration is advised regarding maintenance of a gender friendly environment. Gender sensitive public utilities and separate toilets should be the norm for all schools and institutions. School committees for prevention of bullying and mechanisms for redressal of grievances, with primary care providers and school counsellor as members, should be available and accessible to the child. Respect for privacy and maintaining of anonymity is a legal requirement. Assigning of gender on school leaving certificates needs to be done based on

the gender that the child identifies with and not solely based on the assigned sex. The school needs to encourage gender inclusiveness and be the beacon for shaping societal acceptance of gender variance thus allowing the child to attain their full potential and enjoy equal rights as bestowed by the constitution.

Conflict due to non-confirmation to societal norms forces a large number of Gender Incongruent children to leave the security of their homes. A large number of transgender percolate towards flesh trade, experiment with drugs and indulge in anti-social activities. Incidence of sexually transmitted diseases and drug abuse related issues is found to be very high amongst this subset. This mandates surveillance and provisioning of specialized health care. Lack of sustainable employment or steady jobs limits their ability to seek appropriate Medicare. Hence it is important that policies be formulated by the government to ensure that the special needs of these communities are addressed.

The landmark NALSA Judgement of the Supreme Court in 2014,recognizing the individual's right forself- affirmation of gender and the abolishment of the draconian colonial lawSection 377 of the Indian Penal Courtwhich criminalized consensual intercourse with partners of the same sex,on 6th September 2018 indicates the evolving and progressive mindset of society. The stage is now set for more and more persons, who were till now hiding in the closet, to step out and demand equity. The number of non-conforming persons seeking healthcare has increased exponentially, mimicking the figures being quoted in the western literature. The hitherto unseen gaps in Transgender Healthcare have become unmasked. The matters are made worse by the lack of data and research not being in sync with the felt need of the community. The Medical and paramedical staff is found wanting in both gender education and medical training and the Medical Establishments fail to provide Gender friendly Healthcare. The resultant rise in the percentage of persons being denied the basic human right of right to life and dignity is alarming.

There is no study which gives the prevalence of Gender Incongruence in India. Even in the west there is no consensus as

to the true prevalence with estimates varying from 0.6% to 3.9%. Even if one mathematically extrapolates these figures to India, a country which houses approximately fifth of the world's population, we are faced with very large numbers who require special attention and care. Policy making necessitates that a realistic India specific survey be undertaken by gender sensitive professionals who would assure and ensure anonymity of the participants so as to arrive at the correct conclusions. In the interim we as a nation need toput our plans, policies and training programmes for the health professionals into place and allocate Health resources based on rough estimates extrapolated from the data available so that we are ready to implement the ICD-11 which will come into effect on 1st January 2022. More so since ICD coding is used not only by the national health programme managers and data collection specialists but also by health insurers. Management of Gender Incongruence is a costly affair and demands a coordinated effort from Medical and Paramedical professionals from varied fields of medicine, surgery and social sciences. Hence it is reiterated that the medical fraternity who has always been in the forefront for championing the cause of the marginalized and pioneered social change adopt a holistic approach in addressing Gender Incongruence.

It was this background which prompted likeminded professionals to get together and setup the "Association for Transgender Health in India (ATHI)", a not for profit section 8 company registered with Ministry of Corporate Affairs, Government of India with the aim to address the root of this Public Health issue and plug the lacunae in Transgender Healthcare. ATHI strives for inclusiveness through mental, physical, social and spiritual wellbeing. It envisions an inclusive society, whichcelebrates all hues and colours of gender expression, providing nurturing environments to all human forms helping them to attain full potential and live with dignity.

ATHI intends to work for the welfare of Transgender persons through its social arm KHEM by creating awareness in society and providing a platform for them to use their own skill sets,

lead a healthy and dignified life, provide evidence based care, education, research, advocacy, public policy, clinical and academic research, to bestow respect to transgender persons, provide free accessible, affordable Knowledge, Healthcare, Empowerment and Mainstreaming, undertake social welfare development activities, either directly or by supporting financially individually and otherwise through organizations to carry out the aforesaid activities for charitable purposes and not for profit for the transgender persons irrespective of caste, religion and gender expression and apply profits, if any or other income in promoting the objectives of the company through its professional arm IPATH (Indian professional Association for Transgender Health), provide a platform for professionals working in the field of Transgender Health to interact with each other, learn from their experiences, participate in research and development of evidence based practices, propagate and encourage the implementation of standards of care in delivery of Transgender Healthcare services both in the private and government sector in India.

As a first step towards achieving its goal, ATHI has collaborated with Jamia Hamdardto fill the gaps and formalize the primary, secondary and tertiary aspects of Transgender Healthcare in the country. It has kickstarted the much needed debate by hosting the first national conference on Transgender Healthcare with the theme of "Demystifying Transgender Healthcare: Addressing the felt need" on the 1st and 2nd of November 2019 at the Convention centre of Jamia Hamdard, New Delhi.

This book is an attempt to not only provide the reader an overview of the various aspects of Transgender Health covered in the conference but also serve as a ready reckoner for care givers.

Air Cmde (Dr) Sanjay Sharma (Retd)
CEO & Managing Director ATHI

Contents

1

Demystifying Gender

*Dr. Kavita Arora**

Gender experience and Gender Dysphoria

The ingredients of Identity

The entire premise of any 'identity', of saying and owning the spoken statement –"I am a ….." is about the felt and believed experience of the person.

For any part of our identity, for example- "I am a doctor/ singer/an Indian/daughter" the distinction and ownership is held firmly from within. Where and how do we acquire these convictions?

These ingredients are usually acquired parameters. As we grow up and understand our social context and place ourselves within it, we strive to acquire or we arrive at these parts of our identity. Once we are aware of the construct and context of the profession/ ability/ingredient of identity- we internalise it and own it. And then starts the seamless process of expressing it, getting validation for it, and acquiring more and more conviction to our own expression of these parts of our identity.

In essence, these convictions are not what is perceived by the observer, but the conviction with which the statement is owned by the speaker.

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The conviction of "I am .." is internal.

The statement made, or spoken aloud, is only to convey or express it to another. It is part of sharing and communication. The presence or absence of the spoken statement "I am a Doctor" does not make the experience any less or more real. If I choose not to intrduce myself as Dr. Kavita, it does not take away from me the truth of my identity as a Doctor.

While most people would agree with the above statement, for many ingredients of Identity, there seems to be a difference when it comes to Gender as a component. I have often tried to reflect on why that is so.

Who owns my gender?

Is gender truly assigned by another? Or is it mine to recognise and own for myself. Till quite recently, I would mostly meet families, as well as doctors, who would speak about the sex and the gender of any person as synonymous. Indeed, many trans individuals themselves would arrive confused about whether it was even possible to feel the way they did. They would often ask, "is it okay to feel like this?"

This is like asking – "if I am tasting a mango as sweet, or ice as cold, is it okay to experience that as sweet or cold?" How can anyone else validate the felt internal experience of an individual. Indeed, how can something felt and experienced as real, be anything but true to the individual.

The problem is not in the felt experience, which is as real as for anyone else. The problem is that it clashes with the "notional" and taught experience of boundaries and stereotypes. The binary gender stereotype. The "conform to belong" stereotype.

This is often the experience of many of the "trans" individuals I meet or have met. In my clinical knowledge and experience, from witnessing lived experiences of trans individuals, the difference between being assigned a gender at birth and arriving at the awareness of one's own gender identity, are two different processes. However, the difference seems to be available to only

those, for whom they have not been in sync. For the majority, these two processes occur simultaneously and in parallel.

How and when they express it, to themselves or to others is varied. However, the experience itself is real and felt deeply and held with conviction within.

Process of the assigned gender

A baby's cognition is not developed to understand the construct of "gender". A child has no apparent knowledge of their own gender. The assigned gender process is conducted by adults around them. This process is necessarily based on the presence of identifiable physical Characteristics primarily the external genitalia alone. No other characteristic is usually factored into the assigned gender of a child. This in itself defies the definition of gender. It relates to the concept of sex- NOT gender. However, for many decades these two concepts were seen as synonymous. In many minds, this is still so.

Arriving at the awareness of own gender

As children grow, we introduce them to the concept of gender. "*Boys do this, wear this, say this , play this… versus girls do something else.*" These gender stereotypes are narrated and omnipresent without the mindfulness of another possibility. Most children as they grow will try to adopt one of them and then only try to evaluate this experience within. They look for any examples around them, and sometimes try to conform to one or the other despite not being able to feel at peace within.

But internal experiences do not have comparisons. If the only way I have ever felt about being a girl is "uncomfortable"- how will I know whether every girl feels this way or not.

Some find out earlier that there is another quality to the experience, others will wait and internalise the experience without analysing it. Another subset might express it aloud without reservation, and yet another may be not attending to the gender construct at all at a particular age. The variety is immense and the journey is unique to each.

The experience of this journey is only truly felt by the individual. Regardless of its expression or communication to others, or its manifest, it can only be known by people who experience the difference between the two processes, and no one else. There is no scientific evidence available at this time that can attribute a 'trans identity/expression' to any other parameter. There is no known contribution of the 'biological sex' in the knowledge of one's gender. Indeed, the biological or assigned sex is mostly the cause of distress due to its mismatch with the felt and known gender.

The expression of gender identity to others

Many mental health professionals or families I meet, look for expressions of gender identity at various ages. Indeed, in my initial years at the gender clinic, this was the most meticulous part of the history taking that I would do.

Did this trans-individual ever dress or try to act like the desired gender. How and when did they first tell anyone about how they felt. Are they articulate enough to represent their inner world, and what does their inner world look like. How and what does the dysphoric element come from? Etc etc.

In that journey I learnt more and more, how diverse the expression could be. How each person on this journey was unique. I also came to understand that trying to prove to a stranger (in authority) that their internal world had "enough of the desired gender" was a task only a few could feel comfortable with. I grew to respect the confidence and courage it took to do this. I grew more and more humble when I witnessed the stories of strife, pain, utter terror, anxiety, despair and yet resilience and courage that I had the privilege to hear. And I also started wondering about how it ended up being such a lonesome journey for each and every one of them.

Who holds the distress and the dysphoria ? A systemic perspective.

In the Indian experience, the fear, the utter terror of being ousted or excluded from the community, the family, the school

seems to be often held alone by the trans individual. The experience of coming out, of telling anyone, is in itself one of the biggest distress creating milestones. In many individuals, it's a milestone that they have to work hard to achieve, with no certainty about the outcome or support thereafter.

Where, when, to whom and how – should I come out? Should I tell the employer? Should I tell my parents, or my friends first. Will it affect my sibling's "marriage worthiness"? Will my family lose face? Will I bring shame to my family? Will my parents survive this?

The distress of the parents, once they become aware, is yet another dysphoric element. Who handles that?

Who holds this anxiety? Who owns the dysphoria of the larger family that is now faced with the experience of "coming out" to the next circle of connectedness.

And so the journey progresses. With the trans- individual at the core. Navigating the systems of employment, religious community and the other threads of our social fabric. The eyes that look at them are many, some with curiosity, some wonder, some suspicion, and fear and often in derision or disbelief. The many versus the one. The many focused on one.

I ask you, the reader, who would not be distressed in such a situation? Who would not cower, be depressed, even hopeless when confronted with days, weeks, years of this?

The question that often arises in me is:

Is that the innate nature of the felt gender identity or is that the larger clash of the social construct and the marginalization of an uncertain minority by an unaware but self-certain majority.

As we grapple with this question, I would like to share with you a memory from many years ago that has stayed with me. In 2006, one of the first few individuals we worked with, at the Gender clinic, came from a village in rural Gujarat. M was about 21 years old, he had been living for many years as a boy, and the entire village had slowly accepted that she was not a female. He would be out late at night , as "boys" did, drove a two wheeler

and did monetary and business transactions for his family. This was all part of the "social construct of being a boy". He enjoyed this immensely and played it up whenever he could.

The distress and dysphoria of his early teen years had subsided after acceptance and claiming his own space within his community. After reading a newspaper article, he found his way to us in Delhi. He had not known that surgical intervention was possible or available. He went on to get his "sex reassignment surgery" done as it was then called. However, that is not the reason I speak of him.

What I still remember is my wonder at the wisdom his 78 year old father shared. He said in Hindi "Who am I to decide anyone's gender- when I have no knowledge of how even my own was decided. If this is the felt experience of my child, then the force greater than us must have been in play".

He also pointed out that the sensible choices M made in most of his life actions, made him believe that in essence the personhood was intact. If so, why should we question this fragment of the personhood. He was clear that he was not consulting me for any assessment or diagnosis, he knew what his child was. He was not "sick" or "disordered". All he wanted was to find out if indeed there was a way to help bridge the body appearance.

I would like to leave you, with the reflection of whether we are really speaking about an inherent neurobiological disorder in its entirety ? Or is there a valid case for looking at a subset of what we diagnose as Gender Dysphoria, as simply an "*underrecognised human diversity, superimposed by the clash of a strongly valued and held social construct – that of binary gender being the norm*."

What if we adopted the primarily valued identity of our shared humanity, above all the other ingredients and compartments.

What if we value above all the identity of "I am human". Would we still have the same frequency and intensity of Gender Dysphoria?

2

The Gender Debate: How Much Should we Let it Matter in Mental Health Delivery

*Dr. Deepa Tilak**

Traditionally there was Adam and Eve, believed to be happy in their skins. However, in the UK now, referrals to the Gender Clinic in London have increased manifold. Keeping up with this change, schools as part of Relationships and Sex Education teaching, are increasingly bringing awareness that people may be lesbian, gay, bisexual and transgender, that this should not only be respected in British society, but also that the law affords them and their relationships recognition and protection (acceptance and safety in personal choice). This teaching is to be made mandatory from September 2020.

Gender Dysphoria clinics have seen a 240% rise in referrals in the last 5 years. This together with not enough specialist clinicians, and GPs reluctant to prescribe hormone treatment, is leading to distress in the affected population seeking treatment, as well as for their parents, carers and schools.

Traditionally we have been recipients of the binary 'Gender Roles' ascribed to us. The man is the breadwinner and works to support the family, while the woman stays at home, looks after the family and of course bears children! This changed to a degree in the 60s with the advent of the contraceptive pills, which for

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the first time liberated women from pregnancy; a necessary and possible consequence of having sex. This in my view was a turning point affording women a sense of control, not just over their bodies but also their interests, ambitions and aspirations. Fast forward 60 years and the roles are now even more blurred. How can we now explain the role of gender beyond the narrow confines of biology? Gender captures so much more than just biology- it is not just the way we are taught to dress and behave, but also think and aspire. If the latter has changed, so should not also the idea of gender?

This has inevitably had an impact on the delivery of mental health care. While once any gender incongruity was labelled a 'mental disorder' this has changed in recent Diagnostic manuals. Labels such is 'non binary' and 'gender fluid' have provided safely and choice for those who do not wish to transition. There can now be an acceptance of who we are without having to 'box' ourselves or necessarily change our bodies to conform to societal beliefs of how we should look.

It is the way of the world, to ***locate*** 'blame/fault/defect' in the person/group, we do not agree with. We witnessed this with the suffragettes at the turn of the century, who were demanding nothing more than the humble right to vote! Why is it that we do this? We do this, because, we do not want to confront the reality of a group that might think differently to us. It takes up too much energy and we want to remain in equilibrium- of culture, society, and our belief system. It also helps one group maintain power over another.

The principles of Acceptance and Commitment Therapy (ACT) can help us work through the inevitable challenges faced by those coming to terms with their gender identity and also help, guide and support near and dear ones.

ACT is a third wave psychotherapy, incorporating CBT with Mindfulness based ideas drawn from Buddhist teachings. It was developed over a period of time by Steven Hayes, an American Psychologist, beginning 40 years ago. He created the flexible hexaflex model connecting, accepting our past whilst remaining

'present' and engaging deeply with our 'values' so as to generate value based 'action' or 'deeds,' stemming from a stance of openness and willingness to change.

It is helpful to bring our attention to the idea of the '***triune brain***', recognising that more often than not we respond to the world in an 'automatic' or 'pre-set' manner, without being mindful of context or focus on our fundamental values. This is because our primitive (reptilian) brain, responsible for survival, fires off instructions to our cognitive and somatic centres so much faster than out frontal lobes can reason with them, particularly in times of emotional turmoil.

Imagine for a moment now a child/young person struggling to maintain a façade, for what society expects of them, and the fight between this and where their values and values based action, want to take them. We have to remember that the transgender person does not exist in isolation, but within a society that may be rejecting and critical. Often the gender ***dysphoria*** lies in the minds of ***others*** rather than the young person and this creates a tension between how they ***see themselves*** and how ***others see*** them. It is this that leads to their distress, rather than the gender identity itself. Not infrequently we find that it is these ***others*** who may be more in need of psychological help than the child/ young person concerned!

Part of the difficulty, in my view, lies in the 'roles' ascribed to gender. So for example, the ***female*** must be inherently inferior-weaker, smaller, possibly less intelligent and/talented and if she must be so, this should be in areas that suit being a ***female***. We are therefore indoctrinated into thinking about ourselves along these gender based rules. The 'transgender' identity transcends and challenges this. In our clinical practice, while we are all seeing more individuals presenting as transgender, some but not all, present with 'dysphoria' relating to their physical attributes. A significant number seem to be 'non-binary,' fully accepting of how they are in their bodies and minds and this number appears to be rising.

I tend to see this as an evolutionary process. I suspect that as terms 'actor' and 'actress' are replaced with 'actor,' and 'waiter' and 'waitress', simply with 'server', we will inevitably move towards allowing individuals the freedom to express themselves better as their ***authentic*** selves.

This poem beautifully captures the idea of acceptance.

Allow – Danna Faulds

There is no controlling life.

Try corralling a lightning bolt,

Containing a tornado. Dam a stream and it will create a new channel.

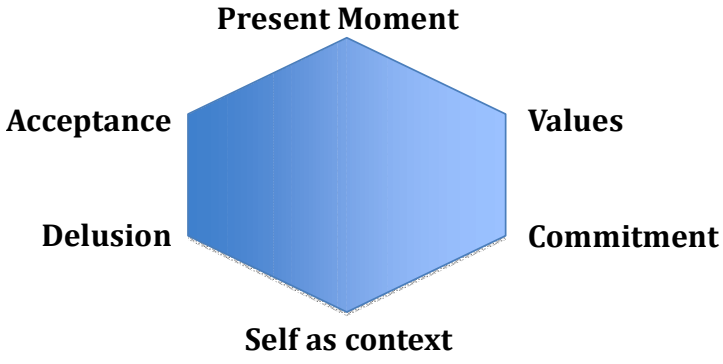
Resist, and tide will sweep you off your feet.

Allow, and grace will carry you to a higher ground. The only safety lies

In letting it all in- the wild and the weak; fear, fantasies, failures and success.

When loss rips off the doors of your heart, or sadness veils your vision with despair, practice simply becomes bearing the truth.

In your choice to let go of your known way of being, the whole world is revealed to your new eyes.



This is the basic Acceptance and Commitment Hexaflex

Our aim is to strive to:

1. Pay ***attention*** to the ***present moment***
2. Hold ones story (history) ***lightly*** (not be attached)
3. ***Accept*** our thoughts and feelings willingly even if we don't like them.
4. Create a ***space*** between our thoughts and 'us,' for we are more than our thoughts.
5. Practice ***choosing our values***
6. Practice engaging in ***behaviours*** towards ***livingout*** our values

Creating a Context for Change

1. Validate painful histories (personal stories).
2. Accept the gap between what is currently happening and where we would like to be.
3. Accept and note the struggle with thoughts and feelings that emerge.
4. Note if is there is value based behaviour.
5. Formulate in behavioural terms.
6. Suggest that in order for change to occur, the depression/ anxiety does nothave to entirely go away

The trick is to accept the person's problem fully, but not buy into the idea that only resolution can solve the problem

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3

Mental Health Issues in Transgender Population

*Dr. Vishal Chhabra**

In this chapter we will cover some basic information related to Transgender, Gender Dysphoria and Mental health issues around it.

Introduction

We have come a long way from the time of branding homosexuality as a mental disorder, to now where we have 'slowly' started to see Homosexuals as normal individuals who need love, care and compassion like any other human being. I wish I could say the same about Transgender population but not much is known about this subset of population to general public and even health care professionals. I hope this chapter is able to shed some light on the mental health issues related to Transgenders.

So let's start with some terms which we have heard a lot but needs to be explained in context of this chapter.

a) Sex: it is something which is assigned at birth depending on the sexual organs (genitalia) you are born with.

b) Gender: Gender is different from Sex, it is our thoughts about who we are which we start experiencing around the age of 4-5 yrs.

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c) Gender nonconformity: It refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (Institute of Medicine, 2011).

d) TGNC (Transgender and Gender Non-Confirming: It is a term used to define the group of individuals who are either unhappy with the gender they are assigned with or they refuse to identify with any one gender (i.e. they see themselves as both male and female) or with any gender (i.e. they don't see themselves as any gender).

e) Gender dysphoria refers to significant discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, &Bockting, 2010b).

f) Gender Incongruence: is similar to Gender Dysphoria minus the significant distress seen in Dysphoria.

Gender is Not a Binary Term

It's important not to look at Gender as a binary term – either male or female. Though India has a long history of accommodating third gender as part of the society but those individuals are usually living on the fringe of the society and there are many myths and taboos attached to them. This prevents them from seeking more 'normal' roles in the society framework. Also the recent understanding of various shades or colours of Gender makes it difficult to include all people into these three genders which are prevalent in Indian context. As mentioned above TGNC is a broad term which includes gender preferences hitherto unacknowledged, hence it's important to look at Gender as an Umbrella term or a rainbow or a broad spectrum.

Mental Health and TGNC

As we have seen above Gender is a term for the way we think and perceive about ourselves especially in terms of our

sexual roles and preferences. TGNC persons due to their gender preferences are at odds with the societal norms for gender which leads to stress from an early age. Starting with the way such children want to dress up to the way they want to live and behave. We are told that as a boy he needs to play certain games which are 'boyish' or 'manly', dress up as males, don't express too much emotions. Similarly for girls, there are certain stereotypes from the way they dress to the way they behave. Such societal pressures from an early age cause a host of mental health issues in these individuals. The pressure mounts up, as such individuals enter puberty and are confronted with the bodily changes which they find are unwanted. They end up hating their body parts or feel ashamed because of the changes. These individuals can go through depression, trauma, abuse, bullying, anxiety, low self-confidence, body image disturbances and other mental health problems. The discrimination and societal abuse/neglect is wide spread and there are hardly any laws to prevent this. It is estimated that the suicide risk in Transgender population is 9 times higher than the general population.

I will be talking briefly about the symptoms of each disorder. Though the symptoms of these following disorders are same for general population and Transgender, some of the symptomatology maybe coloured (i.e. influenced) by the way a Transgender person perceives about self.

1) Depression: Depression is very common in TGNC individuals. The symptoms include Low mood, Lack of interest in pleasurable activities, lack of energy, poor sleep and appetite, crying spells, unexplained aches and pains, negative thinking about self/others/future, death wishes and even suicidal ideations.
2) Anxiety Disorders: there are host of anxiety disorders which can be present like Panic Disorder, Social Anxiety Disorder, Mixed Anxiety and Depressive Disorder.
3) OCD: Obsessive and Compulsive Disorder. It used to be classified under the anxiety disorders but due to its uniqueness, it is seen as a separate disorder. It is characterised

by repetitive, intrusive, irrelevant and unwanted thoughts or images (which are called as Obsessions) along with repetitive/ritualistic behaviours (Compulsions).

4) BDD: Body Dysmorphic Disorder. This is characterised by patient being excessively preoccupied with some imagined or exaggerated deformity in the body.
5) Psychotic disorders: Hallucinations, delusions, abnormal behaviours, aggression

Treatment

The general goal of treatment is to find ways to maximize a person's overall psychological wellbeing, quality of life, and self-fulfilment. The treatment involves Pharmacotherapy and Psychotherapy.

Pharmacotherapy is used to treat the psychological symptoms TGNC patient/client has presented with. The reason for starting medications is taken based on the severity and urgency of the situation. For example, a transgender person expressing death wishes or suicidal ideations will benefit from medicines much faster than psychotherapy (which can take time to start and bring change). Similarly a TGNC person suffering from psychosis or severe OCD/BDD will require medications as first line of treatment.

Psychotherapy is beneficial to explore the underlying stressors and thought patterns or belief systems a TGNC client has, which may be causing distress or anxiety or depression. It can strengthen person's self-image and coping mechanisms.

Psychotherapy is not intended to alter a person's gender identity; rather, psychotherapy can help an individual to explore gender concerns and find ways to alleviate gender dysphoria, if present.

Gender Dysphoria

The American Psychiatric Association permits a diagnosis of *gender dysphoria* in adolescents or adults if two or more of the following criteria are experienced for at least six months duration:

- A strong desire to be of a gender other than one's assigned gender
- A strong desire to be treated as a gender other than one's assigned gender
- A significant incongruence between one's experienced or expressed gender and one's sexual characteristics
- A strong desire for the sexual characteristics of a gender other than one's assigned gender
- A strong desire to be rid of one's sexual characteristics due to incongruence with one's experienced or expressed gender
- A strong conviction that one has the typical reactions and feelings of a gender other than one's assigned gender

In addition, the condition *must be associated with clinically significant distress or impairment.*

Role of Psychiatrists, Psychologists and other Mental Health Professionals

Psychiatrists and other MHPs are integral part of the treatment team of Gender Dysphoria which includes endocrinologists and plastic surgeons. It is important that the Psychiatrist diagnoses and certifies that the person is suffering from Gender Dysphoria and is not suffering from any other significant mental health problem which may interfere in the person's decision making capacity to undertake treatment for Gender Dysphoria, whether its Medical or Surgical or both. It is also important to explore whether the TGNC client is having Gender Incongruence and not Dysphoria. Gender identities and expressions are diverse, and hormones and surgery are just two of many options available to assist people with achieving comfort with self and identity.

It's also important to check the preparedness of the client to undergo the transition which happens at physical, mental, personal, family and societal level. The support system the individual has while undergoing the change. A MHP can help counsel and educate family members about the condition and prepare them for the change they are about to witness. Also despite best intentions

and preparations, some clients do suffer from doubt/ depression/ anxiety post transition due to different factors ranging from the dissatisfaction with the change they have achieved or still feeling incomplete or the physical appearance they aspired post-surgery not up to their satisfaction. Hence it's important to follow up the clients for a significant amount of time post transition till the person is comfortably adjusted in the society in the desired gender role.

Summary

Gender and Sex are not the same concepts and it's important to realise the mental health issues faced by TGNC population. It's pertinent that in 21st century, we as society start respecting and helping these individuals to achieve their desired gender roles for better integration into the society.

4

Hormone Therapy in Transgender Persons

*Dr. Bela Sharma**

Hormonal intervention is recommended as a part of the transition therapy for both transgender men and women. It has been seen that when appropriately prescribed, these medications can greatly improve the quality of life of transgender patients.(1) However, this is still a developing field and not much work has been done so far. Most guidelines for transgender men come from experience with treatment of hypogonadal men, whereas in case of transgender women it's loosely based on treatments used for postmenopausal women. Though most healthcare providers are basing treatments on guidelines provided by WPATH SOC 7 and Endocrine Society Clinical Practice Guidelines, the treatment regime needs to be customised and not generalised.

Age for Starting Hormone Therapy

Age of consent for starting hormone therapy may differ in different countries. It is recommended to use Tanner staging to measure an individual's progress through puberty to initiate appropriate Hormone Therapy.

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TANNER STAGING

Girls

Tanner stage	Breasts	Pubic hair	Growth	Other
Stage 1	Prepubertal - elevation of papilla only.	Prepubertal villus hair only.	Basal level - 5 cm to 6 cm per year.	Adrenarche Ovaries grow and enlarge.
Stage 2	Breast bud appears under an enlarged areola (mean age 11.2 years).	Sparse hair along labia (mean age 11.9 years).	Accelerated growth - about 7 cm to 8 cm per year.	Clitoral enlargement with labial pigmentation Uterine enlargement..
Stage 3	Breast tissue grows beyond areola but without contour separation (mean age 12.4 years).	Hair coarser and pigmented - spreads across pubes (mean age 12.7 years).	Peak velocity - about 8 cm per year (mean age 12.5 years).	Axillary hair (mean age 13.2 years). Acne (mean age 13.2 years).
Stage 4	Projection of areola - papilla forms a secondary mound (mean age 13.1 years).	Adult pattern but without spread to medial thigh (mean age 13.4 years).	Deceleration- less than 7 cm per year.	Menarche (mean age 13.3 years). Regular periods (mean age 13.9 years).
Stage 5	Adult breast contour with projection of papilla only (mean age 14.5 years).	Adult with spread to medial thigh but not up linea alba (mean age 14.6 years).	Cessation of growth at around 16 years.	Adult genitalia.

Boys

Tanner stage	Genitalia	Pubic hair	Growth	Other
Stage 1	Prepubertal - testes less than 2.5 cm.	Villus hair only.	Basal rate - 5 cm to 6 cm per year.	Adrenarche.
Stage 2	Thinning and reddening of scrotal skin (mean age 11.9 years). Testes 2.5 cm to 3.2 cm.	Sparse growth base of penis (mean age 12.3 years).	Basal rate as above.	Reduction in total body fat.
Stage 3	Growth of penis (mean age 13.2 years). Testes 3.3 cm to 4 cm.	Thicker hair - spreads to mons pubis (mean age 13.9 years).	Accelerated growth - 7 cm to 8 cm per year.	Gynaecomastia (mean age 13.2 years). Voice break (mean age 13.5 years). Increase in muscle mass.

Stage 4	Growth of penis and glans with darkening of scrotum (mean age 14.3 years). Testes 4.1 cm to 4.5 cm.	Adult but no spread to medial thigh (mean age 14.7 years).	Peak velocity about 10 cm per year (mean age 13.8 years).	Axillary hair (mean age 14 years). Voice change (mean age 14.1 years). Acne (mean age 14.3 years).
Stage 5	Adult genitalia (mean age 15.1 years). Testes greater than 4.5 cm.	Adult with spread to medial thigh but not linea alba (mean age 15.3 years).	Deceleration and cessation (about 17 years).	Facial hair (mean age 14.9 years). Muscle mass increases further and beyond Stage 5.

Source: Transgender health: a practitioner's guide to binary and non-binary trans patient care. Ben Vincent, PhD.

Ideally, Tanner stage 2 should be reached before starting therapy.

Criteria

WPATH recommends following criteria for therapy:-

1) Persistent well documented gender dysphoria
2) Capacity to make a fully informed decision and consent for treatment
3) Age of majority
4) Good control of significant medical and/or mental comorbid conditions.

FEMALE TO MALE HORMONE THERAPY

Testosterone therapy is used to masculinize transgender men and to suppress their female sex characters. Commonest preparations used are Testosterone Esters.

Route	Formulation	Dosage
Oral	Testosterone undecanoate	160-240mg/day
Parenteral	Testosterone enanthate,	50-200mg/wk
(subcutaneous/ Intramuscular)	Testosterone cypionate	100-200mg/10-14 days
Implant	Testopel	75mg/pellet
(subcutaneous/	Testosterone gel 1%	2.5-10g/day
Transdermal)	Testosterone patch	2.5 -7.5 mg/day

Pre-therapy assessment:

A complete physical and mental assessment Investigations:

- hematocrit
- lipid profile
- liver functions
- bone mineral density (if required)

Aim of therapy:

To achieve testosterone levels of 300-1,000ng/dl

Most physicians start with half the anticipated dose required to reach the maximum virilization in a patient. It has been seen that high doses are no more effective than lower doses in achieving the desired result. Whatever the route of administration, once the desired level has been achieved a maintenance dose is required along with regular follow up.

MALE TO FEMALE HORMONE THERAPY

Hormone therapy for transgender women aims at feminizing the person by redistributing the body fat, inducing breast formation, and reducing male pattern hair growth.(2). However, before surgical orchidectomy is carried out, it is usually necessary to add an anti-androgenic therapy like Spironolactone.

Estrogen and anti-androgen options for transgender women

Route	Formulation	Dosing
Oral	Estradiol	2–4 mg daily
Parental (subcutaneous, intramuscular)	Estradiol valerate	5–30 mg every 2 weeks
Transdermal	Estradiol	0.1–0.4 mg twice weekly
Anti-androgens	Progesterone	20–60 mg PO daily
(subcutaneous,	Medroxyprogesterone	150 mg IM every 3 months
	GnRH agonist (leuprolide)	3.75–7.5 mg IM monthly
	Histrelin implant	50 mg implanted every 12 months
	Spironolactone	100–200 mg PO daily
	Finasteride	1 mg PO daily

EFFECTS OF HORMONE THERAPY

As discussed earlier in the chapter, there is no "one size fits all", where hormone therapy is concerned. Requirement varies from person to person depending upon the requirements and desired results.

Testosterone therapy (3,4)

Visible results can be expected within three months. These would include:

Cessation of menstruation

Increased facial and body hair

Skin changes and acne

Increased muscle mass

Fat redistribution

Increased libido

Deepening of voice, atrophy of vaginal epithelium, lengthening of clitoris, male pattern hair loss are the later effects.

Some biologic changes cannot be reversed with exogenous testosterone like the height and the basic bone structure.

Estrogen therapy

Changes in transgender women include:

Breast growth

Increased body fat

Slowed growth of body and facial hair

Decreased testicular size and erectile function

Use of anti-androgens as an adjunct helps to achieve maximum change.

Hormone therapy improves the quality of life of transgender patients (6) studies by Kranz et al (7) have shown the biologic

evidence that may explain this. Hormone therapy may even have a positive effect on physiologic stress as shown by Colizzi et al (8)

FOLLOW UPS

For transgender men on testosterone

Every 3 months for the first year, then every 6–12 months

Obtain baseline hematocrit and lipid profile and monitor at follow-up visits

Obtain baseline bone mineral density if a patient is at risk for osteoporosis; routine screening after age 60, or earlier if sex hormone levels consistently low

Monitor serum estradiol during the first 6 months and thereafter until uterine bleeding has ceased Monitor serum testosterone at follow-up visits; target 300–1,000 ng/dL

Peak levels for parenteral testosterone measured 24–48 hrs after injection

Trough levels for parenteral testosterone measured before injection.

For transgender women on estrogen

Monitor for feminizing and adverse effects every 3 months for the first year, then every 6–12 months

Check baseline hematocrit, liver functions and lipid profile and monitor at follow-up visits

Check baseline bone mineral density if a patient is at risk for osteoporosis; routine screening after age 60, or earlier if sex hormone levels consistently low

Check baseline prolactin, at 12 months after initiation of treatment, biennially thereafter

Monitor serum testosterone during the first 6 months until levels are <55 ng/dL

Monitor serum estradiol at follow-up visits; target 100–200 pg/Ml.

Puberty Blocking Drugs

Puberty blockers, also called puberty inhibitors, refer to agonists, which inhibit the action of hormones. The World Professional Association for Transgender Health's standards of care also recommend suspending puberty, preferably with the use of gonadotropin-releasing hormone agonists, in certain gender non-conforming minors (aged under 18 years) who have undergone a psychiatric assessment and have reached at least Tanner stage II of puberty. This is particularly useful for children who develop gender incongruence at a very young age. Putting them on puberty blocking drugs may help prevent gender dysphoria. A team of caregivers including the paediatric endocrinologist, mental healthcare professional, child's parents need to have a consensus before this can be started as some of the effects may be irreversible and the child is still below legal age of consent.

Conclusion

As discussed , not much work has been done in this field so far. There is no specific therapy which is tailor made for transgender patients. There is need for more research to prevent mental illnesses associated because of lack of therapy, complications arising from inappropriate therapy and marginalisation of a part of society due to lack of understanding.

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5

Surgical Management of the Gender Dysphoria

Dr. Richie Gupta & Dr. Rajat Gupta***

Gender incongruence and variance is a universal and culturally diverse phenomenon. This results in expression of characteristics and identities, which are not normally associated with one's assigned sexual role at birth[1]. Gender variance is not a disorder and many people live life comfortably without any intervention.

An individual's 'gender' is the innate psychological identification of self in living a particular role in society, typically masculine or feminine. While, 'sex' of the individual refers to the role assigned at birth based on genital phenotype, by parents, physicians and society at large. Generally, these two identities are in sync and as a result, most individuals are considered 'cisgender'. However, if these are not in sync, then the person may be a 'transgender (non-binary, genderqueer, bigender, pangender, genderfluid or agender)'[2], 'gender incongruent', 'gender nonconforming', 'third gender' or with 'gender otherwise non-specified'. Even these terms do not cover the entire spectrum of gender variance and expression.

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This spectrum includes a group of individuals whose gender identity is the opposite of their assigned sex at birth. From the early age of 3-4 years, they exhibit a gender expression, which is different from their assigned sex. As they grow up, they are at odds with their siblings, peers, parents and society, thus leading to a distress, which is known as "gender dysphoria (GD)'. They feel that they are trapped in the wrong body, and wish to get rid of/ remove their existing sex organs, and opt for hormonal and surgical change of sex. This group of individuals is known as transsexuals[3]. Transmen (FTM) are biologic women, who transition to men and transwomen (MTF) are the biologic males, who transition to women. 'Gender' being inbuilt in brain cannot be changed, however, 'sex' being physical body, can be reassigned to bring it into alignment with, or affirm 'gender'. Hence all hormonal and surgical interventions which attempt to correct GD are 'Gender affirming' and not 'Gender reassigning'.

Prevalence rates for transsexualism were often quoted as being around 1:11,900 to 1: 45,000 for MTF individuals and 1:30,400 to 1:200,000 for FTM individuals, as recently as 2007[4], and also in seventh version of 'Standards of Care for the health of transsexual, transgender and gender nonconforming people' (7th SOC's)[1] published by World Professional Association for Transgender Health (WPATH). However, recent data from Amsterdam cohort[5] suggests around 20- fold increase in prevalence, for people reporting for gender affirming treatment, with around 65.2% transwomen and 34.8% transmen. Studies which focus on self- reported transgender and gender incongruence, report prevalence rates of 0.3-0.7%[6] of general population. A 2009 California Health Interview Survey estimated 3.5% adults in U.S. to be LGBT, and around 0.3%, Transgender[7].

Gender Identity Clinic, Managing Gender Dysphoria

A) The author's Gender Identity Clinic (GIC):

The authors have a similar experience, with a currently around 150 new patient registrations every year, compared to rates of 6-7 patients around 26 years ago. It is clear that Gender Incongruent

patients now consist a significant proportion of normal population. For comprehensive management of such persons, authors have a Gender Identity Clinic in which specialists such as Plastic Surgeons, Psychiatrists, Endocrinologists, General and Laparoscopic Surgeons, Urologists, Psychologists etc. interact with the patients and amongst themselves for optimum results. The author's team follows WPATH's 7th SOCs[1], modified by their long experience of around 26 years in managing these patients. In author's GIC, the following requirements need to be fulfilled prior to surgical gender affirmation-

1) Diagnosis and reference letters by one in house psychiatrist (with psychometric analysis) and one psychiatrist outside of the author's GIC.
2) Surgical change of sex/ gender affirmation is only offered to individuals above legal age of majority in India (>18years).
3) Living in a gender congruent role for 12 months.
4) Hormone therapy for 12 months, except in those patients who are unwilling to take it, or those in whom, it is medically contraindicated.
5) A waiver of liability affidavit notarized on a stamp paper of Rs. 100.
6) Generally, for breast surgery or initiation of hormone therapy, only one letter by a mental health professional is sufficient, however, author's GIC prefers to complete all documentation prior to initiating surgical treatment.
7) Breast reduction surgery (transmen) may be carried out at the same time as starting hormone therapy.
8) Breast augmentation surgery (transwomen) may be delayed for 12 months, to allow feminizing hormones to have effect. There may be sufficient breast hypertrophy in many cases to obviate the need for surgery.
9) Feminizing hormone therapy is usually stopped 4 weeks before any surgery in transwomen, to reduce chances of thromboembolism.

Following is the list of gender affirming surgical procedures carried out in transpeople-

Table 1: Gender Affirmation Surgeries Carried Out in Transpeople

Core surgical procedures for transwomen	Orchidectomy
	Penectomy
	Vaginoplasty Clitoroplasty
	Labiaplasty and Breast augmentation.
Core surgical procedures for transmen	Reduction mammoplasty (the top surgery)
	Hysterectomy and bilateral Salpingo-Oophorectomy Vaginectomy
	Phalloplasty or Metaidoioplasty
	Scrotoplasty
	Urethroplasty
	Placement of testicular prosthesis and placement of an erectile implant/ penile prosthesis
Ancillary/ optional procedures for both/ either transmen and transwomen	Hair transplants
	Advancement of hairline
	Pectoral/ Calf implants
	Facial feminizing or masculinizing surgery
	Rhinoplasty
	Thyroid chondroplasty and Voice surgery
	Thoracic shaping
	Abdominoplasty and Liposuction.

B) Surgical Procedures in transpeople:

1) Core surgeries in transwomen:

i) **Breast augmentation**: Breast development occurs, once the patient starts feminizing hormones. But after a 12- month period on feminizing hormones, there is little if any increase. Also, this enlargement is hemispherical and conical, and without distinctive feminine curves or natural ptosis.

Therefore, many transwomen opt for surgical breast augmentation. There are two common methods for breast augmentation-

a) **Autologous fat grafting**- In this procedure, fat is harvested from an area in which there is excess- such as abdomen, love handles, thighs etc. under low suction pressure. This fat is then filtered, centrifuged or otherwise processed in OR itself to obtain the infiltrate, which consists of purified fat cells, stromal vascular fraction and adipose derived stem cells. This infiltrate is then injected into the appropriate area on chest wall for breast development. 2-5 sittings may be required, at intervals of 4-6 weeks each for optimum breast development to take place.

b) **Breast augmentation with implant**- Fifth generation cohesive silicone gel implants are used for augmentation via inframammary or axillary approach most commonly. In contrast to transwomen, biologic women have extra mammary fat overlying the origins and insertions on muscles in chest wall and axilla, thus softening the contours. Also, their thorax is shorter and more conical. As a result, to compensate for this, generally transwomen opt for larger size implants.

ii) **Vaginoplasty, clitoroplasty, labiaplasty, corporectomy and feminizing urethroplasty:** The goals of the procedure are to create a perineo-genital complex, which is aesthetic and as feminine as possible, free of scars and painful neuromas, a vagina of adequate depth and dimensions, and lined by self- lubricating, elastic and hairless epithelium, sensate and with correct axis. The urinary stream should be downwards in a sitting position. Unlike neovaginoplasty (NVP) in biologic women, this procedure is more difficult in transwomen, on account of differences as enumerated in Table 2. Initial steps, which are common to all procedures are- careful dissection of the neovaginal cavity between urinary bladder and rectum, avoiding injury to these important organs. This cavity then needs to be lined by a skin flap or skin graft in order to

make it permanent. Otherwise the body will treat it like any other injury or wound and close it in a few days. Currently, the two commonest methods for lining the NV cavity are **a)use of penile and/or perineoscrotal skin flaps for lining** or **b)the use of an intestinal segment such as sigmoid colon for vaginal lining.** Authors advise self dilatation by the patient, of NV cavity for 3 months.

iii) **Ancillary procedures:** These are carried out as per need, and many transwomen do not require these procedures. If the person suffers from male pattern baldness or receding hairline, this can be readily corrected to approximate a feminine hairline by hairline advancement procedures or hair transplants. Adam's apple can be shaved. Voice can be feminized by a procedure on larynx, similar to the tightening of guitar/ violin strings, in a few minutes, under local anaesthesia. A male forehead, which is more prominent with bulging supraorbital ridges, a wide chin, excessively prominent wide cheek bones, square jaws and nasal hump or convex nose, all of these can be feminized by facial feminization surgery and rhinoplasty. Removal of lower floating ribs can be done so as to mimic the shorter and conical feminine thorax and a narrow waist. Body contouring procedures such as liposuction and abdominoplasty can also be used as per requirement.

Table 2: Differences between Neovaginoplasty in Transwomen and Biologic Women

NVP comparison	NVP in biologic females	NVP in transsexuals	Implications
Differences in pelvic soft tissues	Pelvis is roomier, with greater space in rectovesical area	There is no rectovesical space. There is just a septum.	Easier dissection. Greater success for techniques such as Vecchietti, Lap Vechietti and Lap assisted balloon NVPs in biologic females.
Differences in bony pelvis (Fang, 2003)*	IIRD (Inter Ischiopubic Ramus Distance) 5.2+/- 0.36cms. As bony pelvis is wider, relatively thicker flaps may be used, especially in NVPs for malignant resections.	IIRD 3.95+/- 0.25cms. Chances of bony compression of neovagina, even if a long cavity is created, preventing sexual intercourse.	Only thinnest flaps can be used for transsexual NVPs, such as penile, scrotal skin and grafts.

Differences in pudendal organs	Pudendal organs such as clitoris, labia majora and minora are present. These were sometimes used for reconstructing neovagina.	Pudendal organs also require reconstruction	In transwomen, nearly entire penile tissue except corpora cavernosa is used for reconstruction of pudendal organs. This tissue is often missing in those with castration.

*Fang[8]

2) Core surgeries in transmen:

i) **Breast reduction ('the top surgery')-** This is usually the first surgery carried out in transmen. Reduction of the breast mounds enables them to easily pass off as men, while wearing shirts or T shirts, and thus helps alleviate GD. It also frees them from the difficult and painful practice of breast binding and wearing loose fitting shirts. The common methods for breast reduction surgery are **a) inferior periareolar**, if the breasts are relatively small in size**, b) concentric circular**, if these are moderately large, **and c) Excision and free nipple grafting (FNACG),** if the breasts are really large and ptotic.

ii) **Hysterectomy, bilateral salpingo-oophorectomy and vaginectomy (HSOV)-** This procedure differs from the normal gynecological procedure of hysterectomy in the fact, that in normal hysterectomy of hysterectomy with bilateral salpingo-oophorectomy, the vagina is not removed. Additionally in the HSOV procedure, the authors advance the urethra by 4-6cms, so that it lies more forward, almost near pubic bone. This facilitates the last stage surgery of phalloplasty. Sometimes, the authors also graft the excised vaginal mucosal lining to form urine pipe or urethra in the future flap, which will be used to form penis at a later stage and date, a process called prelamination. This is especially required if the penis is going to be formed from thigh flap later. Additionally, authors also mobilize bilateral labia majora at this sitting, to form scrotum. This not only protects the newly formed urethra, but also enables them to close the perineum.

iii) **Phalloplasty, urethroplasty, scrotoplasty, metaidoioplasty-** The goal of masculinizing genitoplasty is – to produce genital organs, which aesthetically match the biologic male genitalia, allow the transman to easily micturate in erect position in a male washroom without soiling himself, and to enable him to function as a male partner in penetrative sexual intercourse. In this operative procedure, usually, the last and most complex of the core surgeries, penis is reconstructed most commonly from **a) the tissues of forearm (Radial artery forearm flap or RAFF), b) thigh (Anterolateral thigh flap or ALT) or c) back (Musculocutaneous latissimus dorsi flap or MLD).** Other flaps and sites are also used uncommonly. The thigh flap can be transferred directly, but other two procedures require connection of blood vessels like arteries and veins by microsurgery. The nerves are also connected. RAFF is still the commonest procedure for phalloplasty and provides excellent aesthetic result with good sensation, as two nerves are connected, one for general touch and the other for erogenous sensation. However many transmen do not opt for this procedure, as the skin grafted forearm donor site may be readily visible in short sleeved clothing, and could be a giveaway for those conversant with the procedure. The authors carry out glansplasty at the same sitting in RAFF. The resultant neopenis looks like a circumcised erect penis. Urethra is also reconstructed at the same time, by using a part of flap skin rolled inside the outer part, or using previous prelamination. This penile urethra is connected to the previously advanced urethra to restore the continuity of urine pipe. Previously reconstructed scrotum is now sutured to the ventral aspect of neopenis. This procedure after the implantation of erectile device, enables the patient to engage in penetrative sexual intercourse, good erogenous sensation and micturate in erect position without soiling himself. Few patients do not opt for phalloplasty, and instead opt for enlargement of clitoris. In this procedure,

the natural clitoral chordee is released and urethra is advanced to lie at the tip of clitoris. Though this procedure does not enable the patient to engage in penetrative sexual intercourse in most cases, it allows for excellent erogenous sensation and orgasm, and in some cases, allows the patients to micturate in erect position.

iv) **Ancillary procedures:** As there are no erectile tissue in the body similar to penile corpora, a reconstructed penis is made in erect size. However, it still lacks the necessary rigidity, to allow vaginal penetration necessary for a sexual intercourse. For this purpose, erectile devices may be implanted in neopenis (similar to the devices used in biologic male impotence), usually 6 months after penile reconstruction, when necessary protective sensation has returned. The device can be a malleable rod with hinge, or inflatable prosthesis. Mandibular implants, genioplasty, rhinoplasty etc. can help masculinize a face. Laryngeal surgery can masculinize the voice. Pectoral implants in addition to top surgery can help masculinize the chest. Body contouring procedures and 'six pack plasty' can help produce an aesthetic masculine abdominal appearance.

Conclusion

Gender incongruence and variance is a universal and culturally diverse phenomenon. These persons should be managed by multidisciplinary teams (GIC's) comprising of various specialists, who are gender sensitive and well versed in managing such patients. Surgical management is a part of the comprehensive management of such persons and helps in alleviating gender dysphoria. Not all patients require every surgical procedure. The surgical care of these patients needs to be customized to the patient's requirements. The goal of Gender Affirmation Surgery is to allow these patients to easily function in their desired gender role without drawing attention to themselves, or being noticed.

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6

Infectious Diseases and Trans-women

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Infectious diseases are caused by pathogenic microorganisms, such as bacteria, viruses, parasites and fungi. The infectious can be transmitted directly or indirectly, between two humans, and between humans and animals. In the last 100 years between 1918-2017, there were various pathogens causing infectious diseases, including but not limited to, plaque, Human Immunodeficiency Virus (HIV), Tuberculosis (TB), Malaria and influenza. World Health Organization (WHO) in February 2018, developed a list of infectious diseases, potential for epidemic and required for a Research and Development. In the recent past about 30 different infectious diseases had challenged the health of the million of the people around the world. The major challenge to combat infectious diseases, is the non-availability of specific treatment for cure and/ or absence of vaccine. **Figure X.X** indicates various factors that contribute to the emergence/ re-emergence of infectious diseases(DE Bloom and D Cadarette, 2019).

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Figure X.X: Factors Contributing Emergence/Re-emergence of Infectious Diseases

In addition to the above-mentioned factors, Infectious diseases do not get limited by geographical borders, for instance, a new strain of cholera (O139) appeared in South-Eastern India, spread to other parts of Country and continued to the neighbouring countries, including China, Thailand and South-East Asian regions(Suvankar Mukherjee, 2017). Similarly, HIV was first diagnosed in United States of America (USA) among men reporting same-sex behaviour in the year 1981, later in 1986 it was diagnosed among Female Sex Workers (FSWs) in India who were reported to be having sex with other nationals and people who have travelled other countries. Within India, it was first diagnosed in Chennai and Mumbai, while it got spread across the Country and once HIV high prevalence states have now stabilized the infection, while new geographical locations showing rising epidemic.

Among the various infectious diseases' HIV got its global attention due to its impact in the overall development of an individual, countries and world together. The emergence of HIV had led to millions of deaths, taking toll on the financial front but it has helped for development and strengthening of the health care system as well. Interestingly, HIV has facilitated strengthening of health systems, looking health as comprehensive unit, the need

for destigmatizing behaviour among health care providers and within the health care system, the need for anti-discriminatory law at health care settings, the right of the people in access to quality health care and equity at health care system irrespective of one's diseases status, gender status, sexual status and their professional status. For instance, among many other populations, Male-to-Female Transgender (trans-women) is one of the population/community, witnessing the emergence of recognition, equity in health care services, education, job opportunities, property rights and gaining acceptance by their biological family and larger social acceptance.

Trans-women, due to their various reasons, including but not limited to, social status, economic reasons, education, stigmatization, discrimination, mental health status, risky and vulnerable behaviour, are prone to multiple infectious diseases, including HIV(Ana Cristina Garcia Ferreira, 2019). Among the various infectious diseases, HIV and STIs are predominantly studied and reported among trans-women population in India and globally, whereas there is limited or no published literatures on other infectious diseases among this population. The recent evidences across the India too had reported high HIV infection among this population (refer table X.X). A recent retrospective (2011-2015) analysis of tertiary hospital register showed that among 120 trans-women, 63% had reported of any infectious in comparison 42% with non-infectious diseases(Bhanupriya Tamilselvan, 2018).

Table X.X: Prevalence of HIV and STIs among Trans-women in India

Name of the article and year of publication/ Report	Journal/ Report	Year of the study	Sample Size, Design	Geographical Region	HIV prevalence	STIs prevalence
Integrated Biological and Behavioral Survey, 2016	Technical Report, NACO	2014-15	4966, cross-sectional survey	India	7.5%	NA
Study of prevalence of sexually transmitted infections/human immunodeficiency virus and condom use among male-to-female transgender: A retrospective analysis from a tertiary care hospital in Chennai. 2017 (Kalaivani., 2017)	Indian Journal of Sexually Transmitted Diseases and AIDS	2011 – 2014	82, Retrospective	Chennai	13.4% (11/82)	Syphilis – 21 (17/82)

Sexually Transmitted Infections and Risk Behaviors among transgender persons in Pune, India, 2011 (Sushant Sahastrabuddhe, 2011)	JAIDS	1993-2002	84, Cross-sectional	Pune	45%	Syphilis – 10%; GUD – 15%; Genital discharge – 5%
A study on the occurrence of Sexually Transmitted Infections among transgender persons at a transgender clinic in Puducherry (Audhya., 2015)	Journal of Pakisthan Association of Dermatologists	2011-2013	75, Cross-sectional	Puducherry	3%	Condylomo accumanata – 7%; Herpes genitalis – 1%;
A cross-sectional study of sexual practices, sexually Transmitted Infections and Human Immunodeficiency Virus among Male-to-Female Transgender people, 2010 (PS Saravanamurthy, 2010)	American Medical Journal	2007	131, Cross-sectional	Chennai	17%	Syphilis – 5%; Hepatitis-B-Virus – 8%; HSV-2 – 29%; HSV-1 – 48%

Future Directions

Trans-women population are vulnerable for infectious diseases, but limited evidences are available on its prevalence beyond HIV. Hence, efforts need to be towards transgender specific evidences on various infectious diseases. Considering the needs of trans-women health issues, a comprehensive assessment and delivery of health services is recommended, instead of limiting the services to HIV and STIs. Hepatitis-B vaccination should be considered across the country as part of public health interventions among trans-women.

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7

Preventive Healthcare for Transgender Persons

*Dr. Bela Sharma**

Transitioning is a responsible decision, taken not only by an individual but by the whole family. This entails a number of healthcare issues which need to be looked at regularly, some on day to day basis, some as long- term health goals. This also includes a number of lifestyle modifications that the individual has to understand and follow. Preventive healthcare is the cornerstone of any healthy society. Just like any other lifestyle change, this becomes important for persons who have undergone transition, are in the process or are planning to.

In this chapter we shall deal with the preventable health issues for transgender population.

The preventive health issues can be discussed under the headings of: -

1. Specific
2. General

Specific

There are specific conditions which the healthcare professional needs to look for in the patients. These depend upon the procedure the person has undergone along with the medication they are taking.

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1. Risks Associated with HRT
2. Depression/ Anxiety
3. Post- Operative Complications
4. Risk Taking Behavior

Risks Associated with HRT

Hormone Replacement Therapy is associated with increased risk of a few conditions which one need to look for specifically:-

Venous Thromboembolism (VTE)

Ischemic Stroke

Osteopenia/ Osteoporosis

Mood Alterations

Pituitary Prolactinomas

Drug Interactions

While some of the conditions are benign and may not require vigorous or urgent management, nevertheless a constant supervision is required.

VTE: Venous Thromboembolism is a potential risk of estrogen therapy. However, there is a definite improvement in the quality of life for people after starting hormonal therapy. (1)

It has been seen that route of administration, patient profile, and comorbidities, are all linked with development of VTE. Theoretically, there is an increase in risk, the absolute risk remains relatively low, hence, patients are not dissuaded from taking HRT. (3)

Ischemic Stroke: cardiovascular and CVA risks are associated with VTE and have been discussed above.

Osteopenia/ Osteoporosis : There have been no studies to determine whether clinicians should use the natal sex or affirmed gender for assessment of osteoporosis, In one study, researchers found that transgender women had factors which may contribute to an increased risk of osteoporosis, independent of and existing prior to hormone use, such as reduced levels of physical activity, lower muscle mass and grip strength, and lower levels of vitamin D.

Most published studies to date have shown either no change, or an increase in bone mineral density in transgender men treated with testosterone. Risk factors for osteoporosis in this population include oophorectomy before age 45 without optimal hormone replacement. [4,5,6]

Pituitary Prolactinomas: Benign brain tumors may be hormone sensitive. Because these conditions are quite rare, performing regular screenings for such tumors (e.g. regular prolactin measurements for identifying prolactinomas) seems not necessary. (7,8,9,10,11,12)

Mental Health Issues

Altered moods or mood swings can be associated with gender dysphoria or maybe the result of medications. In this particularly vulnerable group, social anxiety and isolation plays a huge role. Before undergoing transition, person needs proper counselling as to the procedure and a reality check. It is important to go for achievable goals and understand outcomes. Family, friends and a positive support group is important for alleviating anxiety and depression.

Post-Operative Complications

These can be immediate and long term.

However, commonest complications are: -

Pain

Infections

Partial success

Inability to attain desired affect

Post- surgical depression

A regular follow up with the surgeon, post-surgical care, medication as advised and desired life-style changes are recommended.

Risk Taking Behavior

Sedentary lifestyle

Unhealthy dietary habits

Smoking

Alcohol and Substance Abuse

Irregular medication

These are all risk-taking behaviors which contribute largely to health risks in any society.

General

Health issues to which a person maybe predisposed by virtue of heredity, environment or lifestyle remain the same even after transitioning. These include conditions like diabetes, high blood pressure, cardiac issues, malignancies and other disorders. However, certain conditions may become unmasked early due to physical and mental stress, medications and lifestyle.

Management

Preventive Healthcare focuses on managing a disorder before it becomes symptomatic. This means making alterations in day to day life which will prevent the disorder if it is not there or delay complications if it has already manifested. This done by making changes as delineated: -

A. Diet Management

Follow a regular healthy diet

1. Avoid fast foods/ junk foods
2. Avoid irregular diet pattern
3. Avoid artificial sweeteners
4. Avoid diet fads and fasting

Have balanced meals

1. Plenty of fluids
2. Green vegetables
3. Fruits

Dietary supplements containing steroids and heavy doses of vitamins and minerals to be avoided.

B. Exercise

Regular exercise- 45 min to one hour daily. It can be included in your daily routine. It can be anything from walking, jogging, cycling, running, skipping etc.

Exercise should be comfortable, pleasant and ideally part of your routine. One can always climb stairs instead of using the lift, park the vehicle a little away from the working place or institute and walk part of the way or cycle to work.

C. Maintain Weight

Most of the hormones are titrated according to the weight. It is important to maintain weight between the prescribed ranges. For person with genetic predisposition for diabetes, Cardiac issues, increase in weight becomes an added factor.

Increase in weight can also contribute to decreased self-esteem, depression, and tendency towards self-harm. Therefore,a regular exercise regime and dietary plan is very essential to both physical and mental wellbeing.

D. Smoking

Smoking can reduce or completely cancel the efficacy of orally administered estrogens. The reduction or loss of therapeutic efficacy is caused by increased liver clearance. This failure of therapeutic action cannot be compensated for by increasing the dose in smokers

Smoking further increases the risk of thromboembolism in person taking HRT. It isalso a risk factor for malignancies, cardiovascular problems and stroke. Nicotine and other constituents interfere in the metabolism of other medications the person might be taking.

Transgender persons are advised to avoid using all tobacco products as it is an unnecessary added risk factor. Active and passive smoking both are harmful. (13)

E. Alcohol and Drugs

It is not known how alcohol affects transgender individuals. The effects of alcohol can vary significantly among people. It is likely that hormone therapy may increase the intoxication effects of alcohol, yet transitioning does not affect other important physiological traits that often play a larger role in processing alcohol (e.g., gastric alcohol dehydrogenase levels and liver size).

Even less is known about how alcohol may impact post-transition bodies. Female-bodied people develop alcohol-related organ damage at lower levels of alcohol consumption and after a shorter history of drinking than male-bodied people.

It is a well-known fact that alcohol damages the liver in the long run. Since most of the HRT drugs are metabolized through the liver, hence, excessive alcohol use is to be avoided. (12)

F. Cancers

There is a high risk of cervical, ovarian, and uterine cancer faced by transgender men who retain genitalia they were born with. Due to stigma and social exclusion, many opt not to undergo regularly examinations and concomitant cervical and ovarian screenings. If detected early, ovarian cancer is a highly treatable disease.Likewise, pregnancyand subsequent breastfeeding have been shown to decrease a person's risk of ovarian cancer, and trans men are less likely to have given birth to biological children. This makes regular and thorough gynecological examinations even more crucial.Risk of breast cancer in Transgender women on HRT may be slightly high but still substantially lower compared with cisgender women in the general population.Similarly, trans men's risk for breast cancer was still lower compared with cisgender women's risk This suggests that hormone treatment alters the risk of breast cancer in transgender people compared with initial risk based on their birth assigned sex (14). Although rare, Cancer Prostate in transgender women has been documented. Therefore, the current evidence suggests that the transgender woman should be screened for Cancer Prostate the same as a cisgender man. (15)

G. Regular follow ups

Regular followup as advised by the Endocrinologist, Surgeon, Mental Health Professionals and Nutritionist need to be undertaken.

In conclusion transitioning is not a one-time procedure as the name itself suggests. It is a continuous process. Hence the management also has to continue lifelong on a day to day basis for a long healthy and productive life.

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8

Hijra and Transgender (HTG): Healthcare and Human Rights in India

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The government in any country is responsible and accountable to secure rights to Justice, Equality and Unity to every citizen of their country. This chapter throws some light on the rights of HTG with respect to healthcare and human rights in India.

Sourav, from Department of Law, University of North Bengal, explains three social exclusions which HTG face in India (Agarwal, 2017):

1. Exclusion from social and cultural participation
2. Exclusion from economy and
3. Exclusion from citizen participation

Historically, atrocities against *Hijra* community started during the colonial period when British colonial government passed the *Criminal Tribes Act in 1871* mainly covering the northern India. Same Act also covered Bengal Presidency and other areas in 1876

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and with the *Criminal Tribes Act, 1911*, it covered Madras Presidency as well. Though primarily directed at tribal communities, various provisions of the *Criminal Tribes Act* also impacted the rights of HTG communities and individuals in India.

The *Criminal Tribes Act of 1871*, created the category of "eunuch" to refer to the many, often unrelated gender non-conforming communities in India, including *hijras*. Under the Act, "Respectable" eunuchs did not engage in kidnapping, castration or sodomy, while "Suspicious" eunuchs would perform in public and wear female clothes classified by the British officials. Thus, practically, the Criminal Tribes Act banned all behaviour which were considered *suspicious*, including traditional *hijra* activities of public dancing or dressing in women's clothing. (Act No XXVII of 1871: A Collection of Acts passed by the Governor General of India in Council in the Year 1871) The state police of Telangana had arbitrary powers to arrest and prosecute transgender persons under the *Telangana Eunuchs Act 1329F*. Recently, in September 2018, the Hyderabad High Court passed an interim order calling the draconian colonial legislation 'wholly unconstitutional' (Staff, 2018).

The constitution of India came into existence in 1950. Though acts like *Criminal Tribes Act* were de-notified soon after Independence, acts like *Telangana Eunuchs Act 1329F* still exists. Indian constitution is neutral with respect to gender. The Article 14 of the Indian Constitution provides equality before law; Article 15 talks about no discrimination based on religion, race, caste, sex or place of birth; Article 16- equality of opportunity in matters of public employment; Article 19- freedom of expression while Article 21 talks about right to life. Though these articles from the Constitution guaranteed equal rights to every citizen, their practicality and application in the routine life remained a question for members from transgender community.

April 2014 brought in a new ray of hope when the Supreme Court affirmed that the fundamental rights granted under the Constitution of India will be equally applicable to transgender people (Mahapatra, 2014). A long pending demand of self-identification of their gender as male, female or third gender

was also accorded through the judgement. The apex court directed the central and state governments to ensure all schemes and entitlements to transgender population, bringing them at par with other citizens.

In the words of Justice K.S. Radhakrishnan, Supreme Court, "Seldom, our society realizes or cares to realize the trauma, agony and pain which the members of Transgender community undergoes, and appreciates the innate feelings of the members of the Transgender community, especially of those whose mind and body disown their biological sex" (National Legal Ser.Auth vs Union Of India & Ors on 15 April, 2014, 2014).

Laxmi N Tripathy, the HTG rights activist says that non-recognition of the identity of *Hijras*, a TG community, as a third gender, denies them the right of equality before the law and equal protection of law guaranteed under Article 14 of the Constitution and violates the rights guaranteed to them under Article 21 of the Constitution of India (National Legal Ser.Auth vs Union Of India & Ors on 15 April, 2014, 2014).

The Court noted that the transgender community (broadly defined by the Court to include *Hijras,* eunuchs, *Kothis, A ravanis* and numerous others) has faced prejudice and disadvantage since the eighteenth century in India. It acknowledged the discrimination that transgender people face in areas of life including health care, employment and education, which often leads to social exclusion. The Court declared that numerous steps were necessary in order for centre and state governments to comply with the constitutional rights to life, equality before the law, non-discrimination and freedom of expression.

In reaching its decision, the Court stated that gender identity is an integral part of the personality and one of the most basic aspects of self-determination, dignity and freedom. Thus, no one can be forced to undergo medical procedures, including sex reassignment surgery, sterilisation or hormonal therapy as a requirement for legal recognition of their gender identity.

Psychological gender is to be given priority over biological sex. Rights have to be protected irrespective of chromosomal sex, genitals, assigned birth sex, or implied gender role. The Court considered international human rights conventions and norms to be significant for the purpose of interpreting gender identity equality and used them to shed light on the interpretation of the Constitution. It stated that the wide discrimination faced by the transgender community creates a "necessity to follow the international conventions to which India is a party and to give due respect to other non-binding international Conventions and principles" and that any international convention not inconsistent with the fundamental rights of the Constitution must be read into the national provisions. Accordingly, it stated that it would recognise and follow the principles in the international covenants and the Yogyakarta principles.

The Court held that the right to choose one's gender identity is integral to the right to lead a life with dignity and therefore falls within the scope of the right to life (Article 21). In this regard, the Court emphasised the need to read the provisions of the Constitution in line with present day conditions, based on a factual and social reality that is constantly changing. Safeguarding the rights of transgender people was especially called for, due to the increasing universal recognition and acceptance of transgender issues. The Court noted that Article 21 has been broadly interpreted to include all aspects that make a person's life meaningful. It protects the dignity of human life, personal autonomy and privacy. As recognition of one's gender identity lies at the heart of the right to dignity and freedom, it must be protected under Article 21 of the Constitution.

With regard to the right to equality before the law (Article 14), the Court recalled that the state shall not deny "any person" equality before the law or equal protection of the laws. Article 14, in ensuring equal protection, imposes a positive obligation on the state "to ensure equal protection of laws by bringing in necessary social and economic changes".

Article 14 is a right enjoyed by "any person" (similarly, the reference to "citizen" in Article 15 is gender-neutral) and so applies equally to men, women and transgender people, who do not identify clearly as male or female. Hence, transgender people are entitled to equal legal protection of the law in all spheres, including employment, health care, education and civil rights. Discrimination on the grounds of sexual orientation and gender identity impairs equality before the law and equal protection of the law and violates Article 14.

Articles 15 and 16 prohibit discrimination in certain areas based on a list of grounds, including sex. The reference to "sex" is to be understood as prohibiting all forms of gender bias and gender based discrimination, including discrimination against transgender people. The emphasis put on tackling sex-based discrimination in the Constitution means that people have a "fundamental right to not be treated differently for the reason of not being in conformity with stereotypical generalisations of the binary genders". Furthermore, Article 15 includes a requirement to take affirmative action for the advancement of socially and educationally disadvantaged groups. The Court notes that transgender persons have not been afforded special provisions as envisaged under Article 15(4) for the advancement of the socially and educationally backward. They constitute such a group and the state is bound to take some affirmative action to remedy the injustice done to them for centuries.

In addition, the Court stated that expressing one's gender identity through words, dress, action or behaviour is included in the right to freedom of expression (Article 19). Privacy, self-identity, autonomy and personal integrity are fundamental rights protected by Article 19. As gender identity lies at the core of one's personal identity, gender expression and presentation, it has to be protected under Article 19(1)(a) of the Constitution. Often the state and its authorities, either due to ignorance or otherwise, fail to digest the innate character and identity of transgender persons, which should be done in order to realise their Article 19 rights.

On these bases, the Court upheld transgender persons' right to self-identify their gender. The Constitution requires equal treatment of all people regardless of their gender identity or expression. The Court declared that the Centre and State governments must grant legal recognition of gender identity as male, female or third gender. A full recognition is to be given even in the absence of any existing statutory regime. Additionally, the Court declared that educational, social and health care issues faced by transgender people must be addressed both at the centre and state government levels.

In another historic decision in September 2018, the Supreme Court struck down the colonial-era sodomy law that criminalized consensual same-sex relations thus upholding the privacy and non-discrimination of LGBT persons. The five-judge bench unanimously ruled clauses under Section 377 as "irrational, arbitrary and incomprehensible" and consensual same-sex relationships are no longer a crime. (India: Supreme Court Strikes Down Sodomy Law, 2018). The case started with filing of a case from The Naz Foundation (India) Trust in 2001 before the Delhi High Court, contending that Section 377 violated both the Indian constitution and the International Human Rights Law and that it impeded the organization's public health outreach. The case went through various milestones before turning into a landmark judgement.

The Transgender Persons (Protections of rights) Bill, 2019

Based on the historic judgment of April 2014, the Rajya Sabha in April 2015, passed the Rights of Transgender Bill, 2014. This was a private member bill. However, the Government of India then passed another Bill- "Rights for Transgender Persons Bill, 2015", modifying on the 2014 bill by removing the provisions relating to Transgender Rights Court as well as the National and State Commissions. The 2015 Bill underwent further changes and Ministry of Social Justice and Empowerment (MoSJE), Govt. of India introduced another bill in the Lok Sabha in 2016 called "Transgender Persons (Protection of Rights) Bill 2016", which was passed in the Lok Sabha in December 2018. Since the bill could

not pass through Rajya Sabha before the dissolution of Lok Sabha, it was lapsed.

The Transgender Persons (Protection of Rights) Bill, 2019, was passed by the Lok Sabha in August 2019. The Bill defines a transgender person as one whose gender does not match the gender assigned at birth. It includes trans-women and trans-men, persons with intersex variations, gender-queers and persons with socio-cultural identities, such as *kinnar* and *hijra*. Intersex variations is defined to mean a person, who at birth shows variation in his or her primary sexual characteristics, external genitalia, chromosomes or hormones from the normative standard of male or female body.

Though most of the 27 amendments mentioned to the original Bill were accepted, it eventually invited criticism from the transgender community and activists for various reasons (Dharmadhikari, 2019).

The Transgender Persons Bill lays out a broad and inclusive definition of "transgender persons" and a clear distinction between identity-based recognition rights and the medical procedure(s) that some transgender people might want. However, even though, the bill says that a transgender person "shall have a right to self-perceived gender identity," its language could also be interpreted to mean that transgender people are required to have certain surgeries before legally changing their gender (India: Transgender Bill Raises Rights Concerns, 2019).

However, passage of Bill from the lower house, also brought in criticism from the community. The 2019 Bill states that a person would have the right to choose to be identified as a man, a woman or a transgender person, irrespective of the hormonal (replacement) therapy and Sex Reassignment Surgery (SRS). Despite this, the Bill requires transgender person to go through a district magistrate and district screening committee to get certified as a trans-person. A revised certificate may be obtained only if the individual undergoes surgery to confirm their gender. In case of denial of the certificate to the transgender, the Bill has no provisions for an appeal for review of the decision taken by the district magistrate. The process of taking a certificate is in no way depicts the spirit

of deleting the word Screening Committee from the original text of bill proposed in 2016.

Health Care as Right

Health care itself is a rights issue for any citizen of India. When health care in India is a distant dream for sexual minorities especially HTG, it may as well be construed that they are denied their rights. Denial of health is brewing to be rights' issues.

Cleavage between HTG and the health care services is on the increase. HTG population is known to be living as/in communities. Advent of technology at our palm, most of them do burry themselves into the virtual world. Virtually active and not being part of larger society is a constraint that reduces themselves to isolation and zero social support. Experiences in India also have shown that the health care services provided at their door step is either being negated or utilized sparingly owing to reasons that has no logic for anybody else to understand. Inadvertently, the lack of awareness and knowledge about sexual vulnerability, social marginalization drives them away from accessing health care services.

HTG population have been disproportionately affected by HIV since the onset of the HIV epidemic, according to several findings (TI Division). Many a times, the medical and para medical professionals are not so sensitized about HTG people, which impacts in stigma and discrimination against them. Absence of space, scope and curriculum in the formal medical education in our country, so as to sensitize and orient the budding medical fraternity on the HTG population and their health concerns and issues, is a matter of concern.

Being equal along with any other citizen, HTG population also enjoys the equal rights for accessing health care services and provisions that ensure their healthy life and thus march towards empowerment. HTG looks forward for certain health privileges, specific to their community in a special way, though most of them are also common to any ordinary citizens of the country:

1. Provision of Sex Reassignment Surgery (SRS) or Gender Affirmation Surgery (GAS) for HTG free of cost aligning with guidelines for SRS laid out by World Professional Association for Transgender Health (WPATH). HTGs preferring for SRS should be provided with free of cost pre & post counselling properly.
2. Provision of Hormonal Therapy and associated follow-up services appropriately at free of cost.
3. Provision of general medical care facilities at designated centres with fixed times
4. Review of medical curriculum and research for doctors to address the specific health issues of HTG population.
5. Provision for coverage of medical expenses by a comprehensive insurance scheme.

The Constitution and multiple judgements from the Honourable Courts of India, time and again emphasised on ensuring equal rights for all the citizens of the country including individuals from *Hijra* and Transgender community. The onus is on the policy makers, implementers and even common citizen to respect them equally in all spheres of life, so as to realise the true spirit of Indian Constitution.

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9

Trans-inclusive Medical Colleges and Medical Curriculum: A Personal Narrative

Dr. Aqsa Shaikh*

Medicine is the noblest profession. Like many other adolescents, I also dreamt of becoming a doctor. The allure of 'Dr.' prefixing my name ensured that I slogged and got into one of the best medical schools of India, Seth GordhandasSunderdas Medical College, Mumbai. I was the Alice in Wonderland; fascinated, curious and anxious, unaware of the adventures and perils ahead. As we sat in the first lecture for Anatomy, we were enthralled by the charm of Prof. Manu Kothari. Boys and girls were seated separately and I still recall his remarks, "*Maalay-Femaalay-Maalay-Femaalay*'. So right from that first day in medical school, I was reminded that alike the world, the medical school is also governed by the binary of sexes and male side is the one I belonged to since I was assigned male at birth. But little did my parents realize that their third *'son'* was unlike the first two. I am a transgender person. But I didn't know about this adjective that could describe my state of existence in one word, back then. All I knew was that I was different; that I did not have a sense of belongingness

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in the male gender assigned to me. I was more comfortable playing the feminine gender role. However, this world is not a suitable place for people like me as I was asked to fit into a mold to which I did not belong. And that was painful; very painful.

Transgender is an umbrella term for persons whose gender identity, gender expression or behavior does not conform to that typically associated with the sex to which they were assigned at birth. Gender identity refers to a person's internal sense of being male, female or something else; gender expression refers to the way a person communicates gender identity to others through behavior, clothing, hairstyles, voice or body characteristics.

Our medical colleges are no islands but a part of the society we live in and reflect our social order. So, being a person assigned male at birth, I was expected to play the male gender role. To give an example, we all know about the physiology practical in which boys are expected to strip off their shirts and get examined by their batchmates to learn the basics of examination. And being a 'male', it was my turn one day. As a woman, I was horrified with the thought that people would see me shirtless and examine me publicly. How better the things would have been if I and my batchmates understood my gender and I was not made to undergo this, something which was akin to molestation! Another place which left scars in my memory was the Operation Theatre changing room. Being a large, busy hospital, we did not have separate cubicles for changing into our OT clothes, but rather two large rooms – one for the Men and other for the Women. Now, imagine a transwoman being asked to change her clothes in front of boys. This is what happens when we are not thoughtful enough and unknowingly end up hurting people. Also, I was very clear about one thing right at the start, whether it was admission into MBBS or MD, that I would not stay in a hostel. For me, the idea of staying in a boys' hostel was a death sentence, if not death atleast daily humiliation. In fact, in the nearly six years of my MBBS

stay in the medical school, I never once ventured into the boys' hostel.

It is not being a Transgender person that is a problem, but to be a transgender person in a largely cis-gender society governed by the binary of sexes is an existential crisis. No doubt then that almost every transgender person suffers some or other physical or mental consequences of the everyday struggle to survive. I too had my share of problems. At the age of 20 years, I was diagnosed with Hypertension and Depression. While I studied medicine at a time when Section 377 was valid and Transgender persons were not recognized by law, not much has changed since then now that we are in 2019. That is why I am writing so that my message reaches out to those who can make a difference. As Mira Nair has said, *"There is a great power in telling our stories. My mantra is that if we don't tell our own stories, no one else will."*

Solutions

1. The first hurdle that anyone faces while entering a medical school is getting admission. We have caste-based, gender-based, religion-based, disability-based, and even NRI-based reservations. But we do not have reservations for Transgenders. The Supreme Court had asked central and state governments to provide reservations to Transgender persons in its NALSA judgment.
2. A policy stating that a particular university, college, and the hospital is trans-inclusive and provides a supportive environment would be a positive start.

Legal Status of Transgender Persons:

In the landmark judgment of National Legal Services Authority v. Union of India, the Supreme Court of India, declared transgender people to be a 'third gender', affirmed that the fundamental rights granted under the Constitution of India will be equally applicable to transgender people, and gave them the right to self-identification of their gender as male, female or third-gender. The court also held that because

transgender people were treated as socially and economically backward classes, they will be granted reservations in admissions to educational institutions and jobs. Centre and State Governments have been directed to take proper measures to provide medical care to Transgender people in the hospitals and also provide them separate public toilets and other facilities.

3. The recognition that there may be transgenders who have not transitioned is important. Do not assume someone's gender by their physical characteristics, clothing or behavior. Ask.
4. It is very essential to create safe spaces for transgenders. This applies to any place where sex-separation is practiced. Be it hostels, common rooms, changing rooms, bathrooms, reading rooms, libraries, canteens or anywhere else. Since there may not be many transgender students, making a separate facility for transgender students is not feasible. Rather, transgender students should be allowed to choose which gender's facility they want to pick. Another good option is to have unisex/gender-neutral facilities. An example closer to home is that of Tata Institute of Social Sciences, Mumbai which a few months back has started a gender-neutral hostel.
5. Having an outdated medical curriculum is not just dangerous and life-threatening but also illegal when it doesn't conform to the legislation and judicial orders of the land. Last month, The Medical Council of India unveiled its Competency-based undergraduate curriculum for the Indian Medical Graduate. Also, the MCI has proposed to make Graduate Medical Education Regulations, 2018 gender-sensitive. However, as per the new curriculum which will be implemented from August 2019, the medical graduate is expected to describe the clinical features and treatment of gender identity disorders including behavioral, psychosocial and pharmacologic therapy, further advocating 'family education' for it. One must note that recently World Health organization has

changed the term Gender Identity Disorder (GID) to Gender Incongruence, and removed it from the category of mental disorders. Similarly, the American Psychiatric Association has also discarded the term GID and adopted Gender Dysphoria in its Diagnostic and Statistical Manual of Mental Disorders. Why is then MCI still stuck with GID and treating it like a mental disorder is baffling? The entire document doesn't mention the word Transgender even once, forget about including the WPATH's Standards of Care or any other guidelines for Transgender Health. It still has in the curriculum, under the heading of 'sexual offenses' – adultery, lesbianism, sodomy, and buccal coitus. Transvestism is described as sexual perversion. All this when Section 377 regarding unnatural sexual offenses and Section 497 regarding adultery have been termed unconstitutional by the Supreme Court.

Standards of care for the Health of Transsexual, Transgender, and Gender Nonconforming People by The World Professional Association for Transgender Health

The SOC are a document for health professionals. They aim to provide clinical guidance for health professionals to assisttranssexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfilment. This assistance may include primary care, gynaecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counselling, psychotherapy), and hormonal and surgical treatments.

6. A medical college is a training ground for learning medicine. And students will learn medicine from how they see their teachers treating patients and providing care. Any teaching hospital which is not trans-inclusive cannot do justice to the comprehensive training of future medical doctors. MCI should consider including criteria for trans-inclusive hospitals

in medical college assessments. Making OPD and IPD facilities acceptable to transgender patients would be a start.

7. Transgender persons, whether transitioning or not, have diverse medical, surgical and rehabilitative needs. As teaching hospitals, providing tertiary levels of care, all medical colleges must focus on providing specialized services needed by transgender persons. A transgender person especially requires services in the departments of Dermatology, Endocrinology, Psychiatry, Urology, General Surgery, Gynecologyand Speech therapy. And being a human being like any other, they need services in all other departments too, for which the staff needs to be sensitized about not just humane, non-discriminatory treatment but also about altered anatomy and physiology that transgenders who have transitioned may have with consequent special needs.
8. India has just launched the *Pradhan Mantri Jan Aarogya Yojana*, under which 1350 procedures have been included, with a cap of Rs. 5 lac per family per annum. Has anyone wondered why gender affirmation procedures have been given a miss in the list?
9. While we focus on making future medical curriculum catering to needs of transgender patients, we must not lose sight of the current practitioners. A series of CME would be needed to sensitize and further make them competent to the needs of Transgender patients.
10. As a transgender person changes legally from one gender to another, a name change is often a part of the package. Someone who has changed their name that reminds them of their wrongly assigned gender at birth, would not want to explain to everyone why they changed their name. But this is not possible unless the educational certificates and documents are changed. However, transgender medical students have had to often run from pillar to post, many a time unsuccessfully, to get their names changed in their degree certificates. Can we do something to avoid this harassment?

Today, we have a legally enabling environment for Transgender persons in India with Supreme Court coming on-board. The Transgender Persons' Bill will soon be an Act, though the community has many objections.

While all this is being done, the Medical educators can very well start working for creating Trans-inclusive medical colleges and hospitals where a trans-inclusive curriculum is taught to the future medical graduates. Medical Institutes have often led the way to social progress and making Trans-inclusive medical colleges and hospitals could just be the start of making a trans-inclusive world. After all, one cannot achieve '*Health for All*', unless the part of humanity consisting of Transgender persons is also taken care of. While this may appear a distant dream, this is nonetheless a dream worth chasing.

10

Transgender Children: Trauma Caused Due to Lack of Parental Support

*Ms. Divya Vaishnava**

Sex and Gender

Though the terms 'sex' and 'gender' are often used interchangeably in everyday language, there exists a significant difference in the meaning and context of use between these two terms. Sex is a biological phenomenon which differentiates human beings on the basis of chromosomal constitution, gonads, sex hormones, anatomy i.e. internal reproductive organs, and secondary sex characteristics such as the presence of facial hair, breast, body structure etc. (American Psychological Association Task Force, 2006, p. 1), and categorizes a person as male, female or intersex. It typically refers to the sex assigned at birth by a medical provider on the basis of appearance of the external genitalia, as observed in the newborn, and is documented in the birth certificate paving the way for a legal construct (Reisner, Baral, & Lloyd, 2013, p. 9). Whereas, gender on the other hand is a social construct, and "denotes the cultural meanings of patterns of behavior, experience, and personality that are labeled masculine or feminine" (Institute of Medicine (US) Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, 2011). It usually refers to the way a person identifies themselves,

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interacts, behaves and expresses oneself, and the perception of gender can vary widely across culture and has multiple dimensions like gender identity, gender expression and gender role. Gender identity refers to a person's sense of being a man, woman or any other gender, and it can be in conformity or non-conformity to the assigned sex at birth (Institute of Medicine (US) Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, 2011). Gender expression refers to the appearance, behavior and mannerisms as expressed by a person to express their gender identity (Reisner, Baral, & Lloyd, 2013) and whereas gender role refers to the specific norms and acceptable behavior as prescribed by the culture, and expected to be followed by someone belonging to a particular gender.

Transgender: Transgender is used as an umbrella term for people who experience or express their gender differently from what others might expect based on the sex they were assigned at birth. This includes people who are transsexual, cross-dressers or otherwise gender non-conforming. Transgender people may identify as trans man or female-to-male (FTM), trans woman or male-to-female (MTF), genderqueer, bi-gender, androgynous or gender variant. Transgender usually refers to all those who cross the socially constructed norms of gender binary and can be defined as to people whose gender identity does not conform to their assigned medical and legal sex at birth (Stroumsa, 2014). Merriam-Webster defines transgender as "of, relating to, or being a person (as a transsexual or transvestite) who identifies with or expresses a gender identity that differs from the one which corresponds to the person's sex at birth"

(Merriam-Webster, Undated). "Transgender is more of a blanket term and encompasses a diverse array of gender identities and expressions, including identities that fit within a binary female/ male classification system and those that do not" (Reisner, Baral, & Lloyd, 2013).

How a Transgender Child is Traumatised within Families

There has been some progress in public awareness about rights of transgender persons, but lack of clear legal protection has resulted in disparities faced by youth who identify as LGBTQ. These disparities stem from multiple sources, which include inequitable laws and policies, societal discrimination, and a lack of access to quality health care, including mental health care. Youth who do not conform to social expectations and norms regarding gender face more intense challenges because of ignorance of society. In India, a complete lack of support can be seen about anyone who is non-conforming and different. This makes it more challenging for people to be open about their sexual preferences, identities or orientation. In our society talking about sex is still a taboo and that's also one of the reasons for lack of safe and non-threatening spaces for transgender children.

I first met Akira, 12-year-old (name changed) when her mother brought her to meet me, according to her mother Akira was behaving abnormally and affecting family's reputation because of the complaints received by neighbours and school. Based on what the mother had shared with me about the behaviour manifestations and how they had reacted to Akira, I knew before I even met Akira that the family had not understood her concerns and had labelled her as a troublemaker. Akira told me she liked to dress as girls and that's what led to most of the fights between her and her family. Akira had always felt she was a girl trapped in a boy's body and she never liked to wear boy's clothes or 'be' like those boys in her family and neighbourhood. Akira was constantly humiliated and physically abused by her grandfather, uncles and father for behaving 'like a girl' – which means she was called names every time they found her wearing her sister's skirt and twirling in front of the mirror, which also meant she would be beaten up if they caught her with make up on her face and enacting a scene from her favourite movie Frozen, once her father punished Akira by forcing her to be topless for the whole day. She was not allowed to meet her friends, most of them were girls as the family feared they will find out about Akira's

abnormality. In school, she was constantly teased for not being strong enough or participating in dance programmes with the other girls during school annual days or functions. School teachers were either indifferent or lacked sensitivity to deal with such incidents. They also contributed to her distress by labelling her as a boy who liked to create trouble to attract attention, they called her parents for meetings which never yielded anything positive as all of them had made up their mind about her- that there was no problem and she was only seeking attention to divert focus from her academics- because of the constant emotional turmoil Akira was facing, she was not able to focus on her studies and her grades had suffered.

Such incidents left Akira traumatised and she developed anxiety which was found out later when I had referred her to a counsellor. For 5-6 years, from the time she had showed interest and inclination in dressing up like a girl or playing with toys which were typically not considered appropriate for boys, Akira was subjected to physical, verbal and emotional abuse by her family as they did not know how to deal with her needs. For all of them, it was shocking to see a child who was born as a boy wanting to become a girl- they labelled her 'abnormal', 'unnatural', 'curse', 'result of their wrong deeds', 'an embarrassment'. They had taken her to few doctors who were not aware of what children like Akira were going through. She suffered because she wanted to dance and live her life as a girl. How cruel is this?

What led to this situation? Akira was experiencing gender dysphoria and she was not understood by anyone in her life. Her rights were violated by her parents, her schoolteachers and her family members who were responsible for her wellbeing.

Akira is one of the many children who suffer because of lack of support system in the communities, schools and hospitals. According to American Psychiatric Association, Gender dysphoria involves a conflict between a person's physical or assigned gender and the gender with which he/she/they identify. People with gender dysphoria may be very uncomfortable with the gender they were assigned, sometimes described as being uncomfortable

with their body (particularly developments during puberty) or being uncomfortable with the expected roles of their assigned gender.

If this is the situation in the capital of our country, Delhi, one can safely assume the situation to be worse in other cities. By the time Akira met me, she had started harming herself by cutting her on thighs and arms. The trauma that she went through has affected her life in ways that words can't express, she told me she had contemplated suicide on many occasions. The suicide rate among transgender individuals in India is about 31%, and 50% of them have attempted suicide at least once before their 20th birthday.

She is 15 years old today and in a happier space. Her family was referred for counselling to deal with their own emotions effectively. Akira has decided to undergo gender affirming surgery after she joins college. Her family is more supportive now and she has found a strong ally in her sister.

Some of the responses of college students are being shared here (with consent)

> *'My brother would beat me up whenever he caught me wearing my cousin's lehenga (long skirt), it made me angry and I still don't talk to him. He would complain to male adults in the family and they would all punish me by either denying me food or hitting me badly)*
>
> (A 20 year old transwoman who is saving for her surgeries).
>
> *'I was sexually abused by my tutor and I could never tell anyone as he had threatened that he will share my secret with everyone. My secret was that I wanted to be a girl and he had caught me using the girl's washroom in school. I was so sacred of my family and being beaten up that I let myself be abused for one year and it stopped only when I had a new female tutor in the next session.*
>
> (a 24 year old transgender person who has been going for counselling for the last 6 years and she told me she still feels guilty for the abuse and blames her family).

> *'I have let myself in many abusive relationships as I thought it will cure me of my problem – I was abused emotionally, sexually, physically by 3 of my partners and I was emotionally weak to resist or quit. It was only when my college friend took me to a support group in an NGO that I got help that I needed'*
>
> (a 23 year old transgender person who plans to go for gender affirming surgery next year and is a healthy sexual relationship at the moment).

Above examples tell us how these people suffered in childhood and it could have been easily prevented if the families were sensitive and had access to support services to deal with the challenges faced by them and their children. According to a GLSEN survey, 42.1% of trans and GNC kids are prevented from using their preferred pronouns. Nearly half of these kids (46.5%) are forced to use the wrong bathrooms.

Through this article, I want to emphasise on the lack of support system available to children like Akira and their families. Math and Seshadri in their editorial, as published in the Indian Journal of Medical Research, discussed about sexual minorities and the problems faced by them due to the existing disparity in the health care. The article states in our hetero-normative society, as male-female dichotomy is the common way of looking at the society, and therefore those who not fit in these two subsets are considered abnormal and become a sexual minority (Math & Seshadri, 2013).The authors have showcased the human rights violation of the sexual minorities and emphasizes "the need for provision of equal opportunities and protection of rights, like any other law abiding citizen" (Math & Seshadri, 2013). Their article also states the problems of access to health care by transgenders as they often not even allowed inside hospitals and do not have any separate in-patient wards for their treatment, and also the quality of service delivered to them are compromised as they discriminated because of the stigma perceived by the health care professionals and other staffs in a health care setting. One of the many complaints we hear from transgender children and young adults is the lack of sensitivity about usage of washrooms- a transgender person

has the right to decide which washroom they are comfortable with. Same is the issue with changing rooms in gyms, schools or hospitals. We have heard from many families that physicians find it difficult to address issues around sexual health, and transgender children continue to suffer due to physician's lack of education or personal discomfort on the topics related to sexuality. Training of support staff in hospitals is important to create a sensitive, non-threatening space for transgender children. There are many barriers in access to health and health care services, like discriminatory attitude, wrong diagnosis, lack of provider knowledge, lack of infrastructure and all these can be addressed with effective strategies in place. But the most important intervention would be to create an awareness campaign focusing on families, schools and communities. The shame, stigma and stereotypes attached to transgenders exist because there have been no campaigns around this, schools are mostly silent about anything to do with sexuality. Regular messages in print media, social media, television can help to some extent. I also suggest incorporating sensitization training in teachers' training institutes like SCERT at state level and NCERT at National level. Regular sensitization sessions should be made mandatory in schools, colleges, corporate offices and residential societies to create a sensitive, fair, safe and non-threatening society around us which doesn't consist of transphobic individuals. Children have a right to a happy, carefree life without being judged for who they are, and we can make it possible by being sensitive to their needs.

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11

The Transgender Persons Bill: A Review

*Dr. Aqsa Shaikh**

Transgender Persons have existed for as long as humanity but there has been no law identifying them till now. That is about to change with the passing of The Transgender Persons Bill in Lok Sabha. This may sound like a welcome move; but is the transgender community satisfied? Let's explore.

The push for passing a law concerning the Transgender persons came from the Supreme Court's judgment in the NALSA (National legal Services Authority) vs Union of India, wherein the apex court declared transgender people to be a 'third gender', affirmed that the fundamental rights granted under the Constitution of India will be equally applicable to transgender people, and gave them the right to self-identification of their gender as male, female or third-gender. The court also directed governments to provide reservations and healthcare services.

So, when the Ministry of Social Justice and Empowerment decided to draft a bill for the Transgender Persons, it was believed that it would be based on the NALSA judgment in its spirit and

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body. However, the bill passed in Lok Sabha, while good in some aspects, treats Transgender persons as unequal. Here are the reasons for saying so-

Legal Status of Transgender Persons:

In the landmark judgment of National Legal Services Authority v. Union of India, the Supreme Court of India, declared transgender people to be a 'third gender', affirmed that the fundamental rights granted under the Constitution of India will be equally applicable to transgender people, and gave them the right to self-identification of their gender as male, female or third-gender. The court also held that because transgender people were treated as socially and economically backward classes, they will be granted reservations in admissions to educational institutions and jobs. Centre and State Governments have been directed to take proper measures to provide medical care to Transgender people in the hospitals and also provide them separate public toilets and other facilities.

Self-identification: While the original draft bill had an obnoxious definition of Transgender persons, the current bill is a slight improvement. Still, it doesn't allow a Transgender person to identify themselves as Male or Female unless they have undergone surgical procedures. This is against the NALSA judgment which stated that insistence on surgical intervention for identification with gender is immoral and illegal.

Transgender is an umbrella term for persons whose gender identity, gender expression or behavior does not conform to that typically associated with the sex to which they were assigned at birth. Gender identity refers to a person's internal sense of being male, female or something else; gender expression refers to the way a person communicates gender identity to others through behavior, clothing, hairstyles, voice or body characteristics.

- American Psychological Association

Shallow: The bill is very shallow on many counts. It doesn't make any binding commitments on educational or employment-based empowerment of Transgenders. There is no provision of reservation in education or jobs as directed by the Supreme Court. The Transgender Persons were to be included in the existing OBC quota for the same.

No safeguards against harassment: The bill treats Transgender persons as unequal by proposing lesser quantum of punishment (ranging from six months to two years) for those sexually abusing a transgender person as against those abusing a woman. An online campaign is running on Facebook with the tagline, 'Rape is Rape' to draw attention towards this miscarriage of justice. It may be noted that in the recently passed Triple *Talaq* bill, the husband will be sentenced for 3 years for saying Triple *Talaq*, even if it is null and void, wherein raping a Transgender person would attract a maximum punishment of just 2 years. Doesn't make sense, right?

Reproductive Rights get missed: The bill considers Transgenders as asexual beings with no aspirations for marriage, surrogacy or adoption. The bill provides for none of these rights. The recently passed Surrogacy Bill effectively ensures that Transgender persons who are single or unoperated cannot avail of it.

Non-Recognition of Hijra Culture: The bill doesn't take into account that some Transgender persons are members of the *Hijra/ Kinnar* community with its age-old tradition of *Guru-Chela*. This is parallel to the familial system and is a relief for the Transgender persons who have been thrown out of their families of birth. There is no provision of inheritance or legal recognition as parent/ guardian for those part of the Hijra families under the proposed bill.

No distinction with Intersex persons: The bill joins Transgender persons and Intersex persons together. This means that those who drafted the bill have no clear idea regarding the difference between biological sex and gender. While a few intersex persons may be Transgender, most are not. Also, this doesn't take into consideration that legally no surgical intervention is allowed in intersex persons prior to the age of 18 years. On the other hand, the needs of

Transgender persons below the age of 18 years may include prescription of puberty blockers to relieve gender dysphoria and help in better transition and passing.

Having said this, the bill in its current form is still better than its previous version which was passed in NDA's preceding term. Two specific provisions of the bill have been done away with much to the relief of the community. Firstly, the current bill has done away with the much-criticized, gate-keeping, screening committee, which was given the task of certifying who gets qualified to be called a Transgender person. Now it's self-identification, with a corollary; the task of screening committee is now shifted to the office of the District Magistrate - not much of a benefit. Secondly, the traditional practice of the *Hijra* community, of *'Badhai'*, was criminalized under the previous version of the bill under the pretext of begging. The same has also been done away with, thankfully.

While the bill, is a welcome step, it still leaves a lot. The seriousness of the government with respect to the Transgender persons' welfare will be tested in the near future as we get to see how effectively they work on the bill's provisions of education, healthcare, and other welfare measures. After the NALSA judgment, which directed central and state governments to provide welfare measures for the Transgender community, some states had sprung into action and set up Transgender welfare boards and provided certain services like separate identity cards, financial aid for sex reassignment surgery and hostel facilities. However, it has been mostly sporadic and highly inadequate for a community whose population runs into millions. So, even if the TG bill were to become a reality soon, how much will change on the ground needs to be seen.

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12

Language Matters

Dr. Aqsa Shaikh & Aritra Chatterjee***

Language matters; more so in the context of Transgender healthcare. A wrongly used word can lead to a loss of trust in the healthcare provider. Hence, it is absolutely necessary that we equip ourselves with the language which is correct, humane and depathologizing. In this context, here is a first-person account by Aritra.

Whose Language Is It?

Not too many years back, the NALSA judgment of 2014 delivered by the Supreme Court of India explicitly granted transgender persons the right to self-identification of their gender identity. To me, this surmises as an appreciable instance of how transgender health and well-being can be impacted by the institution of law and the 'language' in which this institution speaks. Central to the issue of 'language' is also the need to address

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and identify 'whose' interests does 'language' try to cater to, 'whom' does it speak for.

NALSA Judgment as I understand has been instrumental in the generation of two very seminal ideas: first, that gender can be determined by the self (giving agency to the transgender person to recognize themself as they want to); and second, that the self-identified gender of the person be constitutionally respected, protected and safeguarded in all walks of life. From a rights-based perspective that NALSA Judgment vouches for, social institutions must take the call for trans-inclusivity in their 'language' of operation. Asking for a person's preferred (read: correct) ways of addressing in terms of name and pronoun and practicing it in direct or indirect interactions might be a good place to start.

Glancing at NALSA Judgment, the picture in the courtroom might seem quite rose-tinted and progressive for transgender persons in India. However, it becomes necessary to reflect on how much of the 'language' of NALSA translates to the 'language' of the streets which is where most of the interactions of a transgender person vis-a-vis the society are played out. Has the larger society been sensitized to respect the transgender person's right to name their own body and experiences of gender that are embodied in their being? What is the 'language' in which the larger society speaks 'to' a trans individual or 'for' a trans individual-is it 'regardless' or 'regardful' of their gender-identity? These are speculations that we must reflect on when the discourse of 'how language matters' and 'how language can be made to matter' is settled.

Let me cite an instance from the cultural queer capital of the sub-continent to show how 'language' can be reclaimed and how such reclamation lends a different meaning to the same 'language'. In the cis-heteronormative framework of the Indian society, *'Hijra'* or *'chhakka'* still continues to be 'conveniently hijacked' as a 'derogatory', easily available, go-to, 'waste-basket category' for any assigned-male-at-birth individual with alternative gender expressions that digress from the social norm of masculinity. One needs to take to the streets to situate such aggressive stamping

in which shame is instituted into the personhood of the gender non-conforming 'male' individual (who may or may not identify as transgender even). This is not to denigrate the rich heritage of the *Hijra gharanas* as being vanguards of gender variance in the socio-cultural milieu of the Indian sub-continent. However, it is to speak 'for' the 'language' of the individual's right to align themself with the *Hijra* identity and 'against' the society's 'language' to use it as a tool of shame. It is also to reclaim *'Hijra'* from its socially constituted ignominy and shame to a potent and legitimate marker of the gendered self.

This instance has personal relevance for me and it reminds me of my school days when I being a 'male-bodied' individual used to be bullied for my effeminacy with the '*chhakka*' taunt. 'Language' does not merely rest in talk, but also covers gestures, which were thrown at me in the 'language' of my bullies showing how I walk, mimicking my voice, clapping at me (the '*taali*' (clap) is part and parcel of the *Hijra* tradition and a way of claiming space) to police the abomination that I was in being. It took me years of community mingling and feeling comfortable in my skin to be able to articulate my experience without being overwhelmed, to be able to realize that it is not my fault but the fault in their perception. At this juncture, if someone tries to berate me with the '*chhakka*' or "*hijra*' taunt, I have the 'language' to get back at them, to give them a dose of their own medicine, the 'language' to protect my dignity and reclaim 'hijra' in its positive essence. But I did not then, and the social institutions within which I operated never allowed me access to that 'language'. It feels saddening to know so many of my trans women acquaintances having undergone experiences of similar undertones.

To this, I may add the blatant disregard for my non-binary identity as a gender-fluid person that reflects in the 'language' in which I am spoken to. Deliberate usage of masculine pronouns seems vindictive after a point especially when I have taken the onus to spell out my correct pronoun and the ways I am comfortable being addressed. It is not just the mistake, but the reluctance to correct it when pointed out that bothers me more.

The recurrent repetitions of the same mistake across time and circumstances and my exhaustion in correcting it only underscore the sorry plight of affairs. In this instance, also comes the 'language' of self-presentation where one needs to 'appear' 'trans enough' to claim their pronouns. Maybe I need to be an observable melting point of male, female and beyond to be regarded as rightfully gender-fluid! That is the 'language' I have been made to understand by far. The kind of implications such misgendering (and the 'language' of cis-sexism which produces it) might have on my well-being is something I would leave to public speculation.

In the essence of it all, the question that I want to leave the reader with is: Whose language is it? And in that strain, 'who' has the right to hold the gates for the 'language' I want to be addressed by, the 'language' in which I want to be interacted with, referred to, represented as. Who decides my 'language' of identification? I would also implore them to think of this as not just a question that rises from one fragment of trans experience, but to speculate the collective proportion of it and how the 'language' of power and privilege speaks through this question.

A student of psychology, Aritra Chatterjee identifies as a gay and genderfluid person and takes a keen interest in LGBT+ mental healthcare and related issues. They has been actively connected with the Kolkata LGBT+ community and looks forward to building bridges to a just and respectful world that is sensitized to the nuances of gender and sexuality.

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Language matters in the context of conversations and it also matters in the context of scientific dialogues be it in a presentation in conference or writing papers. In this context, it is necessary for all the stakeholders to unlearn and learn the language which is acceptable to the trans individuals.

Language guidelines by the World Professional Association for Transgender Healthcare are worth following-

When submitting or delivering a presentation (plenary, workshop, oral presentation, poster, or otherwise), authors should:

1. Use terminology that is precise, scientifically based and detailed. The goal is to be clear rather than betraying bias. For example, if the evidence is being presented on chromosomal, hormonal, or gonadal status, we ask that authors use the specific terms. The terms actual sex/gender, genital/gonadal sex, or natal sex/gender are ambiguous and should be avoided.
2. Use current English language terminology. For example, in English, the term transgender is an adjective, as in "transgender person." Transgender is not a noun (i.e., the following is incorrect: "a study of 27 transgenders"). Transgendered and cisgendered are not correct.
3. When employing references to a person's sex recorded at birth, authors should say so explicitly or use terms such as sex assigned at birth, or legal sex (as appropriate).
4. Refer to trans-identified individuals in a way that respects current gender expression/identity when possible. Authors should assume, unless there is evidence to the contrary, that persons concerned are identified/referenced in their current gender identities even before undergoing medical or social transition.
5. Employ references to gender and sexual orientation that respect the gender identity of persons to whom they refer. For example, a person identifying as female should be referred to by way of words such as girl, woman, female, she, and her, etc. If she is attracted to men, she should be referred to as heterosexual, straight, androphilic, etc. Exceptions may occur when an individual specifically uses terminology, which differs from this recommendation when self-identifying.
6. Avoid language, which has the intention (or likely effect) of stigmatizing or pathologizing gender expression, gender identity, and/ or bodily characteristics. Stigmatizing and pathologizing language (e.g., "disordered", "abnormal", or "malformation") should be avoided. Affirmative language should be given preference, such as "gender and body

diversity", "gender diverse children", "trans and intersex people." For non-trans individuals, authors should avoid adjectives like "normal", and use terms like "cisgender", "non-transgender", or other similar terms, as appropriate.

7. Avoid language which belittles or undermines a person's gender identity or expression, such as referring to a person who identifies as female as "pretending to be female", "natal male", "transsexual/transgender male", or by using ironic quotation marks ('girl') to describe the person. All identifying language should reference the affirmed gender identity.
8. Avoid advocating interventions and practices, which are not consistent with human rights standards, such as coercing or otherwise imposing gender conformity upon gender and bodily diverse persons.
9. Use photos, videos or any other visual representations of individuals only with the explicit consent of the individuals, and refrain from violating individuals' right to privacy with photos or videos that are identifying. The exception would be for images of public figures that are already in the public domain or images, which have been previously published and are being used with permission from the publisher or copyright holder.
10. Avoid the use of photos, videos or other visual representations that pathologize or stigmatize gender and/or body diversity; avoid comments on visual representations that are disrespectful. Refrain from violating the children's right to privacy by presenting photos or videos that reveal their identity.
11. Collaborate with transgender individuals and communities who may help with language and terminology that can evolve rapidly over time and geographic location. These groups can help to select language and terminology that is relevant and meaningful to a target population.
12. Take care of translating materials. A term or concept such as gender identity may not have a direct counterpart in the

target language. Where translators are employed, they should be knowledgeable of both the target language and the cultural context.

13. Avoid ethnocentric bias. Be inclusive of cultural diversity, taking into account different concepts, practices, and experiences, while including references to the specific cultural context.

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13

A Parents Prespective

*Atul Kumar**

Let me start right at the beginning. Some twenty two years ago, my wife and I were blessed with a baby. The doctor who took care of the delivery told us that the baby was a perfectly healthy boy. We were delighted as were my parents. They became grandparents for the first time, after all. It took our child several years and us two decades to figure out that the doctors were wrong. The child was a girl born into a male body.

All went well for about three years and then when school began we started noticing some inner angst in my child. She was not comfortable going to school. I had to personally drive her to school and back for an entire year before we could get her on to the school bus. Things got better after a couple of years and she got better and happier. She showed signs of amazing brilliance and started enjoying childhood and school. The primary school went by well and she was selected to be the head of the student body of the primary wing when in grade V. After a few more enjoyable years things, started to deteriorate, however.

Puberty struck and that inner angst made a comeback. She became more and more socially reclusive and immersed herself in school and in her passion of computer gaming. The interest in

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gaming brought with it an interest in computer science and that eventually became her career interest. All the while she started becoming more and more reclusive. Wouldn't meet or greet people and kept herself busy with some or the other activity. Never mingled socially and hardly made any friends. At times we had confrontations with her about it all but she never really opened up about what was going on inside her.

After her grade XII, she got selected by a premiere engineering institute in India to study computer science. She was a top percentile kid in the selection process and later in college as well. As she went away from home to live in her residential college, we hoped that she would change for the better and be a happy young person she deserved to be. But no such thing happened. She became more and more reclusive and lived in her own cocoon.

After two and a half years at college, she revealed to us that she was suffering from depression. Always felt low on energy and enthusiasm and felt sad and low. We couldn't fathom any cause for this because she was doing very well academically, and as far as we knew she had no reason to feel low. We consulted a psychiatrist and she was prescribed antidepressants. The psychiatrist assured us that she should be fine very soon. But, even after four months on antidepressants, we saw no improvement in her condition. If anything, she kept getting worse.

By this time we started getting very concerned about her. We felt that there was something she was hiding from us. Something that was causing her to feel so depressed. And we were right. Parents can often sense this. More so, the mothers.

She mustered up the courage one day to reveal to us the cause of her depression. She was in her hostel and mostly using text messages to communicate with us. For reasons, we came to know later, she hated voice conversations. It all started that day with a strange message from her. There were three of us she addressed. Me, her mom and her sister. She asked if we would support her and be with her, no matter what. We were perplexed by the question but said, "yes of course." And then came a longer message. One that brought a change in all our lives that we could never

have anticipated. She revealed in an emotionally charged letter addressed to all three of us, that she was 'transgender'. Since she knew that we would not know what it meant, she went on to add that it meant that she was not a boy. She told us that her gender identity was that of a girl and she was born with a body that did not match with the mental gender identity. In simpler words, our child was a girl born with a male body.

Our acceptance was immediate. We told 'her' right away that we will be with her and support her, no matter what. You might have noticed, that I have used she/her pronouns, all throughout for her, even though we brought her up as a boy for 22 years. This is so crucial for transgender persons. They have this deep felt need for their loved ones to address them using pronouns which match their gender identity. It is an obvious no brainier for parents and families to support their kids under all circumstances. We were being no different in accepting our child for who she really was.

While the acceptance was immediate, coming to terms with this new information wasn't. We were distraught at the thought that our child was going to have a difficult path ahead. We all know how society treats transgender persons. It took a lot of time for us to come to terms with this revelation. We had our social fears. How will the relatives react? How will our friends and colleagues react? But soon we realised that the only way to deal with these social fears was to understand that, 'those who matter don't mind and those who mind don't matter'. Wasn't as easy at that time but after over a year we have realised that our social anxiety was not supported by rationality. Anxiety rarely is. We have since discussed the matter with many of our friends and relatives. Most, have been supporting. In the worst case we have the odd indifferent one but that's about it.

I will not mislead my readers into thinking that it was all easy. Let me assure you it wasn't. The emotional turmoil this revelation caused in the beginning took its toll. Within weeks we seemed to age several years. The central focus of our attention was to ensure that our child could move ahead in life and find

happiness and fulfilment. Just two days later my mother had to be hospitalised after a cardiac event. We felt that she noticed and saw what we were going through. We haven't told her the truth about her grandchild, yet. She came out of hospital in a week and is now in good health but we have not told her the fact that her "grandson" is actually a "granddaughter". We will when we feel that the time is right and I am certain that she will accept and love her granddaughter just the way she has always done.

While all this was on, we researched furiously on the internet. Hundreds and hundreds of YouTube videos and posts on Quora and we started to develop some understanding of what lay ahead. Our daughter shared with us, her deep felt desire to undergo a transition from male body to a female body. We had no idea about how to go about it. At that time our daughter was interning in a multinational company in a different city. We organised for her to come home to Delhi so that we could meet her psychiatrist and his associate counsellor. When these meetings took place, our hopes were dashed. The psychiatrist had practically no experience of guiding a transgender person's transition. He is a wonderful psychiatrist but felt helpless in the case. After another month of looking around we found a psychiatrist who did have a lot of experience in helping transgender persons. After some discussions with our daughter, he was convinced that she had no delusional disorder and she could go ahead with her transition. We then found an endocrinologist who could monitor her hormonal treatment. Our daughter then started her medical transition. It has been on now for over a year now. More on this later.

It was an uphill battle to find doctors who could treat and provide relief to our child. There are very few doctors around who have experience in the field of transgender healthcare. In a country as large as India with such a large population of transgender people, there is no provision for their healthcare needs. There isn't even one gender identity clinic in all of India. Hopefully this will change in time to come. There are thousands and thousands of transgender children out there who have little or

no access to healthcare. Many have no support from their families. Many do have family support but their parents are not resourceful enough to help them. There is a huge vacuum out there that needs to be filled. I would urge our government to look into this very urgent need. As of now only the affluent can afford proper healthcare for their transgender kids and that too is difficult to find. Also, there is a general lack of guidelines for the special healthcare needs. We need to evolve our own guidelines for which the international WPATH guidelines offer an excellent starting point. I am sure this compendium gives more informed perspective on the issue and so I will not dwell on it further.

I want the world out there to know about my struggle and more importantly that of my child so that others can get gainful insight. Hopefully, this will help reduce the trauma that so many trans kids suffer because of the lack of awareness among their family members.

There are so many issues that keep cropping up in the life of a transgender person. A year ago, when we became aware of our daughter's gender identity, we started realising the challenges she faced. She had some awareness of it even as a child but because society would have none of it, a full realisation took several years. She remained deeply closeted because she was born in a male body and was supposed to behave and live like a boy. The lack of opportunity in exploring one's gender identity is often the reason that the full realisation comes late for some trans kids. Some start expressing their gender identity as early as three or four while some do so well into their teens. They suppress themselves and often the closeted life leads to an "imposter syndrome" and severe depression follows. This is what happened with my daughter. Now, after a year on hormones , the depression has eased significantly. Though she still takes antidepressants, the doctor attending to her feels that she will be able to come off them in a few months from now.

Let me make you aware of some more of these challenges. Think of a girl, having to live in and behave like a boy in a boys hostel. Among boys brought up in patriarchal family set ups.

What a life she will have. Having to hide her true identity or face bullying and possibly abuse.There is no support for trans kids undergoing education. Life in college was extremely depressing and difficult for my daughter because there is no support available for trans kids in our educational institutions. She has now graduated and even though she has had this fight against severe depression, she has done very well academically.

After college, there was this offer to join the same MNC where she had interned earlier. Since any further study in a grad school is ruled out before completing transition, a good job offer was Godsent. There were challenges here too. We were apprehensive of her safety at work place. We feared that she might be bullied or harassed at work. Thankfully, most MNCs and some Indian corporates have started incorporating policies that are friendly towards LGBT employees in general and transgender employees in particular. So the MNC office where she works has gender neutral toilets and anti-harassment policies in place. So it's been a good entry for her there. Then there was the struggle for finding a safe accommodation for her. It's now been sorted and she is living safely and getting better every passing week. She has come out to the LGBT community employees at her workplace, though not to everyone. She plans to do so soon and her LGBT friends have assured that there will be no issues there. The building where she lives in is a bunch of studio apartments where no one knows anyone else. This in her case is a blessing in disguise. She feels safe there.

She looks forward to a happy fulfilling life and we as parents plan to be there to support her in every way we can. I know that there is a rocky road ahead. Surgeries, perhaps several of them and onsite visits outside the country loom on the horizon. We are aware that there are challenges ahead. Society as a whole remains hostile. Hopefully, we will be able to take it all in our stride and see our daughter bloom into a happy and contented individual.

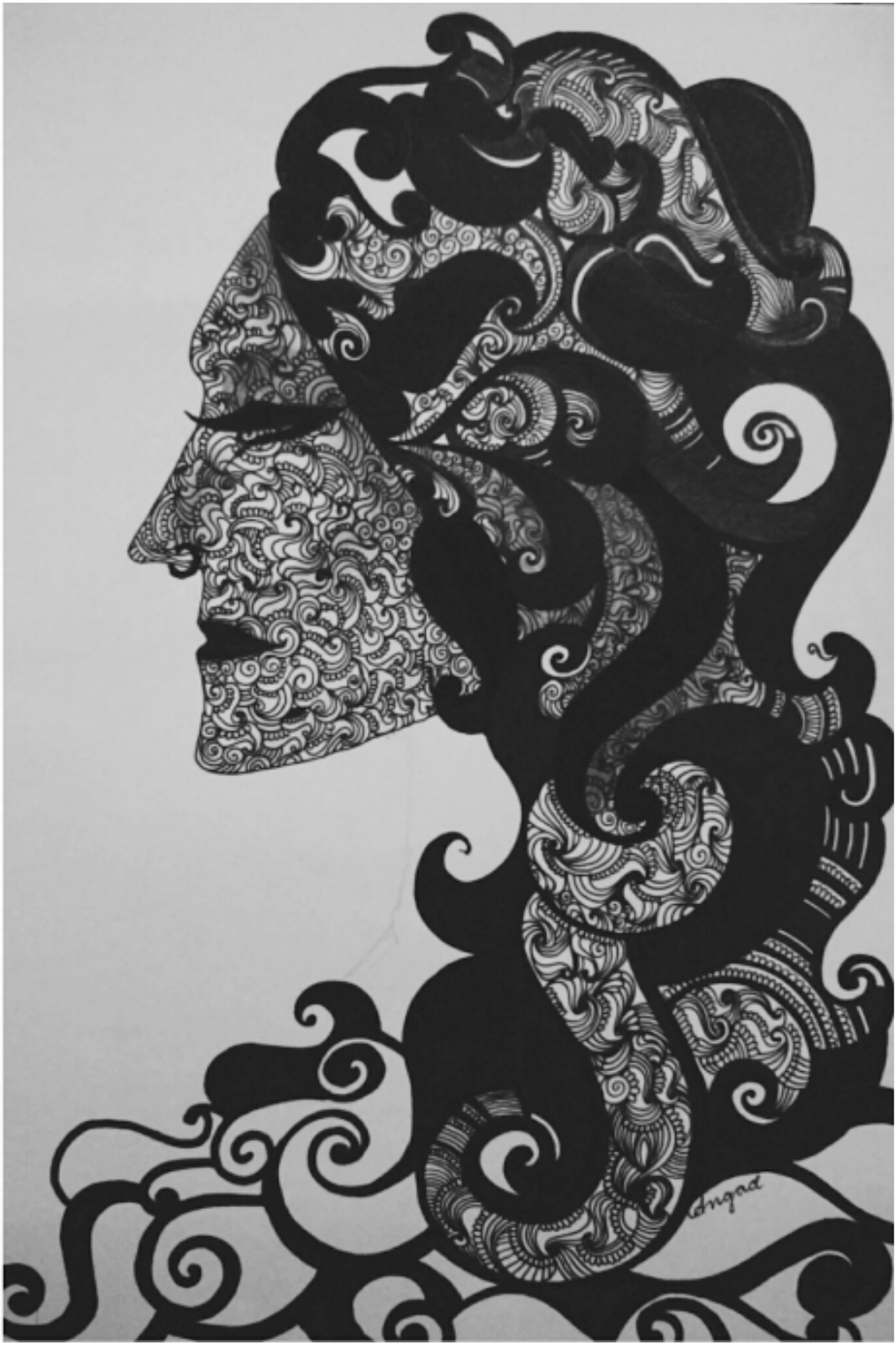
My message to everyone reading this write up is that LGBT people are humans and as much so as the rest of us. Being different

is no crime. Let us cherish them and let them grow. As Lord Ram says in the Ramcharitmanas

पुरुष "नपुंसक" नारीवजीवचराचरकोई
सर्वभावभजकपततजिमोहिपरमप्रियहोइ

PS: Since my daughter is not yet out to everyone at work, I have not revealed her identity details here. Her safety is of paramount importance and hence this decision. I hope the readers will understand.


Angad

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