

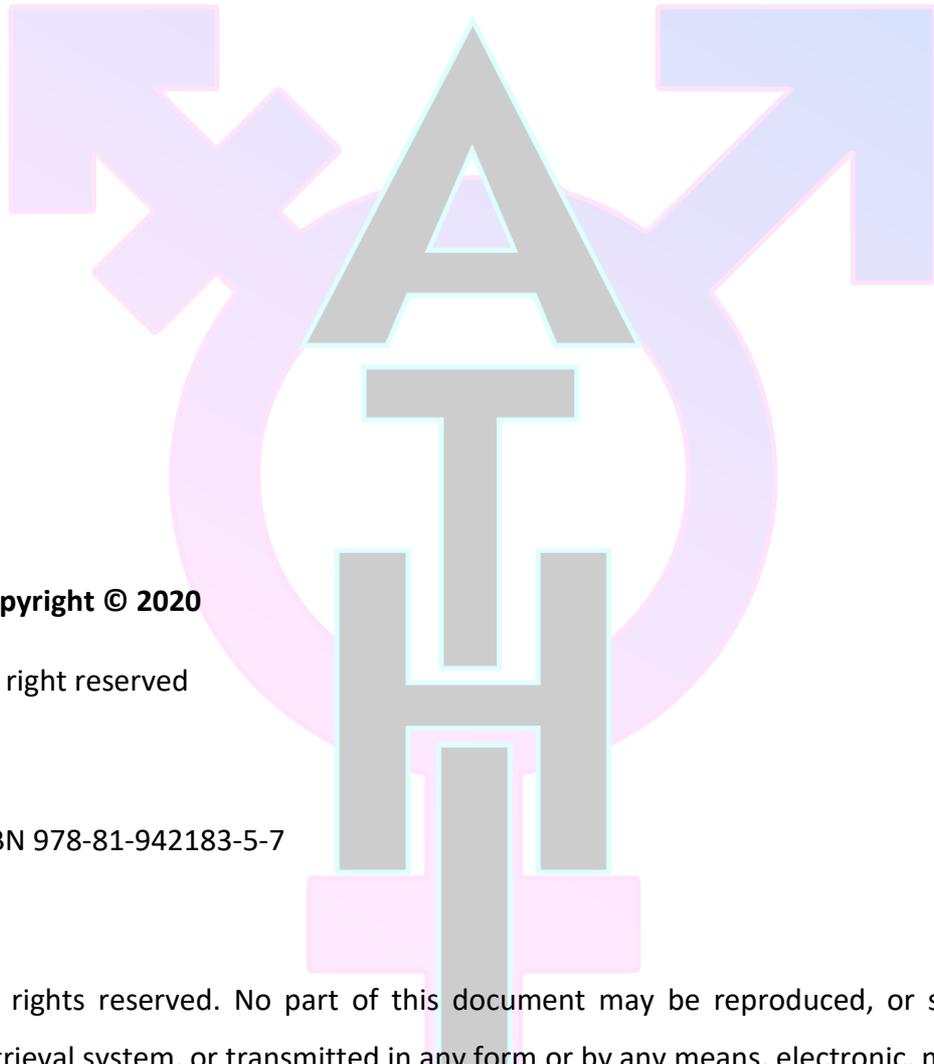
ISOC 1

Indian Standards of Care

Indian Standards of Care for
Persons with Gender Incongruence
and People with differences
in Sexual Development/Orientation



Association for
Transgender Health
in India



Copyright © 2020

All right reserved

ISBN 978-81-942183-5-7

All rights reserved. No part of this document may be reproduced, or stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without express written permission of the respective authors or Association for Transgender Health in India.

write2athi@gmail.com

Preface

Why Indian Standards of Care?

Gender for “humans” is more a matter of the “Being” rather than the “Body”. It is perception of “Who am I?” arising as a result of neural connections made in the biochemical milieu during early development, shaped by environmental influences. It is the pedestal on which the construct of “I” stands. It is an outcome of who one identifies as, the “my kind”, prompted by the “cues” others around them provide, the “who, the person is expected to be”, based on their own perception of “who, the person in question is”. A mismatch of the perception of others with that of the individual is what is termed as Gender Incongruence. The degree of incongruence is propagated by the perception and behavior of the majority in the environment, magnified by their degree of acceptance of diversity which is deeply rooted in the culture and societal norms of the place that the individual belongs to. It has been unequivocally endorsed by the strength of scientific evidence that favorable outcome is directly proportional to the resilience shown by the immediate family and willingness of the care-providers to help the individual navigate the societal hurdles. The task is compounded by the binary viewpoint and poor understanding of the “Transgender Experience” by the agencies, entrusted with the task of giving succor. To make matters worse the majority of the transgender persons have poor health-seeking behaviour as a result of the judgmental attitude of the care providers. The misinformed impressionable “client” is drawn to “Procedures” being offered in an unethical covert manner to a privileged few who can afford the high costs. The nonexistence of Indian Standards of Care and nonadherence to existing protocols in the above situation caused more harm than good, hence necessitating the development of Standards of Care which are both current and Indian in content and context for addressing the needs of the persons with Gender Incongruence and people with differences in sexual development /orientation.

The seed for “ISOC-1: Indian Standards of Care for persons with Gender Incongruence and people with differences in sexual development /orientation” was planted by the “Association for Transgender Health in India (ATHI)” in its first International Conference on Transgender Healthcare, IPATHCON 2019, organized in collaboration with Jamia Hamdard deemed to be university, at New Delhi, on the 1st and 2nd November 2019, wherein more than 200 professionals from various specialties and subspecialties, both from the medical and social sciences, working in the field of Transgender Healthcare came together on a single platform to share their academic and clinical experiences and interacted with members of the community in order to understand and address their felt needs. Enriched by the collective experience and encouraged by the success of IPATHCON 2019, a core group of professionals, allies and community members, cutting across various specialties, took on the onerous task of revisiting the rich heritage of the Indian culture which has celebrated and worshipped diversity, reviewing the existing guidelines and current medical evidence, brainstorming with policy makers to curate the best. It is indeed a result of their hard work that we announce with a resounding “Yes” on the 1st of November 2020, the release of benchmark document ISOC-1 to the medical fraternity during the IPATHCON 2020 aptly themed “Indian Standards of Care, are we there?”

The ISOC-1 endorses the progressive view of WHO which has de-pathologized Gender Incongruence and seeks to fill the lacunae in Transgender Healthcare by formulating best practices which are in sync with the globally accepted Standards of Care published by WPATH, SOC 7 and based on the emerging evidence that conflict arising as a result of incongruity between assigned sex and desired gender magnifies dysphoria and non-resolution may further distort psychosocial development compounded by the insensitive callous attitude of the cisgender majority, perpetuating an environment of mistrust and intolerance forcing the gender incongruent person to further harm at the hands of unscrupulous professionals who peddle pseudo-scientific 'quick fix' procedures.

ISOC-1 is a proponent of Affirmative Care, favoring early recognition of gender incongruity, provisioning of a gender-sensitive environment for psychosocial development and early access to Healthcare services stressing the need for adopting a multipronged proactive approach for the management of gender incongruence. The ISOC-1 aspires to be the base document for addressing the stakeholders' felt-need to acquire and share knowledge, facilitate the delivery of multispecialty Healthcare, empower through advocacy and implement legislation. It presses for a holistic public health approach to be adopted by all agencies, both Governmental and Non-Governmental, working to ensure equity in the delivery of Healthcare and mandates that existing policies be reworked to address the cause rather than manage the outcomes.

ISOC-1 seeks to be a dynamic document, constantly evolving and stimulating the professionals working in the field of Transgender Health, educationists, academicians, social workers, and community members to step out of their silos, interact with each other, undertake research and share their experiences to improve the successive editions of the Indian Standards of Care, making it a benchmark document for providing holistic and affordable Healthcare to all human forms irrespective of their self-affirmed gender identity or sexual orientation, harnessing the time tested strengths and expertise of the various national and international agencies working with or assisting the government to provide Social Justice and Health for All, laying the foundation of an all-inclusive society, wherein, all forms of gender identity and expression are nurtured and celebrated, where, new abilities emerging as a result of scientific progress permit all form of the human to live in harmony with dignity, embracing diversity and enjoying equal rights and privileges, as bestowed by the constitution.

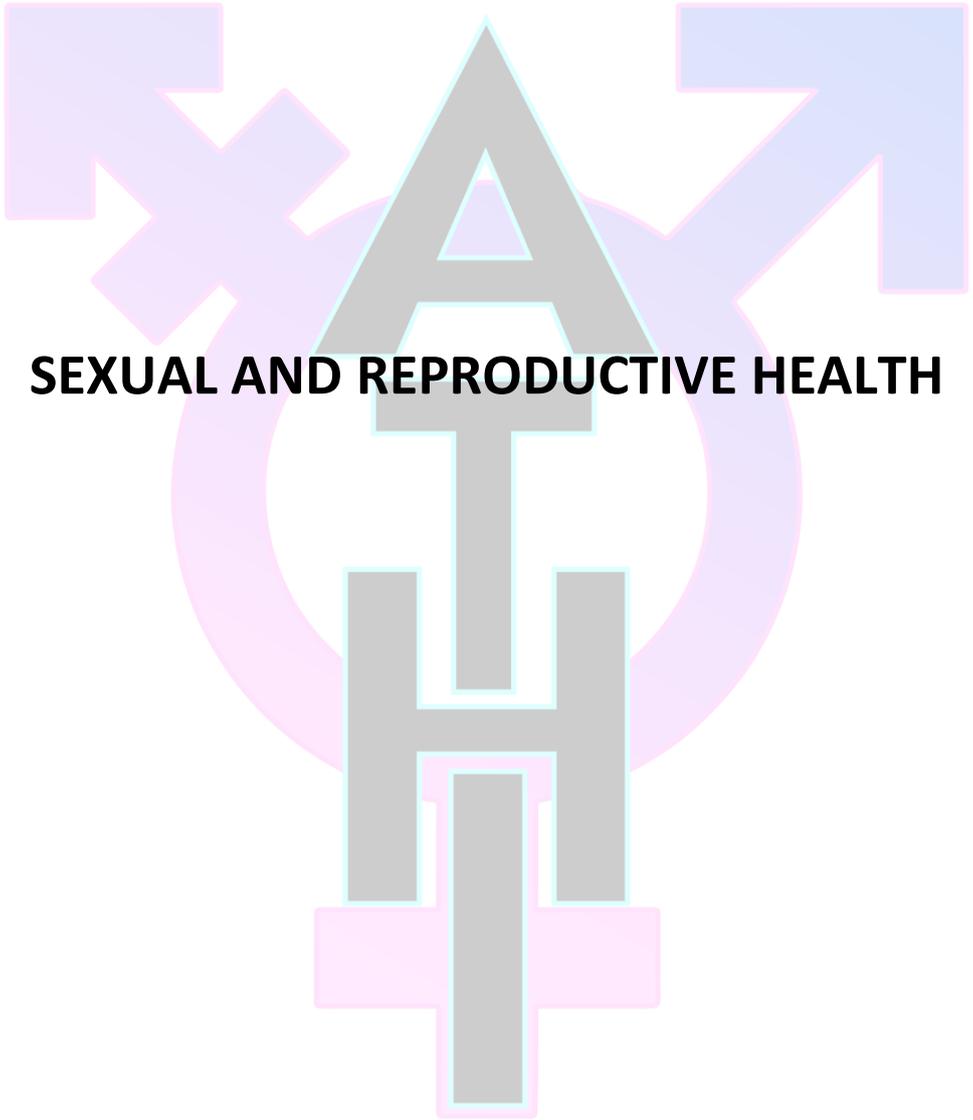
A handwritten signature in black ink, appearing to read "Sanjay Sharma", with a stylized flourish extending from the end.

Air Cmde (Dr) Sanjay Sharma (Retd)
CEO & Managing Director
Association for Transgender Health in India

Table of Contents

1. [Gender Affirmative Care: Sexual and Reproductive Health](#)
2. [Public Health Approach to Gender Incongruence](#)
3. [Parents Support Group](#)





SEXUAL AND REPRODUCTIVE HEALTH

Cancer Screening in Transgender persons

Contributing Author

Dr Sweta Gupta

Clinical Director & Sr Consultant Reproductive medicine
Medicover Fertility, Delhi India



LGBTQIA is the inclusive queer term which stands for lesbian, gay, bisexual, transgender, queer and/or questioning, intersex and asexual and/or allies.

Cancer screening: It is preventive way to detect cancer. Clinicians noted that trans persons' eligibility status was often misclassified¹. Providing appropriate cancer screening services to them can be particularly challenging, as appropriateness depends on an individual's natal and current anatomy, as well as where individuals are at with regard to their gender transition.

Prostate cancer: Discussion regarding risks and benefits of screening should start at age of 50 years. Palpation of prostate by rectal or transvaginal route if neovagina has been created. PSA testing should be performed (upper limit of normal range is 1 ng/ml). Removal of gonads in addition to estrogen exposure likely reduces risk for prostate cancer and benign prostatic hypertrophy.

Testicular cancer: Routine testicular cancer screening is not recommended in cisgender men and there is no evidence to perform screening in transgender women. Transgender women adherent to therapeutic doses of estrogen plus an androgen blocker, and with persistent testosterone elevations, should be evaluated for testicular tumors by physical exam, as well as human chorionic gonadotropin (hCG), alpha-fetoprotein (AFP) and lactic dehydrogenase (LDH) levels, and possibly a scrotal ultrasound.

Transwomen Cancer Screening Guidelines

Type of Cancer	Screening needed?	When to start	Modality of Screening	Frequency
Breast	Yes, when over age 50 years and after at least 5 years of Feminizing Hormonal intervention	No earlier than age 50 years	Mammography	Every two years (USPSTF Guidelines)
Prostate	No, same as cisgender person*	N/A	N/A	N/A
Testicles	No, same as cisgender person	N/A	N/A	N/A

*Transwomen are believed to have lower risk of prostate cancer from estrogen therapy and orchiectomy

Transmen Cancer Screening Guidelines

Type of Cancer	Screening needed?	When to start	Modality of Screening	Frequency
Breast	In case of Bilateral Mastectomy: No clear guideline	Age 50 years	Ultrasound or MRI	Unclear
	In case of breast reduction surgery: same as non-transgender individuals	Age 50 years	Mammogram	Every two years (USPSTF Guidelines)
Cervix	Same as cisgender individuals, discontinue after total Hysterectomy*	Age 21 years**	PAP Smear***	Every three years
Ovary	Not indicated	N/A	N/A	N/A
Uterus	Not indicated, unless new unexplained vaginal bleeding	As needed	Endometrial biopsy	As per clinical status

*Unless history of CIN II/III. In that event, continue screening for 20years after hysterectomy.

** If HIV positive then first PAP smear should be within first one year of diagnosis.

***Consider using pediatric speculum with lubrication, oral benzodiazepine pre-examination or vaginal estrogen for a week prior to collection.

References

1. Grynberg M, Fanchin R, Dubost G, et al. . Histology of genital tract and breast tissue after long-term use testosterone administration in a female-to-male transsexual population. *Reprod Biomed Online*. 2010;20:553–558 [PubMed] [Google Scholar]
2. Puech AM, Russell K, Gray B. Care and Cancer Screening of the Transgender Population. *Journal of women’s health* 2019 Volume 28, Number 6, 201
3. Nelson B A cancer screening crisis for transgender patients. *Cancer Cytopathology* 2019 July
4. Allison M. Puechl, MD
5. Allison M. Puechl, MD Beverly A. Gray, M

Contraceptive needs of Transgender Persons

Contributing Author

Dr Mala Arora

FRCOG (UK) FICOG FICMCH

Chairperson of Indian College of Obst & Gynae 2017

Vice President FOGSI 2011

E-mail: narindermala@gmail.com



Introduction

Transgender men who have not had their pelvic organs removed will need contraceptive advice to prevent pregnancy. This need is never requested by the person, but the physician needs to assess this need by direct questioning. If the pelvic organs have not been removed this issue should be discussed. Sexual abuse by male partners may lead to an unwanted pregnancy.

Desirable Choices

Reversible methods (LARC)

Long term contraception is required. Progesterone has been found to be safe for use in both adult and adolescent transitioning transgender people. Moreover, it does not interfere with testosterone use and contributes to amenorrhea as well. Pills are not a good choice due to compliance issues in the long term and its recurring cost.

- Subdermal implants may be used
- Depo-Provera® injection popularly known as DMPA is a cost effective non-invasive and widely available preparation in India. This is an excellent choice for adolescents as it produces reversible amenorrhea and gives time for detailed psychological assessment. It does cause some reduction in bone mineral density, between 3-7% in the first two years of use but this is completely reversible after its use is discontinued. For detailed discussion on this issue the reader is referred to the position paper of the society of Adolescent medicine published in 2006. (see ref 5,6 below)

Classically puberty is suppressed with the use of depot GnRH agonists in this population. The cost as well as the bone mineral density reduction is greater with injections of GnRH agonists if used long term in this population. Hence, they should be used for the shortest duration possible. Follow up DEXA Scans are recommended to check bone mineral density in this population.

- It is also ideal to insert an Intrauterine device for such individuals. The Copper IUD may be inserted but the hormonal levonorgestrel intrauterine device (LNG-IUS) is suitable as it prevents breakthrough bleeding. The only disadvantage is that it is an invasive procedure.

Insertion will require short anaesthesia as pelvic examination is uncomfortable due to vaginal atrophy as well as it can trigger gender dysphoria.

Permanent Methods

- Sterilization by the laparoscopic route is a suitable form of permanent contraception but is invasive.
- Ensure device placed hysteroscopically to occlude the tubal ostia is also a desirable alternative
- Hysterectomy with bilateral salpingo oophorectomy may be opted for by some to get rid of the menace of undesirable breakthrough bleeding

Undesirable choices

- Oral Contraceptive pills are not an option because they may cause withdrawal bleeding and moreover these individuals are on testosterone intervention.
- Barrier Contraceptives are uncomfortable to use and have a high failure rate. Hence, they are not a desirable choice.

References

1. Light A, Wang LF, Zeymo A, Gomez-Lobo V. Family planning and contraception use in transgender men. *Contraception*. 2018 Oct;98(4):266-269. doi: 10.1016/j.contraception.2018.06.006.
2. Lynch MM, Khandheria MM, Meyer WJ. A retrospective study of the management of childhood and adolescent gender identity disorder using medroxyprogesterone acetate. *Intl J Transgenderism*. 2015;16:201–208 [[Google Scholar](#)]
3. Scholes D, LaCroix AZ, Ott SM, et al. . Bone mineral density in women using depot medroxyprogesterone acetate for contraception. *Obstet Gynecol*. 1999;93:233–238 [[PubMed](#)] [[Google Scholar](#)]
4. World Health Organization. Department of Reproductive Health and Research. WHO statement on hormonal contraception and bone health. *Wkly Epidemiol Rec*. 2005;35:302–304 [[Google Scholar](#)]
5. Cromer BA, Scholes D, Berenson A, et al. . Depot medroxyprogesterone acetate and bone mineral density in adolescents—the black box warning: a position paper of the Society for Adolescent Medicine. *J Adolesc Health*. 2006;39(2):296–301
6. Carel JC, Eugster EA, Rogol A, et al. . Consensus statement on the use of gonadotropin-releasing hormone analogs in children. *Pediatrics*. 2008; 123:e752–e762
7. Vlot MC, Klink DT, den Heijer M, et al. . Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in transgender adolescents. *Bone*. 2017;95:11–19

Recommendations for Fertility Preservation in Transgender Individuals in India

Contributing Author

Dr Nalini Kaul-Mahajan
(MD, M Med Sci (ART), FICOG)
Founder President Fertility Preservation Society of India



Introduction

Transgender person denotes an individual whose sense of personal identity and gender does not correspond with their sex assigned at birth. The term 'Gender dysphoria' is often used to explain the emotional struggle such individuals undergo to deal with their gender identity- a discordance between sex (external appearance of genitalia) and gender (psychological recognition of self). (Ahuja and Bhattacharya 2001) Intersex individuals on the other hand have anatomy that is ambiguous at birth. Transgender individuals can be offered Gender-affirming intervention (GAI) which could be surgical - gonadectomy (removal of testes or ovaries) and/or gender affirmative hormonal intervention. These interventions invariably lead to loss of reproductive potential making it mandatory to have a discussion on fertility preservation before initiation of GAI. The number of persons having Gender Incongruence in India has increased in the past 5 years and many of them are seeking Gender Affirming Surgery (GAS). (Gupta et al 2017)

In recent years, transgender issues are coming to the fore in children and adolescents. Psychological evaluation and counselling are essential before they are given GAI which includes pubertal suppression and gender affirming hormones. Fertility preservation options should be discussed by the Gender Affirmation Team with the child and parents / guardians before starting intervention since they are the decision makers, raising considerable ethical concerns. A major worry being the inability of a young child to fully comprehend the consequences of their decision. The Endocrine Society therefore recommends that only pubertal suppression using GnRH analogues should be offered till the age of 16 years (Hembree et al 2017). GnRH agonists induce a reversible arrest of germ cell maturation and development of secondary sex characteristics.

The preservation of fertility or reproductive capacity developed initially for cancer persons needing gonadotoxic intervention (Chemo intervention/ radio intervention) or gonadal surgery, has been extended to many other person groups at risk of infertility due to medical, surgical and genetic causes, as well as age related ovarian insufficiency. The need for fertility preservation (FP) in the transgender group of individuals has also been acknowledged by medical professionals. Studies show that more than 50% persons want to have children and between 37- 76% would opt for fertility preservation, though the actual number who finally undergo the procedure is small 3.1% (transmen) to 9.6%(transwomen) (Neblett et al 2019). The rate of FP amongst trans-gender youth is reported to be 3-5% (Nahata et al 2017)

Barriers to fertility preservation from the transgender person's perspective include undesired side effects of hormones or apprehension about invasiveness of procedure and a delay in their GAI. Lack of awareness, availability, cost and efficacy of fertility preservation procedures are major barriers on the physician front, particularly in India. (Mahajan et al 2016) Paucity of literature on management of transsexual people in India (Gupta and Morarka 2009) precludes the possibility of assessing the level of discussions on fertility preservation.

In India, the Transgender Persons (Protection of Rights) Bill was passed in July 2019. It includes trans-men, trans-women, persons with intersex variations, gender-queer, and persons with socio-cultural identities, such as kinnar and hijra (Ministry of Social Justice and Welfare)

This bill protects such individuals from discrimination and gives them equal rights to health, education, employment, state welfare and comprehensive medical insurance

schemes. Certificate of identity for a transgender person indicates gender as transgender. A revised certificate can be acquired only after Gender Affirming Surgery (GAS). This long-awaited bill has come as a huge relief to both individuals wanting GAS and doctor performing the surgery, as it affords legal protection.

A list of FP procedures and the recommendations offered, for Indian transgender persons contemplating GAI are extrapolated from FP recommendations for onco-fertility procedures promulgated by The Fertility Preservation Society (India) –(FPSI) with inputs from leading Oncology and Reproductive Medicine experts in the country, keeping in mind social, ethnic and religious differences.

Fertility preservation options include sperm and testicular tissue cryopreservation for males and oocyte, embryo and ovarian tissue cryopreservation (OTC) for females. Oocytes need to undergo ICSI with donor sperm when the individual wants to have a child. All the above procedures except OTC are widely available in India in the private sector and some government hospitals.

Fertility Preservation Recommendations (FPSI)

A. FP counselling should be done prior to GAI in all transgender people desirous of future fertility.

B. Consent - Detailed consent for procedure should be taken. For children and adolescent consent of parents and assent of child is required. Consent for posthumous use/disposal of gametes/tissue should also be taken.

C. Post pubertal Males (Sex assigned at birth) (MtF)

1. Semen cryopreservation (CP) is recommended. Preferably 2-3 samples of semen should be cryopreserved.
2. Collection of ejaculate can be through masturbation. Vibrators – mechanical or electrical, can be used if person is unable to produce a masturbated sample.
3. TESA (Testicular sperm aspiration) can be offered to post-pubertal males when semen collection is not possible.
4. Semen can be used for IUI or IVF to achieve pregnancy. ICSI (intra cytoplasmic sperm injection) is required in case testicular sperm is to be used.

D. Post pubertal Females (Sex assigned at birth) (FtM)

1. FP procedures include oocyte, embryo and ovarian tissue CP.
2. Oocyte cryopreservation (CP) is the procedure of choice.
3. Embryo freezing is an established technique and may be offered. Donor sperm would be required for fertilization
4. Ovarian tissue cryopreservation (OTC) involves surgical retrieval of ovarian tissue and transplantation subsequently when pregnancy is desired.
5. Oocyte and embryo CP necessitates ovarian stimulation (OS) with gonadotrophins for 9-10 days and an approximate delay of 6 – 8 weeks is expected for undergoing GAS and 3-4 weeks for gender affirmative hormonal intervention.
6. Safety of OS in FP has been established.
7. Efficacy: For cryopreserved oocytes - 10-16 oocytes ensure a reasonable chance of

reproductive success in young women. An oocyte-to-baby rate of 6.5% has been estimated (Cobo et al., 2015), probability of live birth increases progressively till number of used oocytes reaches 25.

OTC- is no longer considered experimental. Many births have been reported worldwide after transplantation of CP thawed ovarian tissue.

8. There is no increased risk of birth defects or genetic diseases in infants delivered from CP oocytes, embryos or OTC.

E. FP options in children and adolescents

Pre-pubertal boys: Spermathe occurs at approximately 13 years and can precede testicular growth and development of pubic hair. Experimental techniques such as immature testicular tissue (ITT) and spermatogonial stem cell (SSC) cryopreservation followed by transplantation or in vitro maturation can be performed. No pregnancies have been reported in humans so far.

Post pubertal boys: semen and testicular tissue can be preserved. Masturbation is generally possible even in young adolescents provided testicular volume is more than 5 mL. (Hagenas et al 2010)

Pre-pubertal females: ovarian tissue cryopreservation is an option. Ovarian tissue needs to be transplanted for restoration of endocrine function and ovulation. Transgender boys (FtM) may not be keen on this. Alternatively, in-vitro maturation (IVM) of oocytes can be performed.

F. Pregnancy can be achieved through surrogacy in both MtF and FtM cases. Pregnancy in self is feasible in FtM after stopping testosterone intervention and has been reported. Uterine transplantation may be a future option in MtF individuals but currently it is experimental.

References

Ahuja RB, Bhattacharya S. Intersex Transsexuality and gender reassignment surgery. *Indian J Plast Surg.* 2001;34:83.

Cobo A, Garrido N, Pellicer A, Remohí J. Six years' experience in ovum donation using vitrified oocytes: report of cumulative outcomes, impact of storage time, and development of a predictive model for oocyte survival rate. *Fertil Steril.* 2015;104(6):1426–34.e348. doi:10.1016/j.fertnstert.2015.08.020

Fertility Preservation Society (India) Recommendations for Fertility Preservation in Persons on Gonadotoxic Intervention. www.fpsind.com

Gupta, A., Nanda, B., Mangal, M., Gambhir, S., & Reddy J, S. (2017). Gender reassignment surgery: Our experience of 20 cases. *Current Medicine Research and Practice*, 7(6), 215–219. doi:10.1016/j.cmrp.2017.10.001

Gupta R, Murarka A. Treating transsexuals in India: History, prerequisites for surgery and legal issues. *Indian J Plast Surg.* 2009 Jul;42(2):226-33. doi: 10.4103/0970-0358.59287. PMID: 20368863; PMCID: PMC2845370.

Hagenas I, Jorgensen N, Rechnitzer C, et al. Clinical and biochemical correlates of successful semen collection for cryopreservation from 12-18-year-old persons: a single-center study of 86 adolescents. *Hum Reprod* 2010;25(8):2031–8.

Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine intervention of gender-dysphoric/gender-incongruent persons: an endocrine society clinical practice guideline. *J Clin Endocrinol Metab* 2017;102(11):3869–903. [SEP]

Mahajan N, Patil M, Kaur S, Kaur S, Naidu P. The role of Indian gynecologists in oncofertility care and counselling. *Journal of Human Reproductive Sciences*, Year 2016, Volume 9, Issue 3 [p. 179-186] DOI: 10.4103/0974-1208.192061 PMID: 2780358

Neblett MF 2nd, Hipp HS. Fertility Considerations in Transgender Persons. *Endocrinol Metab Clin North Am.* 2019;48(2):391–402.doi:10.1016/j.ecl.2019.02.003.

Nahata L, Tishelman AC, Caltabellotta NM, et al. Low fertility preservation utilization among transgender youth. *J Adolesc Health* 2017;61(1):40–4.

Hysterectomy and Bilateral Salpingo-oophorectomy

Contributing Author

Dr Mala Arora

FRCOG (UK) FICOG FICMCH

Chairperson of Indian College of Obst & Gynae 2017

Vice President FOGSI 2011

E-mail: narindermala@gmail.com



Many transmen opt for definitive surgery, which is performed in stages. Hysterectomy should be offered along with bilateral salpingo-oophorectomy. Vaginectomy and Genital reconstruction surgery can be performed at another sitting.

Criteria for hysterectomy and salpingo-oophorectomy in FtM persons and for orchiectomy in MtF persons:

1. Persistent, well-documented gender dysphoria.
2. Capacity to make a fully informed decision and to consent for intervention.
3. Age of majority in a given country.
4. If significant medical or mental health concerns are present, they must be well controlled.
5. Twelve continuous months of gender affirmative hormonal intervention as appropriate to the person's gender goals (unless hormones are not clinically indicated for the individual).
6. Recommendation by a mental health specialist

The laparoscopic Total Abdominal Hysterectomy is the preferred method in Transgender individuals.

The options of future fertility should be discussed with the individual prior to embarking on this procedure. Transmen have successfully born children and this option should definitely be discussed. Some may opt out of it for some time and some may not afford this surgery or avoid it for other reasons. They need to be counseled for contraceptive use as well as appropriate screening for cervical ovarian and endometrial cancers.

Reference

1. American College of Obstetricians and Gynecologists (ACOG) Committee on Gynecologic Practice. ACOG Committee Opinion No. 444: choosing the route of hysterectomy for benign disease. *Obstet Gynecol.* 2009;114:1156–1158 [[PubMed](#)] [[Google Scholar](#)]

Reproductive Options

Contributing Author

Dr Mala Arora

FRCOG (UK) FICOG FICMCH

Chairperson of Indian College of Obst & Gynae 2017

Vice President FOGSI 2011

E-mail: narindermala@gmail.com



Presently there are no laws in our country that talk about parenting rights of the transgender population. The bill drafted in 2019 does not discuss this issue. Marriages between transmen and trans or cis women have been reported with increasing frequency and the need for parenting does arise.

Pregnancy may occur in transmen if the uterus and ovaries are present even while taking cross gender affirmative hormonal intervention. Gender affirmative hormonal intervention should be stopped as soon as pregnancy is achieved or in the pre pregnancy counseling clinic. People can experience feelings of loneliness and isolation during pregnancy, caused by gender dysphoria, effective communication and inclusive language in the work has suggested using the term 'pregnant people' instead of 'expectant mothers' so as to include pregnant intersex men and transmen.

Although pregnancy may increase the dysphoria, many transmen continue the pregnancy and welcome a genetic offspring. They shy the public eye and hence antenatal appointments are not attended regularly. From the obstetrician's point of view, Antenatal Care and delivery follow general obstetric principles. Many may request elective cesarean section as compared to vaginal delivery. Chest feeding is also possible, and a testosterone intervention is re-instated post breast feeding.

Conversely some transmen may seek *Assisted reproductive technologies (ART)* to help them achieve a pregnancy. The commonly performed procedure is *Intrauterine Insemination (IUI)* of partner/donor sperms to achieve a pregnancy. If *In vitro fertilization (IVF)* is required, oocytes may be retrieved after ovarian stimulation, fertilized by partner sperms and embryos can be formed. Transwomen partners may opt for sperm retrieval by testicular sperm aspiration (TESA) and intracytoplasmic injection in the oocyte. (ICSI). Embryos thus formed may be replaced in transmen or frozen for future use.

Surrogacy is banned in India for transgender and same sex couples.

Adoption by transgender individuals is not legal in India. However, several transwomen adopt children outside the legal framework. Often very poor children are left uncared for and transwomen are known to take care of them. Gauri Sawant made history by publicly adopting a girl child of an HIV positive sex worker.

If an accidental pregnancy is undesirable, termination can be offered by medical /surgical means. Contraception options should be discussed and implemented prior to discharge from care.

References

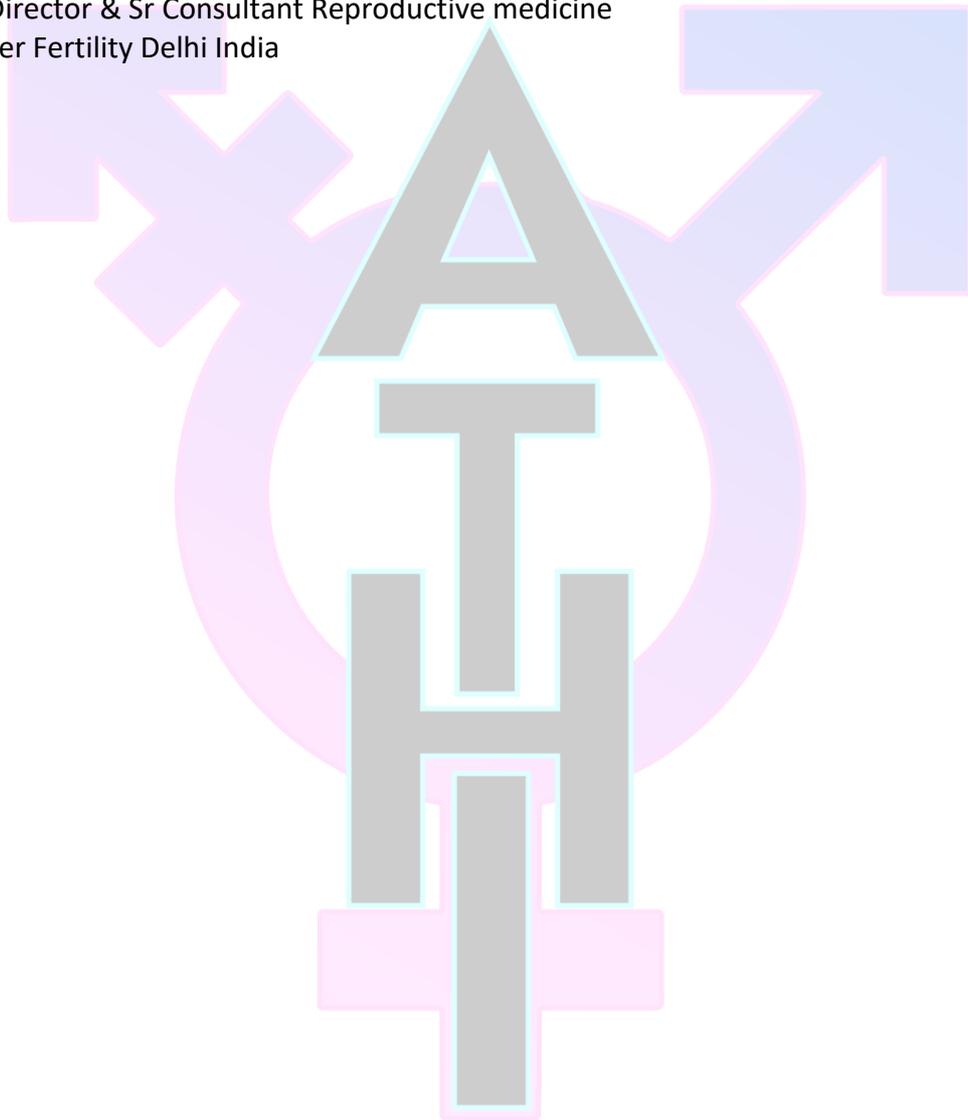
1. Light AD, Obedin-Maliver J, Sevellius JM, Kerns JL. Transgender men who experienced pregnancy after female-to-male gender transitioning. *Obstet Gynecol.* 2014;124:1120–1127 [[PubMed](#)] [[Google Scholar](#)]
2. Hoffkling A, Obedin-Maliver J, Sevelius J [From erasure to opportunity: a qualitative study of the experiences of transgender men around pregnancy and recommendations for providers.](#) *BMC Pregnancy Childbirth.* 2017 Nov 8;17(Suppl 2):332. doi: 10.1186/s12884-017-1491-5

Monitoring Gender affirmative hormonal intervention

Contributing Author

Dr Sweta Gupta

Clinical Director & Sr Consultant Reproductive medicine
Medicover Fertility Delhi India



Commencement

- Prior to commencing hormone intervention, confirm criteria for starting gender affirmative hormonal intervention. A thorough counselling of person for time required for expecting physical response of either feminization or masculinization and possibilities of adverse effects should be discussed. A risk assessment and if required modifications should be done in hormonal regimens, physical examination including blood pressure monitoring and baseline blood tests to assess suitability for the start of the intervention. Blood tests include full blood count, renal profile, liver function tests, fasting blood glucose levels, lipid profile, thyroid function and hormone assay of oestrogen, testosterone and prolactin levels. Reproductive gametes cryopreservation should be considered before initiating gender affirmative hormonal intervention (Refer to section below)

Monitor every 3 months for first year, 6 months for 3 years, then yearly

Monitoring for assessing response and evaluation for any adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs and symptoms of excessive weight gain, acne, uterine break-through bleeding, and cardiovascular impairment, as well as psychiatric symptoms in at risk persons. Physical examinations should include general physical exam including measurement of heart rate, blood pressure, weight, as well as systemic, heart, lung, and skin exams. Laboratory monitoring should be individualised based on the risks of gender affirmative hormonal intervention, and person's individual comorbidities and risk factors.

Target hormone level:

- For hormone (testosterone) intervention for transgender men (FTM) target is to increase testosterone levels to the normal male physiological range (300–1000 ng/dl).
- For gender affirmative hormonal intervention (administering an antiandrogen and estrogen) for transgender women (MTF) is to decrease testosterone levels to the normal female range (30–100 ng/dl) without supra- physiological levels of estradiol (<200 pg/ml).

Monitoring for transgender men (FTM) on gender affirmative hormonal intervention:

1. Monitor for virilizing and adverse effects every 3 months for first year and then every 6 – 12 months.
2. Monitor serum testosterone at follow-up visits with a target in the male range (300 – 1000 ng/dl).
3. Monitor hematocrit and lipid profile before starting hormones and at follow-up visits.
4. Bone mineral density (BMD) screening before starting hormones for persons at risk for osteoporosis and in others at age 60 years onwards or earlier if sex hormones are consistently low.
5. FTM persons with cervixes or breasts should be screened for malignancy from age 40-65 years at regular intervals.

Monitoring for transgender women (MTF) on gender affirmative hormonal intervention:

1. Monitor for feminizing and adverse effects every 3 months for first year and then every 6– 12 months.
2. Monitor serum testosterone and estradiol at follow-up visits with a target in the female range (testosterone 30 – 100 ng/dl; E2 <200 pg/ml).
3. Monitor prolactin and triglycerides before starting hormones and at follow-up visits.
4. Monitor potassium levels if the person is taking spironolactone.
5. BMD screening before starting hormones for persons at risk for osteoporosis. Otherwise, start screening at age 60 or earlier if sex hormone levels are consistently low.
6. MTF persons should be screened for breast and prostate cancer appropriately.

Risks /Adverse effects/Complications:

MTF

One should be watchful of following complications like

- potential risk of *venous thromboembolism (VTE)* associated with estrogen use, transdermal estrogen confers a lower thromboembolic risk
- increased incidence of *gallstones and liver dysfunction* and
- increased incidence of *breast cancer* while using estrogen intervention, same as the background rate of breast cancer in males.

Some absolute contraindications of estrogen intervention includes previous venous thrombotic events related to an underlying hypercoagulable condition, history of estrogen-sensitive neoplasm, and end-stage chronic liver disease.

FTM

Complications of female to male (FTM) include

- *vaginal atrophy* due to long term testosterone intervention,
- *menstrual related problems* because of long term GnRH and testosterone replacement, onset of menstrual bleeding in those previously amenorrhoeic on testosterone, or any abnormal bleeding, should prompt consideration of endometrial hyperplasia as an underlying pathology, Progestogens such as norethisterone or medroxyprogesterone are used to abolish menses if ovarian activity is not adequately suppressed by testosterone intervention alone.
- Testosterone intervention is associated with cortical and thecal thickening of the ovary leading to polycystic ovary metabolic profile and acne.
- Few published reports of *ovarian cancer* in transmen. Earlier surgical recourse in the form of hysterectomy may be indicated , as delay can be detrimental to the person.
- Testosterone induces the production of erythropoietin, serious risk *polycythaemia*.
- Polycythaemia can predispose to a *cerebrovascular accident*.
- Elevated liver enzymes and hyperlipidemia are also possible risks.

Absolute contraindications to testosterone intervention include pregnancy, unstable coronary artery disease, and untreated polycythemia with a hematocrit of 55% or higher.

Because the aromatization of testosterone to estrogen may increase risk in persons with a history of breast or other estrogen dependent cancers

References

1. **Gardner, Ivy and Safer, Joshua D.** 2013 Progress on the road to better medical care for transgender persons. *Current Opinion in Endocrinology, Diabetes and Obesity* 20(6): 553-558.
2. Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA, et al. . Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab.* 2009;94:3132–3154 [[PubMed](#)] [[Google Scholar](#)]
3. Spratt DJ, Stewart I, Savage C, et al. . Subcutaneous injection of testosterone is an effective and preferred alternative to intramuscular injection: demonstration in female-to-male transgender patients. *J Clin Endocrinol Metab.* 2017;102:2349–2355 [[PubMed](#)] [[Google Scholar](#)]
4. World Professional Association for Transgender Health (WPATH). *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, 7th Version. WPATH, 2012 [[Google Scholar](#)]

Management of Uterine Bleeding

Contributing Author

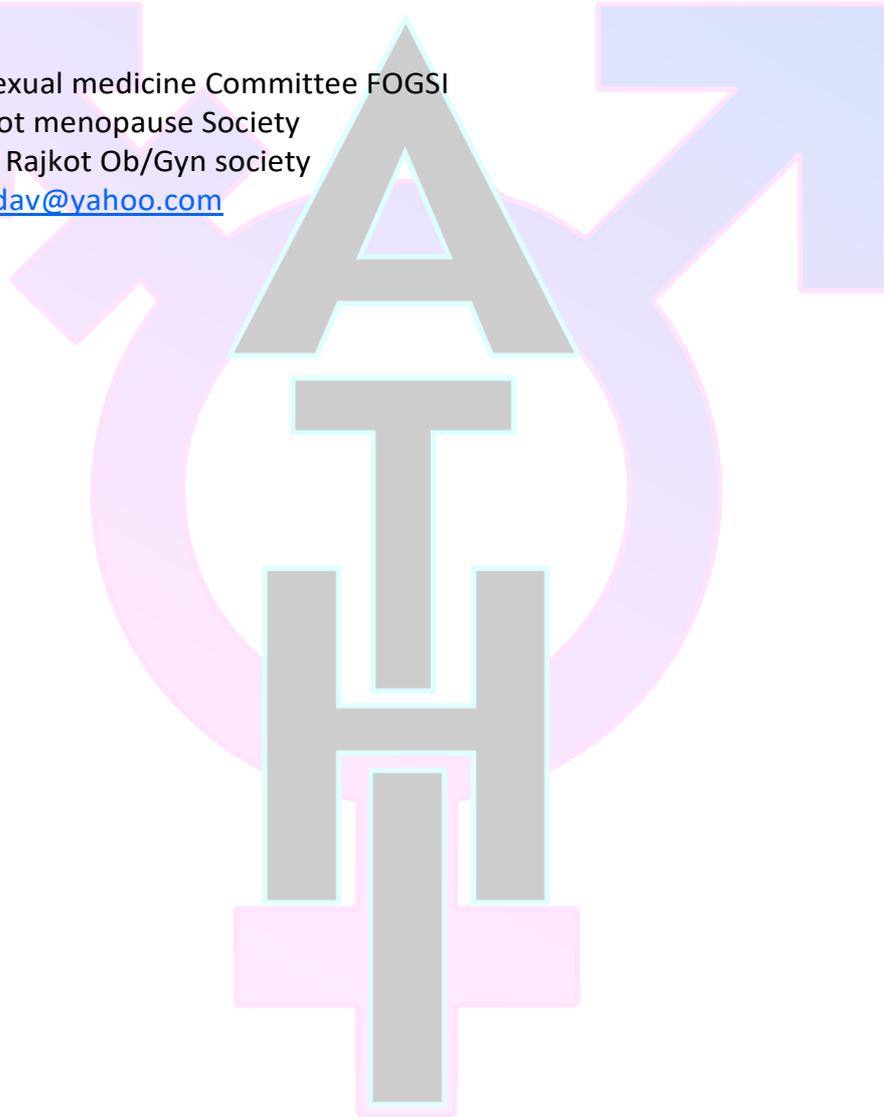
Dr Niraj Jadav

Chairperson Sexual medicine Committee FOGSI

Secretary Rajkot menopause Society

Past president Rajkot Ob/Gyn society

E-mail: nirajjadav@yahoo.com



Introduction

Uterine bleeding can be a source of distress in those for whom their gender identity is incongruent. Clinical experience shows that depressive symptoms and self-harming behaviors may peak during menstrual bleeding. Menstrual cycling is typically suppressible with gender affirmative hormonal intervention, although in a significant proportion of individuals it may persist.

Testosterone

For those adolescents who have met criteria for gender affirming hormone use, testosterone (T) is typically highly effective for induction and maintenance of amenorrhea within 6 months of its initiation, although it may be effective as early as 1 month. Greater than 90% of transmen using either biweekly intramuscular or weekly subcutaneous forms of testosterone achieve amenorrhea within 6 months.

Testosterone acts directly on the endometrium, causing both endometrial and vaginal atrophy as shown by examination of the endometria of transmen who had been on androgen intervention for at least 6 months. Histological analysis of endometrial samples of transmen on testosterone for at least 1 year is similar to that of post-menopausal women. Both groups expressed similar levels of Ki-67, a marker of endometrial proliferation. However, some studies also show an active endometrium and hypertrophic myometrium in some individuals.

While the effects of testosterone on the uterus itself are fairly clear, less is understood about its effects on the hypothalamus and pituitary. There are reports of unplanned pregnancies while on testosterone support due to lack of inhibition of ovulation in at least some individuals.

There does appear to be a dose-dependent amenorrhea response to T, which supports a trial of increased dose or frequency in cases of persistent bleeding. The recommended therapeutic range for testosterone levels is 350–700ng/dL. However, in conditions in which the sex hormone binding globulin levels may be low (e.g., obesity and polycystic ovarian syndrome) total testosterone levels may appear subtherapeutic while free testosterone levels are in the normal range for adult males. Current guidelines recommend monitoring total testosterone levels only.

Progestogens

Progestogens comprise of natural, micronized progesterone and synthetic progestins. They are an important class of medications for induction of amenorrhea in the transmen and nonbinary adolescent. They may be considered in the post-menarchal adolescent who is not yet ready for masculinizing hormones but may be less effective in inducing amenorrhea than combined oral contraceptive pills that contain estrogen. Progesterone and progestins are available in different formulations, including oral, injectable, implantable, and intrauterine. In our practice we typically start with norethindrone or norethindrone acetate.

Progestogens exert most of their effects peripherally at the level of the endometrium primarily through changes in angiogenesis. Systemic forms at higher doses may also suppress the hypothalamic–pituitary–gonadal axis by inhibiting GnRH activity and therefore induce hypothalamic amenorrhea. Both forms counteract the effects of estrogen by inhibiting the proliferation of the endometrium and reducing the mitotic rate of the glands and stromal tissue, through reduction of the estrogen receptors on the glands. Prolonged use typically leads to

endometrial atrophy. Oral medroxyprogesterone has been used historically to suppress the hypothalamic– pituitary–gonadal axis and may be a more cost-effective option.

Intrauterine levonorgestrel (LNG-IUS) is a very effective method of inducing long term amenorrhea in transmen who have not undergone hysterectomy. It leads to partial suppression of ovulation but thought to act more locally at the endometrium. There is less concern for bone health as compared with injectable medroxyprogesterone. With any of the progestogens, irregular and unpredictable bleeding can occur, and this will lead to discontinuation of the agent.

Aromatase Inhibitors

These agents inhibit Cytochrome P450 aromatase enzyme that converts testosterone to estradiol and androstenedione to estrone. This enzyme is active in peripheral tissues throughout the body, including skin, bone, brain, and adipose tissue. They are also effective at increasing testosterone levels in cis men. In the pediatric population they have been used in hypoestrogenic states such as McCune–Albright syndrome, hyper-androgenic states such as familial male-limited peripheral puberty, pubertal gynecomastia, short stature, and/or pubertal delay in cis-gender males.³⁷

Third-generation AIs, including anastrozole and letrozole are the most potent, selective, and least toxic AIs available. These agents may be of particular benefit in the obese person, as aromatase is highly expressed in adipocytes. In many obese trans-persons with low T, increasing the T levels may only serve to be converted to estradiol in adipocytes.

Selective Estrogen Receptor Modulators

These agents interact with intracellular estrogen receptors in target organs as estrogen receptor agonists or antagonists in a tissue-specific manner. Tamoxifen, the oldest member of this class, is a competitive inhibitor of estrogen at the breast, but an agonist in the endometrium. For this reason, there is a risk of endometrial hyperplasia, polyps, carcinoma, and uterine sarcoma as well as ovarian cysts, which is thought to be highest in postmenopausal ciswomen. Other side effects may include menopausal-like symptoms and increased risk of thrombosis. For these reasons, these are **not** commonly used in the intervention of uterine bleeding in transmen.

GnRH Agonists

GnRHa mimic the hypothalamic hormone GnRH; when given continuously they act as an inhibitor of the pituitary gonadotropins LH and FSH. In practice, this is a highly effective way to halt production of estradiol or testosterone. GnRHa are available in intramuscular 1-, 3-, and 6-month formulations. GnRHa are typically used in pediatrics for intervention of central precocious puberty. In the transgender population, they are commonly referred to as “puberty blockers” as they are used to halt and/or prevent development of secondary sexual characteristics of the assigned gender. Side effects are primarily concerns about bone health as this has been shown to decline in both transgirls and transboys on GnRHa. When used in a precocious puberty population, there seem to be no long-term consequences on fertility or bone health. In an individual who has already experienced puberty, and sex steroids (gender affirming or endogenous) are not present, people may experience symptoms similar to those seen in menopause such as hot flashes. We do not recommend routine use in persons who desire a prolonged agonadal state; the lack of sex steroids in these individuals is detrimental to bone health, as inferred by the observation that men without estrogen receptors and those

with very delayed puberty have poor bone health.

Hysterectomy

Performed with or without salpingectomy/oophorectomy, this is a definitive option for the elimination of uterine bleeding. Hysterectomy may be performed abdominally, laparoscopically, robotically, or trans vaginally. Current guidelines set forth by the World Professional Association for Transgender Health recommend persistent, well-documented gender dysphoria, the capacity to make a fully informed decision and consent to intervention, well-controlled mental health or medical concerns if significant, and 1 year of gender-affirming hormones unless not desired or medically contraindicated for the individual. Additionally, it is recommended that the person be the age of majority and have two letters of referral from mental health professionals. The Endocrine Society Practice Guidelines recommend the risks and benefits be evaluated by the individual. In the National Transgender Discrimination Survey, 21% of transmen surveyed had undergone hysterectomy, 58% desired a hysterectomy at some time in the future, and 21% had no desire for a hysterectomy.

Conclusion

Management of uterine bleeding is vital for the mental health of the transmasculine or nonbinary person who desires amenorrhea. Progestogens may be initiated early in medical transition if they are not ready for or not desiring testosterone. For long term progestogen use the LNG-IUS is preferred in transmen with a uterus. If while on testosterone intervention, amenorrhea is not achieved, a trial of an increased dose or change in dose frequency is usually the first step. For persistent bleeding, particularly in the obese individual, a trial of an AI may be beneficial. GnRH agonist are only utilized as a temporary measure while other options take effect. Hysterectomy remains a viable, but the decision must be the result of an informed discussion and consent between the treating physician and person.

References

1. The American College of Obstetricians and Gynecologists: diagnosis of abnormal uterine bleeding in reproductive aged women. Practice Bulletin No. 128. American College of Obstetricians and Gynecologists. *Obstet Gynecol.* 2012;120:197–206 [[PubMed](#)] [[Google Scholar](#)]
2. Nakamura A, Watanabe M, Sugimoto M, et al. . Dose-response analysis of testosterone replacement therapy in patients with female to male gender identity disorder. *Endocr J.* 2013;60:275–281 [[PubMed](#)] [[Google Scholar](#)]
3. Spratt DI, Stewart I, Savage C, et al. . Subcutaneous injection of testosterone is an effective and preferred alternative to intramuscular injection: demonstration in female-to-male transgender patients. *J Clin Endocrinol Metab.* 2017;102:2349–2355 [[PubMed](#)] [[Google Scholar](#)]
4. Moyer DL, Felix JC. The effects of progesterone and progestins on endometrial proliferation. *Contraception.* 1998;57:399–403 [[PubMed](#)] [[Google Scholar](#)]
5. Carswell JM, Roberts SA (2017) Induction and maintenance of amenorrhea in transmasculine and nonbinary adolescents, *Transgender Health* 2:1, 195–201, DOI: 10.1089/trgh.2017.0021.

Public Health Approach to Gender Incongruence

Contributing Authors

Dr Govind K. Bansal, MBA (Health),

National Consultant, National AIDS Control Organization, MoHFW, Govt. of India

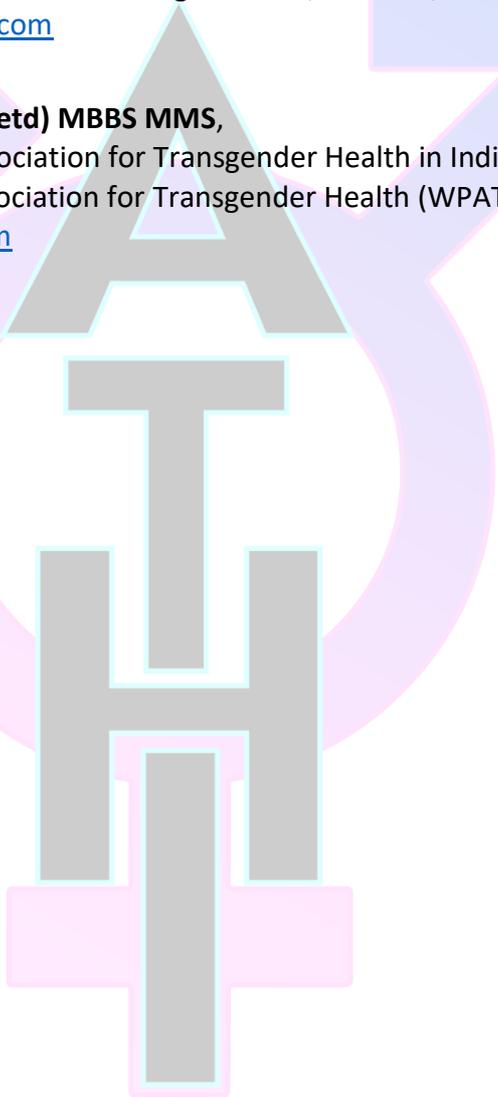
E-mail: drgovindbansal1@gmail.com

Air Cmde (Dr) Sanjay Sharma (Retd) MBBS MMS,

CEO and Managing Director, Association for Transgender Health in India (ATHI),

Member World Professional Association for Transgender Health (WPATH)

E-mail: drsanjay2466@gmail.com



Introduction

Gender incongruence is defined as the mismatch an individual feel as a result of the discrepancy experienced between their gender identity and the gender assigned at birth. The discomfort associated with this incongruence is described as gender dysphoria (Gires, 2019).

The term 'Gender Incongruence' has been introduced as a condition under 'Conditions related to Sexual Health' in the latest International Statistical Classification of Diseases and Related Health Problems (ICD-11), released by the World Health Organization on 18th June 2018 (M. Fernández Rodríguez, 2018). These changes of ICD-11 represent a breakthrough and a great sense of freedom for transgender people. This step, which undoubtedly reflects the progressive mindset of the Medical Fraternity, will go down in the annals of the history of Modern Medicine as the turning point. Henceforth 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 the debate on the appropriateness of the label of Gender Incongruence continues to rage among the academicians and several 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 is by and large a social construct and has cultural relevance. Gender Identity and Sexual orientation are recognized as separate entities and are not binary. Gender is a multifaceted spectrum manifested by the self-assigned role and expression which cannot be limited to Male or Female.

There have been a few studies to enumerate transgender population; however, no such enumeration is available for Gender Incongruence. Transgender is an umbrella term used to describe a wide range of identities whose appearance and characteristics are perceived as gender-atypical —including transsexual people, cross-dressers (sometimes referred to as "transvestites"), and people who identify as the third gender (UNFE, Definitions, n.d.). A study published in *The Lancet* in June 2016 estimates 25 million people, or 0.3 to 0.5% of the global population, as Transgender (Balakrishnan, 2016). Perhaps this is the only accurate estimation available for the worldwide population of Transgender. In the same article, the author cites significant health inequities leading to inaccessible health services because of their social and economic marginalisation. The findings on the health aspect were published by Reisner and his colleagues in *The Lancet*. A GAP report from UNAIDS cites that estimates from countries indicate that the transgender population could be between 0.1% and 1.1% of reproductive age adults (UNAIDS, 2014). As per Census 2011 in India, there are approx. 4.9 Lakhs people in the Others category (which includes Transgender) in the country.

There are very few estimates available for gender incongruence. Two recent population studies have aimed to estimate the prevalence of people who identify as such. Kuyper & Wijzen (2014) examined self-reported gender identity and dysphoria in a large Dutch population sample, and found that 1.1% of people assigned male at birth and 0.8% of people assigned female at birth reported an 'incongruent gender identity', defined as stronger

identification with other sex as with sex assigned at birth (Lisette Kuyper, 2014). Similarly, Van Caenegem et al. (2015) reported results based on two population-based surveys in Belgium. In the general population, gender incongruence was found in 0.7% of men and 0.6% of women. In sexual minority individuals, the same was 0.9% in men and 2.1% in women (Van Caenegem E, 2015).

Census, an exercise to count the population in India, never recognised Hijra/ Transgender until 2011. In 2011, for the first time, it collected data of Transgender with details related to their employment, literacy, and caste. As per this, out of the total estimated population of 1.247 billion, people who have identified themselves as transgender persons, constitute 4,87,303 (Mandal, n.d.). Though Census 2011, mentions above number in the “Others” category (Gol, 2019), various other literature hints towards a higher figure of about 5-6 million eunuchs in India (Mal, 2018).

Even if the census gives a figure of the transgender population, we do not know how many people with gender incongruence are there, or how many of them experience a need for health care, which poses a big problem for healthcare planners. The first challenging task for the survey researcher in this area will be to decide whom to count and by what means in the upcoming census.

Gender identification is the steppingstone for psychosocial development. 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’ procedures.

It has been documented that early recognition of gender incongruence, 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 is adopted for the management of gender incongruence. The stakeholders need to acquire and share knowledge, facilitate the delivery of multispecialty healthcare, empower through advocacy and implement strong legislation for getting these outliers of society into the mainstream as productive citizens.

Discussion:

A holistic public health approach needs to be adopted by all agencies working to ensure equity in the delivery of healthcare. Existing policies, designed to address the problem, need to be reworked to address the cause rather than manage the outcomes. The task is compounded by not only the binary viewpoint and inadequate understanding of the “Transgender

Experience” by the agencies, both Governmental and Non-Governmental, entrusted with the task of giving succor, but also the inherent mistrust by the community of the cis population. To make matters worse, the majority of the transgender persons have poor health-seeking behaviour. The misinformed impressionable “client” is drawn to “Procedures” being offered in an unethical, covert manner to a privileged few who can afford the high costs. The non-existence of Indian Standards of Care and non-adherence to existing protocols lead to further harm. The absence of recognized Centers of Excellence adhering to the norms laid down by national and/or international professional bodies in the country capable of providing Training, Certification and Continuing Medical Education to the professionals desirous of / working in the field of Transgender Medicine and Surgery, adds fuel to the fire by promoting the growth of self-styled experts, who assume the role of gatekeepers, ready to cut corners and flaunt rules for financial gains. Their demand for unnecessary affidavits designed to absolve them of any legal action for procedures carried out over and above the minimum documentation needed for the protection of the interests of the transgender person, further adds to the dysphoria and make the journey of transitioning more arduous. Non-availability of trained manpower working in the Government Sector and absence of the much-needed Government aid / Political will and infrastructure puts affordable healthcare out of reach of this misunderstood, marginalized and often ostracized subset of society. Thus, denying them the fundamental human rights and opportunities to live with dignity as bestowed upon each citizen by the Constitution of India and reinforced by the various international fora of which India is a signatory.

Concerted efforts are needed to bring together, the professionals already working in the field of Transgender Health, educationists, academicians and social workers, on a common platform, wherein, they can step out of their silos, interact with each other and share their experiences to undertake formulation of Indian Standards of Care and work towards provisioning of a holistic and affordable Healthcare to all human forms, irrespective of their self-affirmed gender identity or sexual orientation. Dissemination of knowledge regarding Gender to the Primary Care Providers is essential for early recognition and prevention of gender dysphoria. Development of a progressive society mandates provisioning of a robust, customized healthcare infrastructure which addresses the unique needs and a nurturing, inclusive, social environment which seeks to harness the full potential of this often neglected vibrant human resource by encouraging empowerment and mainstreaming.

Recommendation:

It is important to nurture and promote collaboration between academic institutions, implementing structures and international bodies working on or with the Transgender communities to not only fill the lacunae in Primary, Secondary and Tertiary Healthcare but also to lay down the benchmarks in the delivery of standardized healthcare to the Transgender community in India.

The following action plan, based on a Public Health approach resting on the four domains of Knowledge, Healthcare, Empowerment and Mainstreaming, is proposed.

The domain of Knowledge:

- 1. Setting up of a “Centre of Excellence in Transgender Health” at an academic institution**
As the first step in the multipronged approach, it is recommended to set up a “Centre of Excellence in Transgender Health” at one of the top Universities of India having on its

campus all the requisite departments needed for imparting education in the Medical, Nursing, Paramedical, Social, and Legal fields, but also houses a Pharmacy and a Hospital.

The Centre shall function as the seat of academic excellence imparting training and education to the professionals from the Medical, Nursing, Paramedical, Legal and Social streams in the best practices in Transgender Health in collaboration with WPATH (World Professional Association for Transgender Health). It shall promote evidence-based care, education, research, advocacy and public policy in Transgender Health and set the benchmark for the delivery of Transgender Healthcare in the country. Taking a cue from the current Standards of Care developed by WPATH, the Centre shall, in light of the Indian cultural context, set the Indian Standards of Care. It shall formulate a curriculum specific to the Indian cultural context to enable proficiency in the implementation of the current Indian Standards of Care for delivery of healthcare to the Transgender and Gender nonconforming persons.

The Centre shall run Short term courses starting with a foundation course followed by Advance Courses leading to a Certification course in Transgender Medicine and Surgery.

The short term training courses shall include a Foundation Course in interdisciplinary Transgender Healthcare, Advanced Courses in Mental Health, Advanced Course in Non-Surgical Gender Affirmation Therapies, Advanced Course in Surgical Gender Affirmation Therapies, Advanced Child and Adolescent Transgender Healthcare Course, Course in Transgender Health Planning and Documentation and a Course in Law and Ethics in Transgender Health.

The Centre shall also conduct Continuing Medical Education Workshops containing highly specialized 4-8-hour interactive and/or case-based sessions focused on specific areas of interest for professionals who have completed the Foundations in Transgender Health course. Topics would include - Working with Children and Adolescents; Planning and Documenting for Medical Transition; Ethical Considerations; Pre and Post-Operative Surgical Care; Voice and Communication.

The Centre of Excellence shall also run an outreach programme for sensitization of the primary caregivers, schoolteachers, parents and employers regarding gender-related issues and help them develop gender-friendly safe spaces

The long-term goal is to create a faculty of international standing who shall mentor professionals to excel in the field of Transgender Health and pioneer research aligned to meet the needs of the community.

2. Conduct intensive IEC activities

Intensive IEC activities need to be conducted for raising awareness and among all stakeholders for mitigating the risk of communicable and non-communicable diseases as a result of the high vulnerability of the community members. For running innovative IEC campaigns, the involvement of national and international agencies with prior knowledge and expertise will be required.

The domain of Healthcare:

3. Setting up of a Gender Clinic at the Hospital

Provisioning of affordable and accessible primary, secondary and tertiary care to the community members will be made possible by setting up a Gender Clinic at the Hospital. The gender clinic shall not only provide a hands-on training ground to the students but also allow them to closely interact with and develop a deeper understanding of the community.

4. Develop a Department of Transgender Medicine and Surgery at Medical College

Introduction of Transgender Medicine and Surgery as a separate subject in the Medical curriculum is needed to ensure that every Medical student is aware of the special needs of the Transgender and Gender Nonconforming Persons and issues such as sexual and reproductive health, care of the aging transgender person and preventive healthcare can be addressed by professionals having sound knowledge and proper training. Role of National Medical Council and the Ministry of Health and Family Welfare is supreme for achieving this goal.

The domain of Empowerment:

5. Setting up of a Gender Ethics Committee and Legal Cell

It is of paramount importance to set up an ethics committee and legal cell at the University, to prevent gatekeeping and unethical practices. This cell will work closely with the Gender Team to protect the interests of the Transgender persons and also that of the professionals providing care.

6. Providing Health Insurance cover and Government Support for Gender affirming therapies

Gender Affirming therapies for affecting transition, though considered essential for reducing/preventing dysphoria, are not covered by Medical Insurance/government health schemes. The exorbitant price of treatment in private institutes makes it inaccessible for the large majority. A dialogue with the Insurance sector to address this issue and engagement with the Government to include gender-affirming therapies under the purview of the Government Health Schemes such as Ayushman Bharat will be required to move ahead.

7. Provisioning of a Single Window for change of Gender in official documents

Change of name and gender in official documents such as Aadhar Card, PAN Card, Driving License, Voter ID card, Passport, educational qualifications etc. is an integral part of social transitioning. The Transgender person is often harassed and their dysphoria increases, as he is forced to come face to face with insensitive and prejudiced officials. It is proposed that a single window be set up by the Government for change of name and gender in all official documents.

Domain of Mainstreaming:

8. Reservation and Social protection as regards Education, Housing and avenues for earning a livelihood.

It is recommended that all State Governments should act in accordance to the directions of the Honorable Supreme Court by engaging with the community and form the

Transgender Welfare Boards to address the felt needs as regards Education, Housing and avenues for earning a livelihood.

Conclusion

The vision of an all-inclusive society, wherein, all forms of gender identity and expression are nurtured and celebrated, where, new abilities emerging as a result of scientific progress permit all form of the human to live in harmony with dignity, embracing diversity and enjoying equal rights and privileges, as bestowed by the constitution, can indeed be converted into reality by making a concerted and coordinated effort, harnessing the time tested strengths and expertise of the various national and international agencies working with or assisting the Government in providing Social Justice and Health for All.

Bibliography

Gires. (2019, May). Terminology. Retrieved from Gender Identity Research and Education Society: <https://www.gires.org.uk/resources/terminology/>

GoI. (2019, June 25). Welfare of Transgenders. Retrieved July 2019, from Press Information Bureau: <https://pib.gov.in/PressReleaselframePage.aspx?PRID=1575534>

Lisette Kuyper, C. W. (2014, February). Gender identities and gender dysphoria in the Netherlands. *Arch Sex Behav.*, 43(2), 377-85. doi:10.1007/s10508-013-0140-y

M. Fernández Rodríguez, M. M. (2018). Gender Incongruence is No Longer a Mental Disorder. *Journal of Mental Health & Clinical Psychology*, 2(5), 6-8. Retrieved from [https://www.mentalhealthjournal.org/articles/gender-incongruence-is-no-longer-a-mentaldisorder.html#:~:text=ICD%2D11%20drives%20out%20the,Gender%20Incongruence%22%20\(GI\).&text=Transsexualism%2C%20gender%20identity%20disorder%20or,\(DSM%2D53\)](https://www.mentalhealthjournal.org/articles/gender-incongruence-is-no-longer-a-mentaldisorder.html#:~:text=ICD%2D11%20drives%20out%20the,Gender%20Incongruence%22%20(GI).&text=Transsexualism%2C%20gender%20identity%20disorder%20or,(DSM%2D53)).

Mal, S. (2018). The hijras of India: A marginal community with paradox sexual identity. *Indian Journal of Social Psychiatry*, 34(1), 79-85. doi:10.4103/ijsp.ijsp_21_17

Mandal, C. (n.d.). 'Other' Gender in India: An Analysis of 2011 Census Data. Retrieved January 2020, from <http://paa2019.populationassociation.org/uploads/190235>

Nagarajan, R. (2014, May 30). First count of third gender in census: 4.9 lakh. Delhi: Times of India. Retrieved July 24, 2018, from <https://timesofindia.indiatimes.com/india/First-count-of-third-gender-in-census-4-9-lakh/articleshow/35741613.cms>

UNAIDS. (2014). The Transgender People. Retrieved June 13, 2020, from https://www.unaids.org/sites/default/files/media_asset/08_Transgenderpeople.pdf

UNFE. (n.d.). Definitions. Retrieved March 4, 2020, from United Nations Human Rights Office: <https://www.unfe.org/definitions/>

Van Caenegem E, W. K. (2015, July). Prevalence of Gender Nonconformity in Flanders, Belgium. *Arch Sex Behav*, 44(5), 1281-7. doi:10.1007/s10508-014-0452-6

Parents Support Group

Contributing Authors

Mr. Atul Kumar, HOD Physics, Aakash Institute (Pitampura Centre)

Affiliated with “Sweekar: The Rainbow Parents”

Email: akdhankar@gmail.com

Dr Bela Sharma MD, PGDMLS, Additional director internal medicine, FMRI Gurgaon

Medical Director IPATH, Director KHEM, Member WPATH

Affiliated with “Sweekar: The Rainbow Parents”

Email: Belak1857@gmail.com

How Parent Support Groups Can Help Improve Healthcare for Transgender Youngsters

As a parent, one often wonders as to whether one is doing parenting right. At the best of times parenting is a challenging job. It's a non-stop, relentless 24/7 job. Most of us struggle even when times are good, and the going is all along a beaten path. When it comes to supporting transgender children, the job gets infinitely more complex. There is no help, no guidance because no one around us knows anything. With little to no societal guidance or help, parents of transgender children are often helpless and are on the lookout for help, support and guidance. Internet may help but it is not reliable. In matters pertaining to trans issues, the internet may actually even be a bit problematic. The authenticity of information available and also the quality of it can very well be suspect. Most of it comes from western sources and is therefore not quite what works in our sociocultural milieu. Even the medical info available is mostly of western origin and therefore can be a bit off context for our country. How can we develop a support system for parents of transgender children? Where do the parents of trans kids go, when they need moral support and guidance?

Our country has lacked support groups for almost everything. Unlike the west, support groups have not existed in our country, in general. But things are beginning to change. Support groups have recently come up to help parents find support from other parents who have similar lived experiences. I am myself, a member of Sweekar. The Rainbow Parents group. It's a group of parents of Indian origin from across the globe. All of us in this group are parents of LGBTQIA+ children. The group provides a safe space for parents where they can find support from other parents having similar lived experiences. The group has been a source of much needed moral support and often beyond. Here, I have met many parents of LGBTQIA+ children. We all share the same concerns and challenges and have all been the source of great help for each other. Moral support that we offer to each other is priceless. And, it's not just that. The very fact that we see other parents proudly standing up for their children gives us hope courage and strength. So far however, our role has been to support each other and to provide advocacy for the cause of LGBTQIA+ communities. Through this write up, I plan to suggest a more comprehensive role for such groups (PSGs from now), especially in the context of transgender children and their specific needs. Let me highlight some areas where parents support groups (PSGs) can be of great help.

The bridge between medical care givers and families of transgender children

Transgender children and their families have this difficult challenge of finding the right medical care givers. Trans kids require many different medical interventions. They need psychiatric treatments and counselling to mitigate their dysphoria and distress related with social issues they face. They need endocrinologists to supervise their feminizing/masculinizing hormone therapies. Also, many if not all need surgeries to alter their primary and secondary sex characteristics. In addition, they might require medical interventions to help them with other medical conditions. PSGs can help children to develop an understanding of the medical procedures and their realistically expected outcomes. Also, the help that such PSGs can provide in identifying competent and gender friendly medical professionals would be simply

priceless. Such medical care providers are rare and therefore hard to find. PSGs can therefore be that much needed bridge between medical professionals and trans youngsters.

Help parents of transgender children understand their medical needs

Transgender children have a lot of needs that are specific to them. These require parental support. For instance, they need to be their 'authentic self.' They have to explore their true identity to get to know themselves. It may be very difficult for parents of a child they have brought up say, as a boy, to explore their feminine side. It is however of existential importance to the child. Parents often need to be counselled and should seek help from professional counsellors. They need to be convinced to reach out to counsellors for their own mental health and that of the child. The PSGs can easily provide this guidance and convince parents to take the right steps in this direction. Here a PSG can be the ideal bridge between mental healthcare professionals/counsellors and families of trans children.

Watchdogs

PSGs also have an important role in guiding parents in avoiding medical procedures that are detrimental for children. A lot has been discussed in this regard in the IPATHCON conferences. This is of special importance in case of surgeries that are performed on intersex children before they attain the age of consent. Any lifelong body alterations must wait till the child has attained maturity and is capable of understanding their gender identity and expression. Such surgeries have been performed routinely in the past and the practice must stop. PSGs can easily be the watchdogs and help the parents of intersex children avoid such catastrophes. There is also the need to stop other malpractices like DIY hormone therapy tried out by children. Such instances are very common in countries like the UK, where there is a three to four year waiting list for appointments at NHS gender clinics. In such instance's parents must guide children and their families to find professional help where it's available before taking up any treatment. Any and every treatment must be under medical supervision, by appropriate medical professionals. PSGs can easily act as watchdogs in this regard and safeguard the children.

Here, I would also like to make two important points regarding practices by young trans children. One is the practice of using breast binders by young transmen to 'pass' as men. This is fine if done occasionally. However, if it's done on a regular basis for prolonged periods of time, it starts to alter the nature of tissues creating problems for appropriate surgeries later. The exact same caveats can be made for the practice of 'tucking' the genitals by young transitioning transwomen. This too causes similar problems for surgeons performing gender affirming surgeries later. Parents must make themselves aware of these issues and help their children avoid these practices.

Ensuring a conducive environment for diverse children in schools and educational institutions

There is a huge need for parents to find representation in the PTAs of schools to guide school managements to have policies in place so that children who belong to the LGBTQIA+

spectrum have their needs taken care of. Such children are often bullied and therefore end up deprived of the education they deserve.

For instance, transgender and intersex children have a need for gender neutral bathrooms in schools. Schools need to be made aware of this need. PSGs can do the job here. They can help schools in ensuring inclusive policies and practices for LGBTQIA+ children.

Bring in policy changes at the government level for ensuring equity

According to some recent research, as much as 15% of the population belongs to the LGBTQIA+ spectrum. Hence, they are not the miniscule minority as was the belief earlier. There is a need for activism to ensure political representation for such communities. Here, PSGs can be the activists to ensure policy changes at the level of government to make our country truly inclusive. PSGs can be the harbingers of change at the highest levels of government.

Be the change

The last but not the least. Parents can be the change agents in the society by being the change themselves. By proudly supporting their children and being the example for the society, parents of transgender children can be the agents of change.

When we saw other parents in our parents support group, we felt that we are not alone. To see other parents like ourselves, supporting their children, was a great source of strength and courage for us. Here lies the single most important role that the PSGs can play. To all parents who are struggling with the challenges faced by them we offer a hand of help. As parents and PSGs we promise to be the paradigm for the world at large. We appreciate the work being done by **ATHI** in association with **Jamia Hamdard**. These are stellar organizations and the work being done by them must be recognized. Let us all stand together and be the agents of positive change.

When it comes to being the change agents, parents of transitioning trans children do need advice from those with experience. Therefore, to give parents a helping hand, we have compiled an ABC of parenting checklist. I would suggest parents of transitioning young children to go through this and benefit from it. So here it goes.

The Alphabet of parenting a Transgender child

Accept

Be an ally, not an adversary

Confidence of the child is very fragile, maintain it.

Do not be afraid, and do not be in a denial

Embrace the child wholeheartedly

Follow the lead given by the child

Get rid of guilt, and get information, arm yourself.

Happiness of the child is paramount, get Help if needed.

Ignore all kinds of negativity, whether from relatives or friends.

Judging a person on the basis of their preferences or gender is never right. Your child deserves this consideration.

Knowledge is power, educate yourself

Laws are there to protect you and your family. Know the legality.

Mental health professionals are needed only to dispel dysphoria, seek medical help when required.

Not an illness, No treatment can "cure" gender incongruence.

Be Open in communication, not opinionated.

Professional help for hormonal/surgical treatment should be sought when necessary

Question/ queries often help getting you on the right path. Ask continuously.

Raise happy children

Support groups are helpful. Get in touch with similar minded people.

It's a Teamwork where the leader is the child.

Understand the child's viewpoint

Variation is part of nature, accept it.

"Why me?" is to be replaced with "Yay me".

Xpress yourself positively.

You are the chosen one to bring about a change.

Embrace your calling with a Zeal.

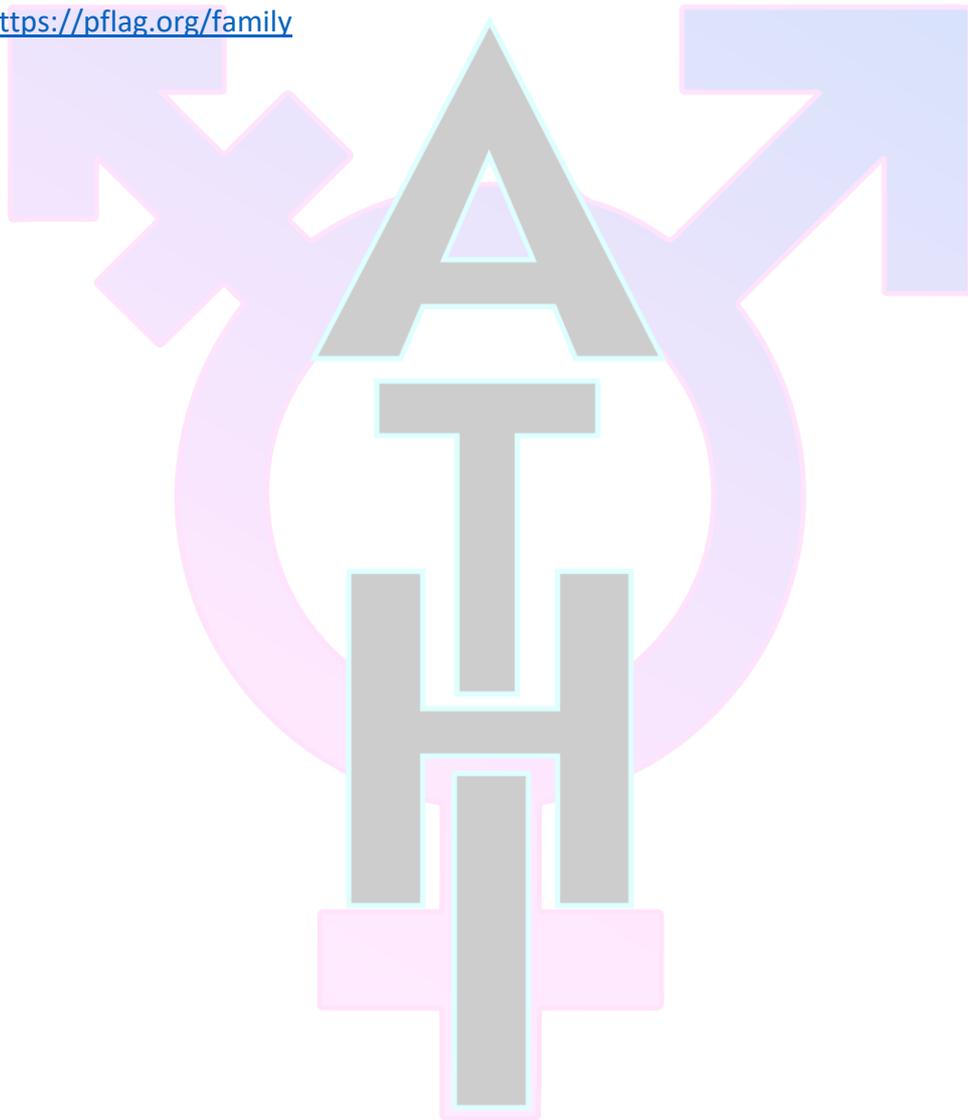
References:

- 1) About tucking practices.

<https://www.healthline.com/health/transgender/tucking#:~:text=Some%20risks%20that%20may%20occur,after%20tucking%20to%20prevent%20infection.>

- 2) <https://pubmed.ncbi.nlm.nih.gov/27300085/>

- 3) <https://pflag.org/family>




Indian Standards of Care

