

2017

A  
Good Practice Guide to  
Gender-Affirmative Care

Initiative by

*Sappho for Equality*  
Kolkata, INDIA



Supported by  
FRI, Norway



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## **ACRONYMS AND ABBREVIATIONS**

DSD – Disorders of Sex Development/Disorders of Sex Differentiation/Differences in Sex Development

DSM – Diagnostic and Statistical Manual of Mental Disorders

FtoM/FtM – Female to Male

GD – Gender Dysphoria

GAC – Gender Affirmative Care

GAT – Gender Affirmative Therapy

GAS – Gender Affirmative Surgery

GID – Gender Identity Disorder

GTRS – Gender-Transition Related Services

HBV – Hepatitis B Virus

HCP – Health Care Professional

HIV – Human Immunodeficiency Virus

ICD – International Classification of Diseases

IPC – Indian Penal Code

MHP – Mental Health Professional

MtoF/MtF – Male to Female

SRS – Sex Reassignment Surgery

SRT – Sex Reassignment Therapy

WHO – World Health Organisation

WPATH – The World Professional Association for Transgender Health

## PREFACE

Sappho for Equality, established in October 2003, is a queer feminist activist forum working for the rights and social justice of persons with non-normative gender-sexual identities/expressions, especially focusing on rights of lesbian, bisexual, queer women and trans\* (transmasculine/FtoM) persons. Some of its important activities are providing safe space for members of the sexually marginalized community, peer counseling, running helpline, providing mental health support, facilitating crisis intervention, interacting with researchers, students and faculty of academic institutions, running a resource center, *Chetana* etc. As part of its efforts at creating bridges with the health and legal system, the organization actively engages with medical and legal practitioners in the eastern part of India, more specifically in West Bengal.

Sappho for Equality took up an initiative, **“Together we are with Doctors”** since September 2012 through which we started engaging with medical professionals on the issue of health needs of Lesbian, Bisexual women and Transmen (LBT). In the process of interacting with health professionals a need was felt to specifically engage with transgender health issues in West Bengal, and subsequently since March 2015, a dialogue was opened through the initiative, **“Together we are with Trans\* Issues”**. Starting from August 2015, a series of meetings and interactive programs were held on the legal and health related issues of transgender persons, as part of that initiative.

Following the NALSA judgement in April 2014<sup>1</sup> by the Supreme Court of India recognising the right of every citizen to self-determine gender, more and more individuals were observed seeking SRT in private hospitals. Individuals have expressed the need for varied degrees of transition – breast reduction, breast augmentation, laser removal of body hair, breast reduction with chest reconstruction without hormone therapy, only hysterectomy, penectomy, etc.

However, a number of factors are creating major hurdles in the meeting of these pertinent health needs. There is no established state health service facility in place for gender transition of transpersons in West Bengal. As of January 2017, there were unconfirmed reports of two state

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<sup>1</sup>In 2012, National Legal Services Authorities (NALSA) filed a writ petition at the Supreme Court of India [Writ Petition (Civil) No. 400 of 2012 v Union of India & Others]. The case concerns legal recognition of transgender people’s gender, and whether the lack of legal measures to cater for the needs of persons not identifying clearly as male or female contradicts the Constitution. The two-judge bench, consisting of Justice K.S. Radhakrishnan and Justice A.K. Sikri on 15<sup>th</sup> April 2014 declared in favour of NALSA.

hospitals in the city of Kolkata to start providing SRT facilities.<sup>2</sup>Most of the transition procedures are taking place in private institutions and often with a certain gap in liaison between the concerned medical and surgical specialties. There is no dedicated gender clinic even in private health institutions in this region. Often the indications for the transition are not assessed and other psychiatric co-morbidities not ruled out adequately. Lack of multi-disciplinary collaborative teamwork to address the various transition-related needs of the transgender persons has resulted in miscommunication and subsequent complications and ineffective outcomes. Moreover, lack of information and knowledge about the legal issues around gender transition give rise to anxieties in transpersons and hinders clinical decision-making by medical professionals who intend to provide such services.

Through interactions with Transgender persons, representative of Transgender Development Board, mental health professionals, Endocrinologists, Plastic Surgeons, Gynecologists, ENT surgeon and voice therapists, General Physicians, lawyers and law trainees, it emerged that there is a need to prepare a medico-legal guideline for gender-transition related services (GTRS) to transgender persons in West Bengal.

There is no published National guideline on sex reassignment therapy. An Interim National Guideline – *Good Practices for Sex Reassignment Surgeries (SRS) for Male-to-Female Transgender People in India*, could be accessed, that is prepared by UNAIDS India-constituted Working Group in 2011. This interim guideline focuses only on genital surgeries of MtoF transgender persons and not on other aspects of gender affirmative care. No India-specific guideline exists for FtoM transgender persons and there is lack of awareness regarding existing universally standardized guidelines amongst the health care professionals (HCP) regarding the same.

### **The Making of the Guide**

In preparation to the good practice guide, Sappho for Equality held a number of consultations with FtoM transgender persons<sup>3</sup> on one hand and with medical and legal professionals on the other hand. Three meetings with FtoM transgender persons were held: August 2015, January 2016 and October 2016. Each meeting had around 25 to 30 participants on an average including

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<sup>2</sup> No official information is available about any gender clinic dedicated solely to the purposes of GAS in any of the state general hospitals as of August 2019, at the time of updating of the present document.

<sup>3</sup> Since Sappho for Equality works with FtoM trans persons only, the consultations held brought forth mostly the needs and concerns of female to male trans persons. However when the good practice guide was being compiled experts took care to include protocols for both trans women and trans men based on their specific needs and concerns. Following 2017 there have been group consultations and in-depth individual interviews with both transmasculine and transfeminine people regarding their experiences of accessing the medical health care services while seeking transition. Excerpts from these conversations feature in Chapter 1.

Sappho for Equality members who came together to discuss various issues and concerns at various points relating to their lives as transmen. With regard to health of transmen and SRT, participants observed that they experienced widespread discrimination and neglect from doctors and nursing staff in hospitals and private clinics leading to further health complications. It was also pointed out that certain infrastructural gaps like lack of trans-sensitive wards and toilets disadvantaged transgender persons and increased their vulnerability in times of illness. Few participants further suggested that if the government takes initiatives in reducing the cost of SRT, it would be beneficial to people who find it difficult to put together the money needed for the transition related medical and surgical procedures. In case of SRT most of the medicines are manufactured outside the country that increases the cost; if such medicines are manufactured locally then it will be available at lower prices. At one meeting it was also discussed if SRT could come under general medical insurance to help reduce the expenditure. Others suggested that gender affirmative accessories like binders, prosthetics etc. need to be made easily affordable and accessible as well.

The process of reaching out to health professionals initially took off with names suggested by members of the trans community since they were already seeking transition-related services from such doctors and psychotherapists. Ujjaini and Ranjita contacted these medical professionals on behalf of Sappho for Equality and gradually more doctors and mental health professionals could be brought together. The first consultation meet with professionals was held in March 2015 between psychiatrists, gynaecologists, psychologists, FtoM transpersons<sup>2</sup> and activists from Sappho for Equality. The meeting brought forth the need to create a pool of doctors and various health professionals, community persons and lawyers to facilitate an understanding of the medico-legal implications and challenges surrounding health related issues of transgender persons. The second meet was thus held in August 2015 with an objective to open up discussion on the medical and legal challenges for transgender persons seeking gender affirmative therapy and how best to address them. The participants of the discussion were health professionals comprising psychiatrists, psychotherapist, endocrinologists, gynaecologists, plastic surgeon, general physicians, ENT specialist; legal experts comprising of lawyers, faculty of law school, lawtrainees and activists/members of Sappho for Equality. In this meeting it was reiterated that in the post NALSA judgement scenario in India there is a dire need for a specific medico-legal guideline that can address the concerns of the transpersons taking into account their socio-cultural location. Issues that were fore-grounded in the discussion: access to information on the part of transgender persons, informed consent, poor infrastructural facilities, affordability of the medico-legal process of transition, legal hurdles in changing identity pre or post transition and

lack of communication and collaboration between the different medical professionals involved in the transition process. Medical and legal experts participating in the meeting suggested the following:

- Standard guideline for the GTRS
- Dedicated Gender Re-assignment Clinics
- Unified medical record keeping system that will have treatment histories and other relevant information regarding SRT of each individual seeking gender transition procedures
- Sensitisation process for doctors and para-medical staffs.
- Protocolised consent procedure emphasizing on involvement of the individual.
- Team of health professionals, experienced in health care of transgender persons from different fields such as psychiatrist, endocrinologist, plastic surgeon, voice surgeon and voice therapist and legal experts experienced in this field, to develop an evidence-based, region specific and culture sensitive guideline for GTRS.

Following this, a team was formed with medical and legal experts who volunteered to contribute to preparing a good practice guideline on GTRS. Sappho for Equality took the initiative and an initial draft of the guideline was prepared compiling the contributions from the medical and legal experts and circulated to all participants of the consultations and other interested professionals. The next consultation was held in March 2016 with lawyers, doctors, psychotherapists, and members/staff of Sappho for Equality to provide feedback on the prepared draft of the guideline. The draft of the good practice guideline was discussed and various inputs were considered, debated and incorporated wherever relevant. It was also decided in this meeting to hold an academic exchange between medical professionals regarding the various processes and stages of gender affirmative therapy before finalising the good practice guide. Accordingly a panel discussion was organised in July 2016 where psychiatrists, psychotherapists, plastic surgeons, endocrinologists, gynaecologists and ENT surgeon specialised on voice surgery and voice therapist shared their clinical experience of working with transgender persons. This exchange provided a justification for the proposed good practice guide and facilitated a better understanding of the collaborative process of a multi-disciplinary team in case of gender affirmative therapy.

### **Medical and Legal Experts who Contributed in Preparing the Guideline**

The Medical, surgical and legal experts from Kolkata, who have volunteered in the drafting of the guidelines are –



## **Psychiatrists**

Dr. Aniruddha Deb: Aniruddha Deb has been practicing as a consultant psychiatrist in a private capacity for more than 20 years in Kolkata. His psychiatry training was in NIMHANS, Bangalore and CIP, Ranchi.

Dr. Ranjita Biswas: Ranjita Biswas is a practicing psychiatrist and an independent researcher. She is associated with Sappho for Equality as a therapist, activist and researcher.

Dr. Ujjaini Srimani: Ujjaini Srimani, MBBS, MD, is a consultant psychiatrist, with special interest in the area of gender-sexuality and psycho-social-spiritual aspect of mind and mental health. As a member of Sappho for Equality, she has been associated with its health related initiatives.

## **Endocrinologists**

Prof (Dr).AnirbanMazumdar: AnirbanMazumdar is Professor (Endocrinology), KPC Medical College and Hospital, Kolkata. He has been Regional Faculty for Certificate in Evidence Based Diabetes Management (CEBDM) (2010-2016) and Advanced Certificate Course in Prevention and Management of Diabetes & Cardiovascular Disease (ACMDC) (2015-2016) of Public Health Foundation of India, New Delhi, Faculty for Integrated Diabetes and Endocrine Certificate Course (IDECC), affiliated by The University Of Newcastle, Australia (2016 – 2017) and Conjoint Faculty for the Graduate Diploma in Diabetes Care, The University Of Newcastle, Australia (2002 – 2004). He has published widely in national and international Journals. He is also serving as Principal Investigator of phase 3 Clinical Research.

Dr.DebmalyaSanyal:DebmalyaSanyal is Professor, Department of Endocrinology, KPC Medical College, Consultant Endocrinologist, Narayana Health-RTIICS & GDDI. He holds the following degrees: DTM&H, MD(General Medicine), MRCP, DM (Endocrinology), FACE (Fellow American College of Endocrinology).

## **Plastic Surgeon**

Dr. Manish MukulGhosh: Manish MukulGhosh, MBBS (Cal), MS (Cal), MD (Sheffield), FRCS (Eng), FRCS (Plastic Surgery), is a Consultant Plastic & Reconstructive Surgeon currently practicing in Kolkata. He is the Surgical Team Leader, Operation Smile International, Director of Mission Smile India. He has expertise and rich experience in Sex Reassignment surgery of transgender persons.

## **ENT Surgeon**

Dr. SoumitraGhosh: SoumitraGhosh, MBBS, DLO (Gold Medallist), DNB, is Associate Professor, Department of ENT and Head Neck Surgery, Vivekananda Institute of Medical

Sciences, Kolkata. He is also Associate Editor, International Journal of Phonosurgery and Laryngology. He is specialist in Microear Surgery and Endoscopic Sinus Surgery with special interest in Laryngology (Voice Surgery).

### **Voice Therapist**

Mr. ChandanSaha: ChandanSaha, completed his Masters (MSc) degree in Speech Language and Hearing sciences from All India Institute of Speech and Hearing, Mysore in 1999. He has worked in various clinical setups in Kolkata, Chennai and Mumbai as audiologist and Speech pathologist and has served as faculty in several National and International workshops on Voice and phonosurgery since 2010. He started working as Voice therapist in “voice Kolkata” since July 2010 and is founder member of “Voice Kolkata”. He has been working with special interest on transgender Voice management since 2014.

### **Legal Expert**

Dr. ShameekSen: ShameekSen is an Assistant Professor at the West Bengal National University of Juridical Sciences, Kolkata, one of the premier Law Schools of India. He pursued his B.Sc. LL.B. (Hons.), LL.M., M.Phil. and Ph.D. degrees from the same university and was awarded several accolades and medals in the process. His areas of specialisation include Constitutional Law, Human Rights Law, Public Health Law and Media Law. He is also actively involved in Legal Aid and awareness drives, and takes keen interest in securing access to justice for the economically and socially marginalised groups.

We are also indebted to the following medical and legal experts who have voluntarily contributed in making of the guideline, by attending the meetings, participating in panel discussions, sharing their experiences, giving their valuable opinions and sometimes even disagreeing with us.

### **Psychiatrists**

Dr. Abir Mukherjee  
Dr. Ayanangshu Nayak  
Dr. DebashisChatterjee  
Dr. Indrajit SenGupta  
Dr. Neelanjana Paul  
Dr. Rima Mukherji  
Dr. SabyasachiMitra  
Dr. Sarmishtha Chakrabarti  
Dr. Satyajit Ash  
Dr. Suchandra Brahma

### **Psychotherapists**

Dr. Anuttama Banerjee

Prof.(Dr.) JayantiBasu  
Dr. JhumaBasak  
Ms. Parmeet Soni  
Dr.SreemoyeeTarafderChattopadhyay,  
Dr.Ushri Banerjee

**Plastic Surgeons**

Dr.AkhileshAgarwal  
Dr. V.S. Rathore

**Gynaecologists**

Dr. ChaitaliDatta Ray  
Dr. PallabGangopadhyay  
Dr. ParomitaSrimani  
Dr. SamarendraMondal  
Dr. Sanjay Kumar Biswas  
Dr. Susmita Chattopadhyay

**Endocrinologist**

Dr. Rana Bhattacharjee

**ENT Surgeons**

Dr. Amitabha Roychoudhury  
Dr.ChirojitDutta

**Physicians**

Dr. Arup Dhali  
Dr. ParthaChakraborti

**Legal Experts/Lawyers**

Ms. Bijaya Chanda  
Mr.Debashis Banerjee  
Ms. SanandaGanguly  
Mr.Tapas Mukherjee

**Student Volunteers from the NUJS Queer-Friendly Law Network**

Akshita Jha  
Drishti Das  
Mihika Poddar  
Priyambada Datta  
Raktima Roy  
Ringicha Chakma  
Shreya Mishra  
Shreyashi Ray

Vishakha Gupta  
Vyjayanthi Raghu  
Yamini Kumar

#### **Members of Sappho for Equality Contributing in Various Capacities**

Anush  
Apu  
Deep  
Dev  
Epsita Halder  
Minakshi Sanyal  
Neel  
Paromita Banerjee  
Provat  
Ree  
Rukmini  
Sayan Bhattacharya  
ShreosiRay  
Srabasti Majumdar  
Dr. Subhagata Ghosh  
Sutanuka Bhattacharya  
Swarup

#### **Purpose and Scope of this Guideline**

The purpose of preparing this guideline is to provide comprehensive, evidence-based and culturally-sensitive medico-legal services related to gender affirmative care of transpersons and to utilize it as an advocacy tool for good practices in this region. The objective of compiling this good practice guide is to facilitate health professionals engaged in providing gender transition related services to transgender persons. We hope that this evidence-based, culturally sensitive guide prepared with the help of medical and legal experts experienced in this field, would contribute in developing much needed multi-disciplinary collaborative gender affirmative care in this region. These guidelines can be used by health professionals, by individuals, their families, and social institutions to understand how they can assist with promoting optimal health for members of this diverse population. Our attempt has been to use non-technical language as much as possible while compiling this guideline so that any interested individual including legal experts, transgender persons, and activists engaged in this field can obtain an overview of medico-legal aspects of gender affirmative therapy.

In this guideline we have used the term ‘gender affirmative care’ to denote the wide range of services sought by a transgender person who wishes to change the gender assigned at birth to the gender desired as more appropriately expressing the individual’s personality. For transgender people transition/Gender Affirmation Process refers to the process of coming to recognize, accept, and express one’s desired gender identity. This is also the time when a self-identified transgender person makes the important conscious decision to take social, legal, and/or medical steps such as an appearance makeover, change name and/or sex designation legally, and use medical interventions. This process is often called gender affirmation, because it allows people to affirm their gender identity by making outward changes. Gender affirmation/ transition can greatly improve a transgender person’s mental health and general well-being.<sup>4</sup> Gender affirmative care/service would encompass all forms of medical and surgical interventions including psychological assessment, psychotherapy, occupational therapy, vocational counseling, pre and post-operative nursing care, as well as social and legal interventions.

In this guideline, for convenience, gender transition has been used synonymously with gender affirmative care or therapy denoting the wide range of services mentioned above. We in this guide prefer ‘gender affirmation’ over ‘sex reassignment’ as a more affirmative and inclusive word. The widely used terminology, Sex Reassignment Therapy (SRT) means all forms of medical and surgical interventions to alleviate ‘gender dysphoria’, such as cross-sex hormone therapy and Sex Reassignment Surgery (SRS). All of the various surgical procedures, genital, breast or non-genital/non-breast surgeries, performed as part of treatment for ‘gender dysphoria’ are included in SRS.

Though almost all the available standard guidelines on gender transition related services, addressed the transgender/transsexual persons as ‘patients’, we consider it more appropriate to address them as individuals/persons/clients in this guide. Notwithstanding the fact that ‘Gender Dysphoria’ is still included under the classificatory system of mental disorders, there is enough evidence to suggest that ‘Gender Dysphoria’ is not a pathological condition of the concerned individual.

This guideline is applicable for assessing and treating transgender people who have attained the legal age of 18 years. It does not cover therapeutic interventions for gender transition of gender non-conforming minor children and adolescent. There are number of reasons for the same such

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<sup>4</sup>Affirmative Care for Transgender and Gender Non-Conforming People: Best Practices for Front-line Health Care Staff, NATIONAL LGBT HEALTH EDUCATION CENTER A PROGRAM OF THE FENWAY INSTITUTE [http://www.lgbthealtheducation.org/wp-content/uploads/13-017\\_TransBestPracticesforFrontlineStaff\\_v6\\_02-19-13\\_FINAL.pdf](http://www.lgbthealtheducation.org/wp-content/uploads/13-017_TransBestPracticesforFrontlineStaff_v6_02-19-13_FINAL.pdf)

as, lack of expertise in intervention around puberty,<sup>5</sup> lack of support system to cater to the gender-transition related needs of children and adolescents, lack of access to relevant endocrinal agents etc. However, this guide can be utilized to provide emotional and social support for affirmation of desired gender expression of the gender non-conforming children.

***Disclaimer:*** The guideline will focus on the medico-legal aspects of the transition and not on the socio-legal implications of such transition which is beyond the scope of this guideline.

These guidelines are not intended to replace the clinical judgment and acumen of experienced health care professionals. The medico-legal team that prepared these guidelines claim no responsibility for the accuracy of these guidelines as medical science and law are rapidly evolving fields and new evidence emerge continuously, and thus should not be held responsible for any harm done to clients by following these guidelines.

Sappho for Equality takes great pleasure in facilitating the team work and compiling the present guideline. The guideline has been compiled by Dr. UjjainiSrimani and Dr. Ranjita Biswas on behalf of Sappho for Equality. All practices and therapy protocols are contributions of medical and legal experts in their respective fields who have contributed to different sections of the draft and finalized after being debated and discussed in the larger meetings held over a period of one year.

[Following the development of the *Good Practice Guide to Gender-Affirmative Care* by Sappho for Equality in 2017, an initial round of feedback was obtained from doctors, activists and members of the transgender community. The guideline has been updated in accordance with the feedback received from friends and well-wishers and some of the recent changes in law. A new chapter containing excerpts from experiences of transgender persons seeking *GAC* has also been incorporated. A new annexure containing a glossary of commonly used terminologies related to gender sexual diversity has been attached.

We look forward to further feedback and hope to continue this journey together in friendship and solidarity.]

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<sup>5</sup>DSM-5 has separated Gender Dysphoria in children from that seen in adults and notes that many children with Gender Dysphoria outgrow it as they grow older.

## INTRODUCTION

Health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and legal reforms that promote tolerance and equity for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma. The National Planning Commission, India in its Twelfth Five Year Plan has accepted the need to meet the health and social protection needs of lesbian, gay, bisexual and transgendered (LGBT) community who have been neglected for a long time.<sup>6</sup>

On 15th April 2014, the Supreme Court of India passed a historic verdict, which recognizes the “third gender” category in our country. According to this verdict transgender persons have the right to identify as woman, man or transgender with or without going through Sex Re-assignment Surgery (SRS). The verdict further orders the Central and the State Governments to form Transgender Boards for looking into the matters of health, education and employment of the transgender people. Accordingly, The West Bengal state government formed the West Bengal Transgender Development Board in April 2015. Two members on the Board, a transman (working in a foreign cultural centre and a cis woman (independent scholar working on trans-issues) are active members of Sappho for Equality.

There is great diversity of gender experience between the binary man and woman, some of which cause discomfort and may need medical intervention; others may need little or none. Language in the field of gender non-conformity is constantly evolving as understandings and perceptions of gender expression and identity change. There is growing recognition that many people do not regard themselves as conforming to the binary man/woman divide and a wide variety of atypical gender experiences and behaviors are emerging which need to be taken on board by medical practitioners as well. For some their gender is a fixed entity, on either side of the binary. For others it is a never ending journey of self-discovery and transformation. Some examples of self-descriptions are pangender, polygender, genderqueer, genderdiverse, etc. In all these gender identities the body is an important component giving shape and substance to the unfolding of the gender chosen to be lived. Medical intervention therefore becomes crucial in approximating, if not accomplishing, the body-ideal that satisfies one’s sense of gender. It is important to note that such medical interventions are not optional but extremely necessary for the person to be able to achieve a satisfactory gender identity. However, the extent of desired body

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<sup>6</sup> [http://www.in.undp.org/content/dam/india/docs/HIV\\_and\\_development/the-case-of-tamil-nadu-transgender-welfare-board--insights-for-d.pdf](http://www.in.undp.org/content/dam/india/docs/HIV_and_development/the-case-of-tamil-nadu-transgender-welfare-board--insights-for-d.pdf)

transformation/medical-surgical intervention may vary from person to person and may not conform to the “normal” sex-gender binary.

### **Gender Dysphoria in DSM 5**

According to the DSM 5, transgender identity is termed as Gender Dysphoria and not a disorder. There are two major universally standardized classificatory systems of mental disorders, Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD). The DSM-5, published by American Psychiatric Association (APA) in 2013 has a newer and more inclusive understanding of Gender Identity. The category, ‘Gender Identity Disorder’ in DSM-IV-TR has been replaced by ‘Gender Dysphoria’ in DSM-5. Gender Dysphoria is defined as a condition with marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months duration, that is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning (See **Annexure 1**). In this guideline we follow the criteria for Gender Dysphoria as per DSM-5.

Gender Dysphoria denotes the distress associated with the experience of one’s personal gender identity being inconsistent with the phenotype or the gender role typically associated with that phenotype. The expression of gender characteristics that are not stereotypically associated with one’s assigned gender at birth is a common and culturally diverse human phenomenon and is not inherently pathological or a result of negative self-image. Non-conformity may lead to psychological distress when confronted by social prejudice and non-acceptance. This distress is not inherent in being transsexual, transgender or gender non-conforming. Gender variant people and gender non-conforming people do not necessarily have Gender Dysphoria. The distress of Gender Dysphoria, when present, might give rise to an individual seeking clinical consultation. Till date, in order to undertake medical and surgical intervention to gain relief of the subjective distress, the person has to be certified by a psychiatrist as suffering from Gender Dysphoria. This process of gender transition or sex reassignment therapy includes hormone therapy, surgery, genital, breast/chest and other non-genital like voice reconstruction, hair removal etc.

### **Gender Dysphoria in ICD 11**

In May 2019 the WHO removed transsexualism and replaced “gender identity disorder” with “gender incongruence” in the latest version of its diagnostic manual, the ICD 11. It has further removed the condition from the chapter on “mental and behavioural disorders” and included it in the chapter on “conditions related to sexual health”. This inclusion of gender incongruence in



the diagnostic manual serves to affirm the health care needs of the transgender population while depathologising it. It has been categorically stated that being trans or gender diverse is not a mental disorder.

### **Definition of Transgender and Transsexual**

The term transgender is used more widely to refer to all individuals whose lived and expressed gender does not match with the gender assigned to them at birth. Transsexual is an older term used to indicate people whose expressed gender identity is different from their socially assigned gender and seek transition from female to male and male to female. The term is not preferred too much nowadays. Trans\* (spelt with an asterisk) is an umbrella term referring to all non-cisgender identities including transsexual, transvestite, genderqueer, genderfluid, genderless, nongendered, “third gender” and many others.

With regard to the definition of the term ‘transgender’ as given in the NALSA judgment, it fluctuates between the inclusion of all gender identities which are different from the ones typically assigned to one’s biological sex as well as intersex persons and transvestites, to traditional communities with specific socio-cultural connotations such as *hijras*, *kothis*, *aravanis*, *etc.* Moreover, although the judgment formally says that SRS would not be a necessary step for re-assignment of one’s gender identity which can be self-assigned, certain parts of the judgment harp on the importance of undergoing physiological changes consistent with the self-assigned gender; and many state institutions which formally effect changes in official documents of a person seeking the same include SRS certificate as a pre-requisite.

### **Intersex conditions and gender affirmative care**

Intersex is an umbrella term that describes a range of natural variations in sex characteristics of the human body that do not fit the given binary model of male/female bodies. Renamed as Disorders of Sex Development (DSD), it is also sometimes referred to as Disorders of Sex Differentiation. Statistics inform us that roughly about 0.05 to 1.7% of the population is born with intersex traits.<sup>7</sup> These traits come to be known either at birth, sometimes during puberty and sometimes never at all. Such variations in sexual development of a child can happen at three levels: differences in sex chromosomal type; differences in the development of the reproductive system; and differences in development of the external genitalia. Children are born whose external genitalia do not match either of the markers for male or female, or carry traces of both.

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<sup>7</sup><https://www.intersexequality.com/how-common-is-intersex-in-humans/>

Some other children are born whose external genital organs do not match with their internal sex organs or the chromosomal sex.

Activists, scholars and members of the intersex community have for long protested the pathologization of their differently sexed bodies. They reject the medical nomenclature and argue that rather than “disorders” they should be seen as individuals born with Differences in Sexual Development (DSD). In other words, contrary to common belief of two kinds of sexed human bodies, there is a variety in the kind of human bodies that are born. Intersex is a socially constructed category that reflects natural variations in the sexed body. The size and shape of our internal and external genitalia are bound to vary. So can chromosomal types. Instead of recognizing the spectrum of human bodies scientific categories reduce them to the two categories of male and female. Children with such forms of sexual development are in no way abnormal or disordered, only statistically uncommon. However, in most instances, given the presence of ambiguity in sex determination, doctors in consultation with parents assign a particular sex to the newborn based on the size and shape of the external genitalia and the perceived convenience of upbringing. Thus, in such cases the child is assigned a certain gender first (according to parental and environmental suitability) and accordingly declared to belong to its corresponding sex. Sometimes the sex is assigned surgically too arguably to make life easier for the child and the parents. These surgeries are irreversible and lead to adverse consequences that last a lifetime.

Members of the intersex community have protested these surgeries as medically unnecessary and violative since their participation in the decision-making is ruled out due to the timing of the “normalizing” procedure.<sup>8</sup> They argue that these surgeries are done mostly to relieve parental anxieties and to keep the medico-social model of binary sex-gender intact. It is important to note again that intersex conditions are natural, normal and inherent variations in physical bodies that challenge outdated concepts of sex understood in terms of the male/female binary. Intersex conditions do not always carry a life risk. Only some conditions signify life risk and need to be treated, for example, Congenital Adrenal Hyperplasia that causes hormonal imbalance and requires professional intervention.

Tamil Nadu is the first state in India to ban corrective surgeries on intersexed babies except in life threatening situations like facilitating urination or menstruation.<sup>9</sup> The order passed in August

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<sup>8</sup> In our country in most cases sex female is assigned to these children for both medical and social reasons. Medically it is easier to create a vagina than to create a penis and scrotum; socially it is conventional for girls to live a sheltered life, indoors and without much body exposure, therefore protecting the child from humiliation and violence.

<sup>9</sup> A team of pediatric surgeons/urologists, endocrinologists, a social worker/intersex activist and a government representative is to decide the urgency.

2019 comes in response to a Madras High Court judgment<sup>10</sup> prohibiting “normalizing” surgeries until the patient is old enough to consent. The court raised concern over parents’ anxiety to ascribe sex on their children surgically and noted that children must be given time and opportunity to arrive at their innate gender identity.<sup>11</sup>

Some people with intersex conditions also identify as transgender persons, choosing to live in a gender identity different from what is ascribed to them at birth. In general intersex persons’ needs and concerns do sometimes overlap with those of transgender persons but not necessarily always. Therefore, it is wrong to club intersex persons as a subcategory under the transgender umbrella as is often done. This invisibilizes their priorities and unique life struggles.

### **Is sex and gender really binary opposites?**

The two-sex model of human anatomy (male/female) came to dominate our minds, bodies and our medical sciences since the 18<sup>th</sup> century<sup>12</sup> and laid the foundations for gender as we know them today (male=male and female=female). However, given that the two-sex model is based on the heterosexist peno-vaginal procreative-sexual imperative, all bodies that do not participate in the process of biological reproduction are deemed abnormal, aberrant. Merely the absence of a particular physiological process (reproduction) that carries more social than biological significance serves to banish individuals with differences in sexual development to the peripheries of common cognizance. The medical act of compulsorily assigning these bodies into one of the either sexes pushes individuals with differences in sexual development outside shared collective knowledge, into the fuzzy zone of indifference-ignorance. We tend to overlook, misrepresent and finally forget their existence, not realizing that a section of human beings face discrimination and violation of rights because the world is still stuck in the obsolete two-sex model.

Similarly, gender identity is each person’s innate and individual experience of gender that may or may not correspond to the sex assigned at birth. However, in our daily lives and in our scientific discourses, we see the dominance of the two-sex model – two sexes that determine their corresponding two genders. Some commonly granted features that are considered to be hallmarks

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<sup>10</sup>[https://www.livelaw.in/pdf\\_upload/pdf\\_upload-360185.pdf](https://www.livelaw.in/pdf_upload/pdf_upload-360185.pdf)

<sup>11</sup>Malta and Portugal also have laws banning corrective surgeries on intersex babies.

<sup>12</sup> For more information on this, read *Making Sex: Body and Gender from the Greeks to Freud* (1994) by Thomas Laqueur.

of the masculine and feminine gender like, physical strength, intellect, rationality, beauty, emotion, etc. appear oppositional. But, most of us do not live our lives through such stereotypes; in fact, there are really no identifiable fixed type-differences between men and women. Both genders show varying degrees of these traits and the assumed polarity between the genders is in reality a false one. It is the practice of creating such binaries of masculine and feminine behavior that lead to disordering of gender non-conformity, that lead to stigma, discrimination and dysphoria.

The fact that DSM 5 retains the diagnostic criteria of “A marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics” proves in itself that the assignment of gender based on the sex assigned at birth is treated as normal and natural in medical sciences. There is a growing need to question the necessity of congruence between sex and gender. As of now, the shift from disorder to dysphoria makes it clear that it is not the duty of mental health professionals to comment on the “appropriateness” of a person’s gender identity, rather more important is to point out the distress caused by parochial understandings of self-expression and lived lives.

## CHAPTER 1

### EXPERIENCES OF TRANSGENDER INDIVIDUALS SEEKING GENDER AFFIRMATIVE THERAPY

#### Introduction

The Good Practice Guide to Gender-Affirmative Care (GAC guide) has attempted to lay down some basic information and pertinent guidelines to help both service seekers and service providers ensure a smooth transition and minimize emotional and physical pain and injury. It has been our continuing attempt to hold conversation with members of the transgender community to understand better their needs and concerns regarding the health care services. We have organised focused group discussions, individual interactions and public meetings in this regard. Discussions and conversations have provided us with insights on how the transgender community view the process of transition, their experiences in seeking GTRS and the challenges faced by them. Their experiences of accessing medical, surgical transition related services helped flag a number of entry points into initiating dialogue between service providers and service seekers with the larger objective of improving health care services for the gender sexuality minority community.

Through these interactions and the focused group discussion, some of the experiences of transitioning individuals came to the fore which in most cases remains undocumented and therefore unacknowledged. Confusion around gender affirmative therapy is pervasive. Getting information on the steps and expenses of the gender affirmative therapy is crucial for every individual seeking GAT. Owing to lack of information and perpetuation of misinformation within the community, individuals frequently engage in self-medication and experimentation on their own bodies which may at times result in unintended and negative consequences. Members of the community working at the grassroots are often unable to offer appropriate information owing to their own lack of knowledge. Post-operative care, which is crucial for a healthy recovery, is not a reality for many due to poor family support, abandonment by relatives and lack of material resources among community friends. The need for psychotherapy and psychometric tests before going for HRT (Hormone Replacement Therapy) or surgery remains a question for many. In the midst of severe gender and body dysphoria, and the desire to fit into the preferred body and gender role, trans persons show haste at times without giving much importance to psychotherapy and psychological counseling. Counseling does play a role in understanding

oneself and reflecting on the decision to go for transition, which may be a life-long process, as well as to be able to better cope with post-transition distress, if any. For some, it has been smooth and uneventful and yet for some others transition has given rise to further suffering, self-depreciation and protracted pain. There have been incidences where continuing stigma and discrimination in the transition period as well as in their new lives has led to self-harm and even death.

With the NALSA verdict and the decriminalisation of homosexuality, and with emerging awareness about GAT, more and more transgender persons are seeking medical and psychiatric help for gender affirmation. Several factors influence an individual's decision to transition and their choice of service. On the one hand, the availability of experts, the expenditure, the appropriateness of the transition guaranteed, the time period required to achieve best results and the probable side effects are some of the concerns that individuals seeking transition express. On the other hand, certain attitudinal and infrastructural barriers from the side of the service providers operate to hinder a smooth transition and cause serious doubts about the medical system.

On the whole, experiences with the medical service facility have been varied. People have spoken about their negative experiences related not just to transition but in general health care too. Some of these experiences have led them to either avoid it or access it only in dire circumstances. Incidents of discrimination and violence from service providers are rampant and are perpetuated at various levels. Trans persons (both trans men and trans women) share their painful stories of being rejected by doctors, denied services, or of being refused to be touched by medical staff. They have spoken about facing unnecessary, awkward and uncomfortable questions by health care professionals. At times, they are told to open their clothes without any concern for privacy or consent; at other times doctors come up with confusing opinions about their conditions. Transgender persons have deplored the fact that their bodies become the site for experimentation and for making business, fueled by their desperation to achieve a gender-affirmative body. Given such a situation, most of them refrain from going to the doctor even for a simple cough or cold.

The experiences that describe transgender lives are still treated as medical conditions that need certification by medical professionals. Though DSM 5 has changed the diagnostic category of GID to GD and the ICD 11 mentions gender incongruence instead of gender identity disorder, till this day, transgender individuals wanting to undergo gender affirmation need to obtain a certificate from a mental health professional, psychiatrist in most cases. Lack of multi-disciplinary collaborative teamwork to address the various transition-related needs of the

transgender persons has resulted in miscommunication and subsequent complications and ineffective outcomes. Lack of information and knowledge about the legal issues around gender transition give rise to anxieties in trans persons and hinders clinical decision-making by medical professionals who intend to provide such services.

Evidently there remains a gap in understanding and reckoning with the vast reserve of experiences of transitioning individuals that remain under-documented and therefore unacknowledged. With the motive of listening attentively to these voices and stories so that these can provide entry points for rich discussions and debates in the medical service sector and help improve the services provided, as well as facilitate further research in this direction, we decided to incorporate this chapter on the experiences of both trans men and trans women identified individuals while engaging the GAT service providers. This document has been compiled from the numerous conversations we have had on many occasions (between 2016 and 2018) with people in Kolkata and its neighbouring regions who have undergone transition, who have abandoned the same at some point for various reasons, and also who are still planning to start or are at some stage of the gender affirmation process. Being trapped in the wrong body, transgender individuals (both transfeminine and transmasculine) share their stories of accessing gender affirmative services which unfortunately perpetuate discrimination and violence at multiple levels. The purpose of this compilation is to bridge the information and attitudinal gap between service seekers and service providers. Lack of information on both sides leads to misunderstandings, miscommunications and sometimes serious health risks. Medical professionals must realize that GAT is not a cosmetic change for transgender individuals seeking transition; it is an essential medium for survival. Members of the transgender community seeking health care services, on their part, need to appreciate the fact that all medical and surgical interventions done to their best extent have limited scope in achieving the desired transformation and there are certain physical and physiological processes that function beyond the control of the injectable and the scalpel.

### **Motivations for and expectations from GAT**

GAT is very much a desire that most trans men and trans women seeking gender affirmation live with. However, financial constraints, feasibility issues, lack of material and emotional support and fear of social ostracisation are some of the factors that curb the desires. The extent to which gender affirmation procedures are taken up, vary from person to person and there are many reasons for that. Some individuals have cited financial reasons for opting for only a certain surgery and not anymore. Others have talked of being satisfied with the change in external

appearance only. There are still others who want to undergo the full procedure without which they feel incomplete. Lack of adequate and appropriate transition related health services often delay the procedure or compel the person to look for alternatives outside their home state incurring a huge financial burden. Education and job prospects become another point of consideration given the fact that change in documents is never easily achieved. In some cases it is preferred to complete the transition process before embarking on an important career, while in other cases the idea is to settle in a secure job and then start transition. The decision is never easily taken. However, in some instances transition has taken place on the job as and when it has been possible.

Some of the motivations and reasons behind opting for GAT were expressed as:

- to have physical features conforming to their gender identity
- to have a body and appearance they always wanted
- to have better social interaction
- to marry and settle down
- to be more accepted in the workplace
- to get rid of the confusion one sees in the eyes of common people
- to no longer 'pretend' before the society
- to no longer be misgendered...

Extreme body dysphoria makes it imperative to align one's body to the mind and soul, and be accepted socially in the preferred gender. Individuals associate the discovering of a new world with the new body that they dream of attaining with GAT. The new body not only indicates a new identity, it also signifies doing things they wanted to do, going to places they dreamt of, travelling on their own etc. In Kishor's (a young trans man working in the banking sector) words, "My top surgery has given me a new life. It is interesting how I felt incomplete, and after transition, I started feeling complete gradually". This is the most common and most compelling motivation. As Rayan, a seventeen year old student, identifying as heterosexual trans man puts it, "I will have peace of mind". "I will be home". Or as Santu, 28 years old, identifying as a heterosexual trans man says, "I want to be that what I feel mentally", or as Jeet, 24 years old, teacher and identifying as heterosexual male says, "To look the way I am from inside". Being accepted in the preferred gender can come from having the body that matches the soul and is further motivation to settle down in the role and identity of the preferred gender in a socially appropriate way. For Suman being able to go out at night, the freedom from not having to follow diktats about dress and behaviour, the possibility of being able to work as much as desired and living alone are the factors that make him look forward to GAT.



The body acts as a hindrance; being trapped in a different body is frustrating; the inability to perform certain acts and meet certain desires is debilitating. As 22 year old make-up artist Tania, identifying as a trans woman, confesses, “I would be able to explore a career in belly dance which remains a passion”. The discomfort with the body or the idea of the body as hindrance is expressed in other ways too. Priyam says, “See, I am born with a wrong body. At least if I could die with a correct body, I would be happy”. Sajal describes his pain thus, “The greatest obstacle to my gender identity is my own physical body... it’s because of this!”. The lack of identification with the body organs one is born with, is such that sometimes they do not want to seek treatment for any condition related to them. Srijit suffers from Polycystic Ovarian Disease and on being asked if he takes treatment he says, “I don't feel comfortable. I mean I don't feel comfortable getting treated for this organ”. However, he is willing to consult the doctor to find out if this condition will in any way hamper his HRT or transition process.

Just learning about the possibility of living your desired life can act as the motivation to transition towards that life. Some participants shared that once they came upon information regarding the process they could give voice to their felt need for gender affirmation. Some have also talked about being influenced by their friend’s decision to undergo transition. Once you get to know about others who are in the process of transitioning or have transitioned, you feel emboldened to fulfil your dream of living a more complete life.

Expressing sexual desire in the preferred body and fulfilling partners’ expectations is an important driving force. The dysphoric body sometimes comes in the way of a fulfilling romantic sexual relationship. The body that is abhorred needs to be “perfected” before one can embark on a life journey of commitment and togetherness. Intimate relationships are an important medium to validate the lived gender identity. Subrata, an adolescent student and identifying as a pansexual male, while talking of his sexual desires shares, “Whatever I maybe from childhood, for the last two years I am experiencing some changes in myself. I am feeling like I should bring upon a change in myself. And certain experiences that I have had are making me realize that from within also being 'male' matters". Having the perfect body for having sex is important. Suman talks of the time when he would have his preferred body post-surgery, “And then if I want to have sex with a woman, I would not feel uncomfortable about the fact that I too have breasts...that’s something important for me.” In a few instances the wishes of the girlfriend have played a role in deciding about surgery. Swarup’s decision not to transition is similarly influenced. “I will not do that [phalloplasty] at this moment because my partner also does not prefer it. She is satisfied the way I can satisfy her and won’t be able to take anything more,

because she already is unable to take what I do. And in phalloplasty, a substance will enter my body, a silicone transplant and I don't know how far my body will be able to take it".

Some narratives also expressed the burden of social and individual pressures that feed stereotypes of sexual performance and pleasure and impact lives and relationships accordingly. Sajal who went for chest reduction shares,

Actually our body has this huge part dedicated to our sexual desires for partners. The physical body plays a huge role in this and that is closely related to our psychological state... that includes how our partner is feeling... and even though there are a lot of discomforts, I don't know what a woman desires ... but I do believe that women prefer penis... and those who do, they would then prefer a biological penis... all right? So at that point I have to face rejection... I am a man. When I first see a woman, I don't prefer a plain, flat chested woman, all right? I have this weird fascination with breasts. So ... the woman can also be obsessed with a penis... they want certain things... and if I want them, I need to provide them with those certain things.

### **Access to information and challenges thereof**

Most people start the process with very limited or no knowledge about the steps, adverse effects, consequences etc. No standard source of information about service providers, in terms of their reliability, experience, location, estimated cost, etc. is publicly and easily available. Hearsay complicates matters further. People tend to compare each other's experiences of therapy overlooking the fact that different bodies react to different processes differently, and no two experiences can match or are comparable. Magazines, YouTube videos, Facebook pages, social media groups, community interactions, personal interactions, workshops, online articles, seminars, etc. are the sources of information on GAT. Some are lucky to have friends, teachers and relatives who provide them with information and encouragement to go ahead with transition. Intimate partners and parents have also played a role in helping the person with information, contacting support groups and supporting the decision for going into GAT. Overall the internet remains the major source of information and research. There is access to various kinds of information and resources though all of it is not always authentic or dependable. But most people seeking gender affirmation care lack information and understanding about the different and nuanced technical procedures like breast reduction, mastectomy and chest reconstruction, castration, emasculation; metoidioplasty, phalloplasty etc., that go on to ultimately grant our wishes for a more preferred-gender-appropriate body.

The narratives brought to focus how unlike a few years back, the present times enjoy the advantages of the social media connecting people both within the community and with sensitive health care providers. However, until recently, the scenario was completely different. Dearth of

doctors meant that one had to travel long distances to visit the only available doctor, however insensitive he might turn out to be. Transition being a lifelong process, there was no one to warn them or inform them about the side effects or the consequences, good or bad. They had to rely solely on the scarce resources available. However, even then, as is true today, friends from the community came to the rescue and provided whatever limited information was available and connected people seeking gender affirmation therapy to doctors or mental health professionals. Simran who identifies as a trans woman and works in an NGO shares,

So when I took the decision to transition, it was mostly because I did not feel that my body was attuned to how I felt my body should be and from that point of recognition of disparity, my need for transition came. Now at that time, there were not too many doctors and not too many people, unlike today, who knew what to do, to go through it. There was just a single doctor who was there, I decided to go for hormone treatment first and he helped me out, and no matter where one lived, one had to go to this particular doctor. It was the need of the hour. If you had an appointment on some day, no matter during which hour of the day, you had to be there no matter what. I guess the one doctor in the whole town was the thing I feel most uncomfortable about, from the time that I transitioned.

Many a times, transition happens out of uninformed choice. Not being able to access medical services, or adequate information, and given the urgency to achieve their desired body, self-medication and risky experimentations are rampant, but appears as the only plausible way out.

Srija, a transwoman and a transgender activist shares her life story:

Presently maybe I am not going through hormone therapy as such but I do take some pills on and off, and do some small experiments on myself which I have been doing since I was very young....and the problem of lack of information...we actually believe in a lot of hearsay....like if you eat ‘shukhi’ (contraceptive pill available over the counter) or something else or some pills, then you will get breasts, or if you take some injections which are anti-pregnancy like depoprovamine – that will give you breasts. These things actually harm us because we believe in them. I think there is a great need for proper information especially for the community. I am talking about the time when people are just about to join college, they are starting to dress up and maybe even venture out of the house etc. so then from such deep desires, the problems aggravate when hearsay is all around us, no one knows exactly what they are trying out, that’s the problem.

Trina, who identifies as a trans person and works in the social development sector, emphasizes the need to access appropriate information and warns against “jumping” into the process without weighing the pros and cons. She points out,

I am not saying that one should not go for it and that age is the only reason, but one has to count in the fact that the thought processes of the 'holistic society' go into the way we individuals think. That everything has to be quickly achieved and only then it's a palpable gain. When I was undergoing my surgery, there were two trans-women who came... to get breast implants. One of them wanted breasts because that would increase her market value... the other one said her husband would accept her as a complete woman after the implant. 'We need it as soon as possible.' And they got operated and the second woman came back! She came back and she made the doctors take the thing out! Her husband did not think that she was more of a woman or more womanly and she took it out after six months. So our whole focus is to wait and move forward, do it today and get results tomorrow.

For transmasculine individuals, lack of proper information is also accompanied by less visibility. Chandan, 28 years old trans man working in a foreign cultural centre and member of an activist collective, shared how he gathered information about transition related procedures from a conference in Mumbai in 2014, organized by a transgender support group. Since he knew no transman in Kolkata who was transitioning, he had to wait till he could find others like him and get appropriate information about the services available in his city. "At that time, I did not know any transman who was undergoing transition... and I felt alone. In Kolkata, there was nobody whom I knew was a transman and transitioning. So lack of information at that time was crucial. I had to get to know various other trans people before I could discuss and finally take the decision of transitioning. And I am talking about 2014-15, not even so long back; now it is gradually changing".

### **Challenges of undergoing GAT**

Often times transgender persons seeking transition start therapy without much idea about the adverse effects. Self-administration of hormone preparations without appropriate medical prescription, getting surgeries done by quacks, not visiting the clinic after the first visit, are some of the problems that are common. Surgeries from non-professionals are mostly done because of monetary issues, lack of guidance and patience and due to lack of access to safe and holistic GAC services. Such processes in non-professional settings or by unskilled persons have led to life long suffering in some cases and proved fatal in other cases. However, health risks from self-medication or monetary constraints are not the only challenges faced by transgender people. Even those who have gone through regular institutional GAT have reported physical side effects, and psychological stress like pain, discomfort and depression, especially after hormone replacement.

Adverse consequences are not always medical or surgical. Physical transition may lead to trauma due to negative comments and reactions from family, colleagues and society at large, reduced work opportunities and limited access to public spaces. Challenges at the workplace, hurdles in accessing public spaces and facing criticism from family and relatives are situations that also need coping. For example, Amal, a 21 year old student identifying as heterosexual male talks of body pain, acne, loss of hair, etc. and along with these he expresses concern about accessing sex-segregated public spaces like washrooms or trial rooms while being in the process of transition.

Families are not always able to support their children's desire for transition. Fear of social ostracisation, inability to come to terms with the thought of a transitioned child, financial constraints and anxiety over health effects and adverse consequences of surgery have prevented family members from giving full or partial support. Gopal's parents did not support him during his transition, not feeling confident enough to accompany him to his surgery. While Gopal could think of going against his parents' wishes, Ujwal has to defer his wishes keeping in mind his mother's distress at the suggestion of transition and inability to accept surgical intervention. Kishor's parents are still in a stage of denial though Kishor has started hormone replacement and was planning to undergo top surgery at the time of the interview. His parents somehow cannot accept that Gender Dysphoria is a real condition and their child needs support and healing. They were ready to accept his cross dressing but had problems with his going to the "extreme of surgery". Describing how he saved up for his treatment and not finding family support in the initial stages of his transition Kishor says, "Yes, they are not on board with the surgery, they found it unnecessary. They still don't understand the agony of being trapped in a wrong body. Only someone going through the same struggle would understand what I am trying to say. If someone thinks I am making things up, they would never believe how much pain I am in".

For some, transitioning medically means leaving the family home, severing ties with loved ones, and at times, shifting jobs and localities even. Often, loneliness remains the only companion. For others, leaving their families or shifting profession is not an option. They have to bear their social burden and bury their wishes and desires under it. Srinjan is desperate to undergo change but cannot decide due to many factors. His mother who is his only support cannot accept it and asks him to restrict his wishes to cross dressing only. He is worried about his job prospects and feels there would be many hassles in case he changes before getting a job and he might be refused. The locality he lives in is pretty orthodox and in his own words "People don't even know what a tomboy is... a trans man is a word they never heard of in their lives".

Sajal an engineer trans man and doing his post-graduation says,

I had high gender dysphoria and I was suffering, if people looked at my chest region I would cringe, it was horrible...but I will have to work. I decided I cannot do female to male, maintaining the protocol, I had to leave one job at that time around 2014-15. I thought I will reduce my breast but not undergo the full transition and I also changed my job because I felt that I will become very visible if I stayed on. The thing is I am not a kind of person who will be able to live separately from my family and the people I know. I remember Keshav (transman), he spoke about how his family had thrown him out of the house, I cannot deal with that kind of thing and life would have been really difficult for me if I had gone through HRT then and followed the procedure...It would have been extremely challenging for me.

Srijit, a self-employed trans man living with his mother and waiting to start gender affirmative therapy at the time of this conversation adds,

I think myself to be a man but I simply cannot abandon my family. If suppose I start hormone therapy today, tomorrow I will have to leave my job and I will have to think about my family. How can I take care of my family if I do not have a job? So there, I know that I will have to move to some other profession. I don't know which profession it is going to be, but I will have to shift because as I said, my family depends on me. And so a job for me is a sheer necessity.

Growing up as a person assigned female at birth in a patriarchal, heteronormative and gender stereotypical family setting, where there is little scope for discussions on gender and sexuality or even one's choices, contacting doctors or finding proper source of information also lead to a difficult situation for trans men. Trans men shared their experiences where doctors have advised parents and other family members to treat them like women in order to “bring out the feminine in them”. At these times, taking uninformed decisions for themselves and self-medication remain their only choice to attain their preferred body.

Rudra, working in a private concern and identifying as a trans man, recollected the times when neither he nor his family had any information about the different processes involved in gender affirmative therapy. Rudra spent his childhood in one of the states in the North-east where medical facilities are still scarce. When he was still in his teens he came out to his parents who took him to one of the cities in the southern part of the country for “treatment”. He shared,

At that stage, they advised that at least for six months in a row I should be treated like a female child. So they threw out all my old clothes and a huge pressure was created. Then I went again... for some treatment for my mother, and I had read in the newspaper about a person who had undergone operation and had married their girlfriend in the hospital itself...this gave me hope...so this time I looked for a doctor by myself and found one. The doctor did some psychological tests on me and

asked me to take some medicines... now at that time (in 1997), there wasn't any hormone therapy as such, and he gave me a gel.

### **Institutional and attitudinal barriers in accessing safe GAC**

There is no substantive research and documentation in the field of GAC and in the absence of a standard protocol regarding GAT, doctors are sometimes compelled to go by their clinical acumen in a field that is still emerging and which has not been part of their professional training, at least in this country. Additionally, most clinicians work in isolation in private clinics preventing a team approach as is possible in an institution, for instance, a state hospital. This creates a barrier in communication among the different clinicians involved – psychiatrist, endocrinologist, surgeon, voice therapist among others, causing confusion and ultimately poor quality care. In the absence of a communication protocol among doctors, transgender persons seeking professional help undergo traumatic experiences. Some professionals insist on following the steps meticulously (hormone replacement followed by top surgery and then bottom surgery) while some are happy to jump steps to satisfy their clients. Sometimes, as Swarup mentioned, they ask for a certificate from the State Medical Board before undertaking surgery or ask to bring their parents before giving a Gender Dysphoria certificate as in the case of Gopal. The expense also varies from place to place, doctor to doctor.

Reflecting on the knowledge gap, Sula (trans woman) shared her experiences of her family taking her to a renowned psychiatrist when she had come out to them. The doctors at the hospital diagnosed her but were so confused about the terminology, Gender Dysphoria, that she was prescribed 10-15 medicines to be taken regularly which then made her sick. Her parents took her to another hospital where the doctor diagnosed her as having Gender Dysphoria but also labeled her as mentally unwell! She goes on to say, “From there, I was sent to Lumbini mental hospital where, even at that time they used to do shock treatments. For six to seven months, I was there and constantly given shock therapy. I still have all the documents that are a proof of these”. But that was not all for her. She was referred to a hospital down south where she ended up spending over 75000 rupees for checkup. Today both she and her family know, “Gender dysphoria is just a small thing, there is no such hue and cry to be made about it, neither is diagnosis so expensive.” Approaching psychologists and the psychiatrists is important for trans persons going through medical transition to get the GD (Gender Dysphoria) certificate. However, some also acknowledge that visiting a psychologist or a psychiatrist does not necessarily limit to getting a certificate. It is crucial to continue with the therapy, to understand oneself, and then to decide on what they want, with full conviction. And this is also where the psychiatrist and other mental

health professionals have a duty to act responsibly. Learning from her experience Sula cautions others who seek transition, “There is need to self-identify as well as go for counselling because we need some sort of guidance in what we have decided but at the same time need to know things ourselves so that we do not face the kind of harassment that I have faced.”

Sometimes the inability to comprehend the needs of a trans body can result in discrimination and delay in initiating treatment. As Gopal says, “If one has cough and cold and goes to the doctor they can refuse just by seeing the trans person”. Toton narrates a harrowing experience while receiving treatment for Tuberculosis from a renowned pulmonologist who refused to treat him because he wore binders. He did not go back to the doctor even when he discontinued his meds and had severe side effects. In his own words, the doctor had this to say, “What is all this stuff you come to me wearing? If you wear all this you will not be able to breathe properly and such diseases are bound to happen. If you come to me like this, I will not treat you...Do not come to me adorned in this manner, I cannot tolerate all this. Try and live the way you were born.”Toton rued, “On one hand, he was such a great doctor while on the other hand he did not understand anything... He disheartened me and gave me a lot of pain... I was very sad”.

Apart from the gap in knowledge and training, individuals spoke of experiencing different forms of bias from health care service providers. The reluctance to give out information, the insensitivity in the dealing, the refusal to try and understand the needs or constraints of the candidates is quite prevalent producing a gap between the service seekers and the service providers. The unfriendly attitude of the hospitals and the doctors’ chambers act as a big hindrance in seeking medical-surgical services. Transgender persons have spoken about their discomfort under the gaze they are subjected to in a hospital or a clinic. The discomfort is not limited to uncomfortable stares and insensitive questions alone. Mis-gendering is another negative experience that trans persons have talked about. Having gone for the consultation with concerns around gender dysphoria it is rather painful to be referred by the gender ascribed at birth. Often, individuals may not have completed their legal transition (change of name and gender in official documents) and they still need to use their birth name. In such cases not being able to “pass” in the gender ascribed at birth – in other words, cross dressing or embodying the external mannerisms of their preferred gender invites the once-over from people outside the doctor’s room, starting from the staff to the other waiting patients and their accompanying persons. The gaze and attitude of medical personnel while trying to unravel the mystery of the apparent disconnect between name and appearance can become very disconcerting, as expressed by many. As Priya (a young trans woman doing her Masters) rued, “We are not asked our



preferred gender during registration and our names are deliberately called out loud as a cue for some brief entertainment for all present”.

Doctors appear embarrassed and apologetic for seeing gender non-conforming patients and tend to speed up the consultation so as to get them to leave the clinic. They are also said to refrain from giving clarifications and information unless asked questions. However, most times people seeking professional help do not have much idea about what questions they need to ask to have a clear idea about the procedures, side effects and long term consequences. When they do have questions they feel shy and hesitant to ask.

Individuals also face awkward questions which make them uncomfortable and difficult to open up or make further conversations.

Trina explains,

Going to the psychologist, the first question that you will be asked is, ‘Since how long have you felt this way and since how long are you dressing up this way?’ Now she [pointing at someone] has been feeling like this and dressing up this way since some fifteen years back and some more years later I found the courage to wear such clothes. I have felt like this from back then itself, but I did not have that much courage to dress up in this manner. So the doctor turns round to me and says, ‘Oh so she has been doing this for so long and you have not been doing it for as long, so did you think of behaving this way by seeing someone else?’ These questions have come towards me...I told the doctor that yes I am wearing these clothes very recently but I have been feeling like this since forever! Even there are many men who are still afraid to come out due to a plethora of reasons and even though they have the deep desire to dress up and be women, they just can’t...a lot of boundaries are always in place...but the doctor thinks that she [the other person] is more legitimate than me... so if this kind of bias could be taken away and doctors could be better educated on the subject... to have a holistic approach and not such a narrow one, then it would be good and helpful for all.

Srija adds,

Once when I had gone to a doctor then there was this set of questions that I was asked and it was kind of endless...I’m sure many others have also been asked such questions...like since how many years did you feel you were different than the others, since how many years have you started to cross dress, since how many years have you been standing at the mirror and imagining yourself to be a woman, since how many years have you done this have you done that...in this hoard of ‘how many’s’ I actually started asking myself how many more of these questions can I answer!! It’s almost as if my desire to be a woman went away.

Apart from facing awkward uncomfortable questions, individuals also face harassment in other ways which often results in discontinuation of therapy. Anirban who is a musician opens up, “I

have consulted doctors many times. They don't understand at first, but while going for a full checkup, their eyes stop at my chest. Now it's easier, doctors know I am biologically female. So when I talked to a doctor, I had to feminize my voice as much as possible, so that I didn't have to face any awkward question". Partha, a transmasculine person in his late 20s adds, "I was asked to do this test. The doctor looked at me in a strange manner. To me it seemed to be a different gaze. I did not like it; I felt bad. I did not do the test. The doctor has a big reputation but I did not like the gaze and so I will not do the test."

Kaushik's experience amounted to sexual abuse where the doctor to whom he was taken for counselling decided to give him a taste of what it is to have a physical relation with a man by showing him pornographic material. In Kaushik's case he was constantly instructed by the gynaecologist and psychologist to conform to the life of a girl since society would not accept it and it was best to "live the life the way you were born". Another gynaecologist examined his genitalia to rule out intersex condition and then advised him to live a normal life since he had no defects.

Chandan shared a detailed account of his experience of visiting the endocrinologist whom he later stopped consulting.

I first consulted my doctor at a state affiliated hospital. There, in a room, two endocrinologists share one table. With so many people around me and the crowded hospital environment, I was finding it difficult to talk. There were people listening to what I was saying, gaping and gazing as this was something which people rarely hear. There were many questions that I was not able to ask the doctor and so after that I have always visited his chamber. After visiting his chamber my experience has been that he does not feel comfortable and does not want to answer questions which he tries to avoid. When he does answer, it is out of compulsion. I was asked a lot of questions. I have no problems with that; it's just that I felt the manner in which the questions were asked to be insensitive. 'Do you have a physical relationship with your girlfriend?' I replied 'Yes.' Then he asked me 'How do you do it? Well, you don't have a penis; then how do you do it?' I found this attitude very insensitive. And he is reluctant to get into a conversation. He just looks at test reports and adjusts the dose. His working methods are such that it makes me very uncomfortable.

For some, though interaction with the doctor seems to be impressive and encouraging, the surgery and its aftermath may not be fine and as expected. Transitioning into the desired body is the need to live with dignity. The desire to acquire their preferred body far surpasses the risk of negative consequences that may occur owing to self-medication and surgical intervention by untrained professionals. There are people who are ready to pay exorbitant amounts, or take life risk by increasing the dosage of medicines, to be able to attain the desired body and the life they

have been dreaming for so long. The desperation of the transitioning individuals gets exploited by some unethical service providers.

Rudra had this to say,

This was in 1997, I was in class IX I think, so I had this gel and I started to use it... and it was quite expensive, like it was 900 rupees at that time! But I got some problems from it. Actually I was in a hurry for it to work, and I was taking more than the dosage amount and so the problem started and then, I made a trunk call and the doctor advised me to immediately stop its usage and consult any endocrinologist if there was one in my area.

People also shared their experiences of exploitation at the hands of surgeons. The exploitation is to the extent that such operations often take place in shabby dilapidated rooms turned into makeshift operation theatres with no proper equipment or sanitation. Also, after the operation, they are told to leave in an hour or two without much post-operative care in order to escape any responsibility for adverse consequences. In such situations, legal formalities are also a facade. Talking of his experience with the surgeon Sekhar expressed dissatisfaction regarding the delay of the phalloplasty with the surgical procedure getting deferred several times without explication leading him to incur huge expenses and loss of working days.

Sajal reminisces about the time when he went for his chest reduction,

Nobody gave me any document or anything. I had no written proof that I had undergone this surgery on that date. I just had no proof that the doctors had performed this surgery on me and they did not provide me with the rough estimate of just how far they were going to reduce (breast reduction) this. Even the doctor who was supposed to perform the surgery was absent... this was a different surgeon, not the person I had been talking to on all those days. It took a long time for me to heal... though perhaps this is a standard time period for a lot of people to heal. But the thing is I was told something else... I was told that they would perform the reduction to the level I had asked them to, but at the end they did nothing as such.

Since people opting for surgeries need admission, the harassment continues there too. Admission in the hospital is always a trauma when they have to wear clothes that do not affirm their preferred gender or are put into accommodations according to the gender ascribed at birth. Along with the uninvited curious gaze and unnecessary questions /comments from hospital staff like ward boys, attendants and nurses, as well as, at times, visitors of other patients, one has to deal with physical abuse as well by them because they think it is their cis right to look and/or examine the body of a trans person even without their consent. Body stripping and head

to toe examination is also something one is often exposed to. The hospital environment fails to remedy this and at times, the transgression is sought to be normalized.

Sekhar who had undergone breast reduction surgery, hysterectomy and metoidioplasty at the time of the interview narrates his harrowing experience at the nursing home and how the male attendant became curious about his state of genitalia pre and post-surgery. On two occasions the male attendant stripped him without his consent and against his will. In his own words,

There was a man. So I was too uncomfortable because he wanted to see my genitalia to find out just how much of my body was female, I called a sister (nurse) and told her not to allow him near me. She talked him down, stating that the doctor himself would take care of everything. And then after the operation, when I was still unconscious, some attendant came over and lifted the bedcover to see my genitalia; my friends came in just then and he left quickly. So later, I complained to the doctor that these things could not be tolerated. Then another incident, after my mastectomy, some fat was left, I was asked to strip down in front of a man, he insisted that it would not be a problem since we both were men.

Dibyos story is that of utmost harassment and brilliant fighting back with the medical system. For Dibyo, his doctor is like god for having delivered him from the daily nightmare of inhabiting a wrong body. Though the surgery did not go as expected and might require a second surgery to correct it, Dibyo feels grateful towards his doctor for having given him a new birth. However, Dibyo also relates how he felt harassed and humiliated when he was asked to strip in front of the medical and paramedical staff in the OPD of a state hospital, to be examined and photographed. Having overcome the initial feeling of paralysis and humiliation, Dibyo was able to answer back. "Their point was if I could not strip in front of them, I was not a man. I objected to that, I said if being a man meant being naked then how come there was no naked man roaming in the streets?"!

In the midst of misinformation, discrimination and exploitation, transgender persons shift from one doctor to the other with the hope of better treatment and behavior. Among all this despair there are some professionals who treat with compassion and understanding and are mostly sought out by members of this community. For instance, when Soumya went for his hernia operation that required dressing, the nurse could sense his discomfort and had this to say, "I've nothing to do, I can understand that you feel uneasy, please bear it."

A supportive and understanding attitude from the health care service provider can go a long way in affirming one's self-identity and leave a happy memory for the individual.

Gopal (trans man) shares his idea about gender identity, dysphoria and transition, and his experiences with one such professional,

For me, I had no dysphoria. When I had first gone to the counsellor in 2012, I was a very happy person and conducted my lifestyle very confidently and I felt that if I could carry on with this confidence, then my life would be perfect and everything would be fine. So I carried on like this...even today, Science has advanced so much that we can elongate our small nose or even make it smaller if we have too big a nose and we do not bother ourselves over this too much then why do we do this in the case of gender? Aligning your sex or gender to what you feel seems like a massive thing in society...it's almost like we cannot get out of the rigidity behind it and is a testimony of how narrow minded we are as a society....I have to be gender dysphoric to be able to get a certificate for my SRS, why? When I first went to a psychologist that person was seeing that I am a good and happy person, I was under no stress or sadness because of whatever body I was in. Ever since I was a child I knew that I wanted to become a boy and I was always a feminine boy and perfectly happy... I said that I will not waste my money on frauds, I will not go for SRS unless I find someone better. It is my body, it is my gender and it is my right and no doctor can tell me what I should think about myself or what my gender should be...it should always be self-identified and later when I went to a good Psychologist, he said the same thing to me. He also said that gender dysphoria was not necessary to undergo SRS and anybody could undergo as per their wish but he did ask me why I wanted to undergo SRS. I just said that no girl would want to cut off their breasts, they will always love their breasts and not want to part from them but me, I was different, and I do not want them at all. He only smiled and he said that although I was not gender dysphoric yet for the purposes of the GID it had to be written so that I could go through further procedure.

### **Way ahead**

Amidst all experiences of discrimination, partial information and lack of awareness one cannot erase the fact that it is a question of survival to be able to acquire a sexed body that matches their lived gender, rather than having to live with a mis-matched sex.

The huge cost of GAT in private institutions, the lack of services in state medical hospitals and absence of medical insurance for gender affirmation treatment prevents a good number of people from going for transition. At times, the situation becomes helpless with the discomfort and dysphoria around their bodies becoming unbearable. They find themselves in life threatening situations, where getting rid of the dysphoric body is primary and yet, there is neither support from their loved ones, nor proper information from the end of the service providers.

In such a situation, the need for a guideline for people opting for GTRS came up from the community itself.

Srija, reflecting on her work of supporting individuals seeking GAT, says,

Most of us here are from areas around Kolkata and have some connections with these issues or a somewhat better understanding and we (support group) being located where it is, we have to deal with a lot of clients who come from these areas, however, there are also a lot of others who come to us from the hinterlands of rural districts and have rushed to us because they have heard some piece of news or have read something in the newspaper and to them, these surgeries are like water for the thirsty... so if at least for their sake, there is a guideline that we could work towards so that we as organizations and individuals could guide them properly as to what they can do or might consider doing, then that would definitely be a good idea and would make our work easier too.

In response to the urgency of providing some basic and essential information to the community people opting for transition and those who withhold from transition due to various fears and experiences of discrimination from the service providers, Sappho for Equality is in the process of developing a booklet in the local language containing some basic information which can be circulated among the community and which can make the process of transition more informed and less risky.

Individuals in transition also acknowledge the socio-cultural baggage that the medical system and the doctors carry with them – as the medical is also not beyond the social. The social baggage of treating or providing care to people with alternate gender and sexualities are huge. At times, sensitive doctors trying to make efforts to bring about changes in the services rendered to gender non-conforming and transgender individuals are otherised and excluded. However, the situation has changed now to some extent where at least there is an opportunity of engaging in a dialogue with the doctors and other health service providers. In a situation where the NALSA verdict passed on 15 April 2014 by the Honorable Supreme Court recognizes the category of transgender in the country and provides the right to self-determine their gender, it becomes unacceptable to the community that medical practitioners would still be in the dark and would not understand the vitality of the situation for transgender people willing to go through transition. Chandan believes,

The way I looked at SRS, I don't know... the way they (meaning doctors) talk to people; I agree that they too have grown up in this social system and cannot think of anything outside it. But there are a lot of things that we do not know and there I feel a problem. There are many doctors who are experts in their own fields but are not aware of things outside it and here I feel that they should have an open mind. It is important to have an ear to listen. This could solve a lot of problems. Just the openness to listen and try and understand is enough. I only have a problem with that and with nothing else. So if they develop an ear to listen and a mindset to try and understand; that I feel would solve the problem to a large extent.

He further asserts,

After the NALSA, it should become imperative that any doctor, any endocrinologist will have the knowhow about transition. This is something that has come from the courts and the situation should be made such that we, the citizens, can go to whichever doctor and get the full information. Now earlier, there was no fixed rule about it so doctors were also insecure about whether to do it or not, and doctors have their own reasons for this insecurity. Now the situation has changed, there is a fixed law so what the government should do is, instead of treating us as a minority and not taking our needs into account, they should make it mandatory in such a way that all doctors have to know it.

Meanwhile, transgender people look out for sensitive and queer-friendly medical personnel with expertise in their fields and a reasonable expense package. Their fight for self-determination and dignity continues in every sphere as in the sphere of health care. Below are some recommendations they have come up through conversations. The transgender community believes that these issues need to be taken on board, to be discussed and debated, if the right to liberty and equality for all is to be realized.

- A special medical unit for transgender persons (can be called a Gender Clinic) where all experts work under the same roof and the services are available to save time and adverse consequences.
- State coordinated training and awareness building among medicos needs to be taken up on a priority basis.
- Separate wards for trans men and trans women is required for healing and maintaining personal dignity.
- Adequate information on GAT needs to be dispensed at the state level so as to facilitate easy, affordable and safe health care service to a majority section of the community.
- Subsidy in treatment and medical insurance, both for transition related medical and surgical procedures and other general illnesses, is recommended to ensure appropriate and safe treatment facilities and the attainment of self-identity.
- The creation of adolescent clinics to raise awareness within the trans community about the specific needs and concerns of a trans body and available health care services is recommended to fight myths and misconceptions leading to harm and ill-health.
- Awareness and sensitization among health care staff is absolutely necessary to make them aware that even a trans man (who is otherwise eager to embody all the social and cultural markers of a cisman) could feel ashamed to undress in the presence of a female or a male

person in public, despite it being a doctor or other health professionals.

- Recruiting trans people for taking care of transgender patients can be an opportunity to generate employment for the community as well as ensure safe and secure care for individuals from the community.
- Medical syllabus must include reading material and information in all disciplines (and not just in Psychiatry) about the issue of transgender health.



## CHAPTER 2

### INDIAN LAW, TRANSGENDER IDENTITY AND GENDER TRANSITION

An in-depth look at the GAT procedures in different parts of the world, along with the legal bases for the same will show that while it is by and large recognised that the guidelines of the World Professional Association for Transgender Health (WPATH) acts as a model template for most of the countries, many of them have enacted specific laws aimed at regulating SRS as such. India also needs to come up with a comprehensive legislation on GAT so as to ensure specific legal protections for transgender people seeking gender affirmation procedures in this country. A uniform legal framework which ensures safety, dignity, accessibility and convenience of transgender persons in every state of the country who wish to undergo SRS, is crucial to realizing an important facet of transgender persons' rights. This framework should also seek to ensure that medical professionals in charge of implementing GAT are sufficiently sensitized and trained, and protected from harassment due to litigation arising from criminal laws which may be used against them in various instances, *e.g.* for emasculating an MtF person during an SRS process.

#### Challenges Faced *vis a vis* Gender Transition

There is lack of clarity or official documents regarding the medical procedure that needs to be followed, and is followed, in India. Insufficient awareness regarding the concept of self-identification of gender and Gender Dysphoria; criminalisation of emasculation under S. 325 of the IPC without clarification about exception provided under S. 88; equation of 'transgender' to people from groups with specific socio-cultural connotations such as *hijra, kothi, aravani, etc.* and the taboo surrounding the latter since colonial times; and the lack of training within the medical profession regarding related procedures are among the many reasons that contribute to this lack of clarity.

Other challenges are related to access and use of these services in the public hospitals which are identified at individual (self-stigma, poverty), institutional (registration policies) and structural levels (societal stigma).

One example of a barrier at the **individual** level is the lack of support for travel expenses pertaining to SRS procedures.

At the **institutional** level, some of the stigma and discrimination experiences documented to have occurred in public hospitals include:

- Lack of hospital policies on whether transgender people can get registered as ‘man’ or ‘woman’ in the outpatient department; and in which ward (male or female ward) they get admitted. For example, it has been seen that MtoF transgender persons living full-time as ‘woman’ and who had undergone male genital removal were asked to put on male attire and admitted in male wards. On the other hand, FtoM transgender persons undergoing hysterectomy or mastectomy have been admitted in female wards and asked to put on female gowns.
- Access is not easy to psychological assessment which is still assumed to be important by psychiatrists preceding surgeries and hormone treatment, and harassment (physical, psychological and sexual) is faced in certain instances during the medical assessment process. Lack of adequate training of psychiatrists, surgeons and endocrinologists regarding assessment and treatment relating to SRS further increases the vulnerability of this population. Insensitivity on the part of physicians, counsellors, nurses and paramedical workers within the hospital settings deters people from approaching state hospitals.
- Harassment from the relatives of the co-patients in the outpatient and in-patient departments. Lack of information and adequate safeguards from the side of the hospital authorities is the cause of such harassment.
- Lack of accessibility to institutions which offer SRS services- either due to the miniscule number of hospitals offering SRS or the exorbitant costs. Barring a few government hospitals, sex reassignment surgery and other gender transition related services are not available for free or at low cost, in tertiary level government hospitals in different states.

A study conducted in 2013<sup>13</sup> to assess the situation of gender transition related health services for MtF transgender people reported the following issues:

- Lack of free sex reassignment surgery (SRS) in public hospitals and the prohibitive cost of SRS in private hospitals seem to be the key reasons behind why some *hijras* and other MtF trans people go to unqualified medical practitioners for surgery – resulting in post-operative complications that could have been avoided had the surgery been provided by qualified

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<sup>13</sup>*Transforming Identity: Access to Gender Transition Services for Male-to-Female Transgender People in India: A Study* conducted by India HIV/AIDS Alliance, New Delhi in 2013 [mentioned in Ministry of Social Justice and Empowerment, ‘Access to Healthcare: General Health Services (Physical/Mental) and Gender Transition Services (including Sex Reassignment Surgery)’, *Report of the Expert Committee on the Issues relating to Transgender Persons*(Chapter 10), 2014; available at <<http://socialjustice.nic.in/pdf/chapter10.pdf>>].

medical practitioners in public hospitals. In private hospitals, the cost of the surgery for male to female often varies between Rs. 2 to 5 lakhs while cost of surgery for female to male is between Rs 4 to 8 lakhs (prices quoted here are just an indication, and not specific to any doctor or clinic).

- Lack of national guidelines on gender transition services and ambiguous status of the process of SRS mean even qualified medical practitioners are hesitant to perform SRS.
- Unwillingness among qualified medical practitioners to prescribe hormone therapy (for feminization) leads to self-administration of female hormonal tablets among *hijras* and other MtoF transgender people.
- It was noticed that doctors in India perform male genital removal (orchiectomy and/or penectomy) for patients with invasive testicular or penile cancer, and perform vaginoplasty on biological females with certain urogenital conditions (such as absence of vagina at birth among biological females or persons having urogenital sinus-related problems). Thus, one can find general and plastic surgeons in both public and private hospitals who are familiar with surgical procedures which can be adopted for SRS among MtF transgender people.

However, very little academic or grey literature is available on access to gender transition services for female to male (FtoM) transgender people in India. Information from a study conducted among 50 identified FtoM people in Mumbai (LABIA, 2013)<sup>14</sup> and interactions with FtoM people who are part of support groups or activist collectives indicate the following issues:

- Limited expertise in India on SRS (especially penile construction or metadioplasty<sup>4</sup>) for FtoM people: This means many FtoM transgender persons wait for years before they undergo penile construction (phalloplasty). In this context, it is important to note that expertise for other surgical procedures such as hysterectomy, salpingo-oophorectomy, and mastectomy already exist in India, as these surgeries are commonly performed among cis-women with certain medical/surgical conditions.
- Limited knowledge among health care providers on the range of surgical and non-surgical options available for FtoM transgender people for example, devices used by FtoM transgender people such as binders, packers, urinating devices, and penile prosthesis (with air

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<sup>14</sup>*Breaking the Binary: Understanding Concerns and Realities Of Queer Persons Assigned Gender Female at Birth Across a Spectrum of Lived Gender Identities*: A study conducted by LABIA–A Queer Feminist LBT Collective in 2013 [mentioned in Ministry of Social Justice and Empowerment, ‘Access to Healthcare: General Health Services (Physical/Mental) and Gender Transition Services (including Sex Reassignment Surgery)’, *Report of the Expert Committee on the Issues relating to Transgender Persons* (Chapter 10), 2014; available at <<http://socialjustice.nic.in/pdf/chapter10.pdf>>].

pumps to facilitate erection). Limited knowledge about testosterone therapy (for FtoM transgender people) among HCPs means many FtoM transgender people are led to self-administer testosterone.

- While phalloplasty maybe a difficult surgical procedure, the alternative – metadioplasty (enlargement of clitoral tissue), which may be preferred by some section of FtoM transgender people are seldom offered by surgeons.

At the **structural level**, societal stigma against people who transgress gender norms, especially against transgender people, is internalized by the HCPs themselves. MtoF transgender people belonging to socio-cultural transgender communities face intersecting stigmas – stigma related to being a transgender person, being a sex worker, and being a person suspected to be at high risk for HIV. On the other hand, FtoM transgender persons face complete invisibilisation and immobility due to their location within a patriarchal society that does not confer any rights to the female bodied person. Such lack of voice and visibility restricts their access to any form of transition related services. Lack of awareness and general stigma surrounding transgender persons in the society, media as well as medical professionals, despite the widely publicized *NALSA* judgment is a challenge.

### **Legislations in relation to the rights of transgender persons**

#### **NALSA judgment 2014**

In recent times the *NALSA* judgment in 2014 by the Supreme Court has served as an instrument for recommending certain legal policies for transgender people. The judgment affirms that even in the absence of any statutory regime in this country, transgender persons have the right to identify as woman, man or transgender with or without going through Sex Re-assignment Surgery (SRS). In other words, surgery, hormones or other interventions are not required for legal recognition of one's change in gender identity. The verdict further orders the Central and the State Governments to look into and take steps proactively in matters of health, education and employment of the transgender people. Any form of discrimination in any of the above will be open to challenge and redress. With legal status accorded, transgender people have full moral citizenship. However, it is to be noted that the judgment is fraught with inconsistencies. The judgment oscillates between gender self-determination (understanding gender identity as determined by oneself) and biological essentialism (seeing 'biological' or physical characteristics

as the basis for gender identification). The court also held that the Yogyakarta Principles<sup>15</sup> are not inconsistent with the rights under the constitution or the domestic laws and hence should be recognised and followed. Extract from principle 3 of the Yogyakarta principle includes the words “No one shall be forced to undergo medical procedures, including sex reassignment surgery, sterilisation or hormonal therapy, as a requirement for legal recognition of their gender identity” There are also many operational difficulties due to infrastructural, informational and other factors. In this perspective, it is submitted that there is an acute need for having a comprehensive legislation on GAC in India that can duly address many of these concerns. A uniform legal framework which ensures safety, dignity, accessibility and convenience of transgender persons in every state of the country who wish to undergo GAS, is crucial to realizing an important facet of transgender persons’ rights. This framework should also seek to ensure that medical professionals in charge of implementing GAS are sufficiently sensitized and trained, and protected from harassment due to litigation arising from criminal laws which may be used against them in various instances, for example, ‘emasculating’ an MtoF person during a GAS process.

The present guideline takes as its legal substratum the NALSA judgment of 2014. There have been other allied legislations that have been proposed from time to time. In early 2014 the Ministry of Social Justice and Empowerment (GOI) published a report titled ‘Report of the Expert Committee on the Issues relating to Transgender Persons’ which for the first time put forth a definition for the term transgender along with its diverse sub-categories as are seen in the Indian context. The report clearly stated that a person can identify as a transgender regardless of undergoing any medical interventions such as hormone therapy, laser therapy or sex re-assignment surgeries. Following closely on the NALSA judgment a private member bill was introduced by Tiruchi Siva and passed in the Rajya Sabha in April 2015 and introduced in Lok Sabha in February 2016. The bill upholds the spirit of the NALSA judgment and ensures self-determination of gender irrespective of any medical interventions.

Two more bills were introduced by the government namely, ‘The Rights of Transgender Persons Bill, 2015’ and ‘The Transgender Persons (Protection of Rights) Bill 2016’ respectively. The 2015 bill is a draft bill by Ministry of Social Justice and Empowerment on which the ministry invited feedback from the transgender community members and civil society. This bill shifted from the NALSA judgment in two primary ways – first, it was silent on the provision that transgender persons can also identify as man or woman and second, it mentioned about a District

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<sup>15</sup> The Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity: [http://www.yogyakartaprinciples.org/principles\\_en.htm](http://www.yogyakartaprinciples.org/principles_en.htm)

level Screening Committee that would certify transgender persons. This provision stood completely against the NALSA judgment's provision of self-determination of gender.

The Transgender Persons (Protection of Rights) Bill 2016 which was passed in the Lok Sabha and was pending consideration and passing in the Rajya Sabha lapsed on dissolution of the sixteenth Lok Sabha in May 2019. The clauses laid down in the 2016 version shifted heavily from the NALSA judgement and the previous two bills. The bill defined transgender persons as 'neither wholly female nor wholly male; or a combination of female or male; or neither female nor male; and whose sense of gender does not match with the gender assigned to that person at the time of birth, and included trans-men and trans-women, persons with intersex variations and gender-queers'. Moreover, the bill also maintains that transgender persons have to undergo a certification process and an identity card is required to validate their transgender identity. Such a clause curbs transgender persons' right to self-determination of gender that has been ensured by the NALSA judgement.<sup>16</sup>

### **Transgender Person's (Protection of Rights) Bill 2019<sup>17</sup>**

The Transgender Person's (Protection of Rights) Bill 2019 (which is a modified version of the 2018 Bill) was introduced by the government in the parliament on 19 July 2019 and passed in the Lok Sabha. In a clear deviation from the NALSA verdict of the Supreme Court in 2014, this Bill appears to suggest that certain sex transition surgeries would become the precondition to legal transition of gender. As per the 2019 Bill, a transgender person has the right to self-perceived gender identity. However, this right can be legally validated only through certification by the District Magistrate, on application. This certificate of identity issued by the Magistrate will be the "proof" of their identity and a ticket to record the person's preferred gender in all other official documents. It will also make the person eligible for rights as guaranteed under the law. However, if the transgender person wishes to change their gender to male or female, they would have to apply for a further certificate from the District Magistrate, this time with proof of having undergone surgery from an institutional Medical Officer. This double gate keeping hugely curbs the right to self-determination of gender as laid down in the NALSA verdict.<sup>18</sup>

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<sup>16</sup> Both the Bills introduced by the government were met with critique and nationwide protests by the transgender community.

<sup>17</sup> For full text of the Bill and critical discussions on it refer to <http://orinam.net/resources-for/law-and-enforcement/the-transgender-persons-protection-of-rights-bill-2019/>

<sup>18</sup> There is uncertainty about the role of a mental health professional in issuing a GD certificate in case the law comes into operation.

The 2019 Bill lays down certain tenets that are to be followed with regard to protecting transgender person's right to discrimination-free health. Section 15 in Chapter VI of the Bill talks of the following measures to be taken in relation to a transgender person:

- (a) to set up separate human immunodeficiency virus Sero-surveillance Centres to conduct sero-surveillance for such persons in accordance with the guidelines issued by the National AIDS Control Organisation in this behalf;
- (b) to provide for medical care facility including sex reassignment surgery and hormonal therapy;
- (c) before and after sex reassignment surgery and hormonal therapy counselling;
- (d) bring out a Health Manual related to sex reassignment surgery in accordance with the World Profession Association for Transgender Health guidelines;
- (e) review of medical curriculum and research for doctors to address their specific health issues;
- (f) to facilitate access to transgender persons in hospitals and other healthcare institutions and centres;
- (g) provision for coverage of medical expenses by a comprehensive insurance scheme for Sex Reassignment Surgery, hormonal therapy, laser therapy or any other health issues of transgender persons.

### **Issues Pertaining to Legal Status of People Seeking GAS**

- The NALSA judgment as well as The Transgender Person's (Protection of Rights) Bill 2019 grants legal status to Gender Affirmation Surgery.
- The Transgender Person's (Protection of Rights) Bill 2019 requires one to acquire a transgender certificate issued by the District Magistrate to be able to avail legal rights that accrue to a transgender person including those related to food, education and health. Moreover, a transgender person has to undergo GAS and further certification by a Magistrate to be able to identify as male or female.
- The NALSA judgment does not require any GD or GAS certificate for legal transition. Affidavits are needed for a change in name and gender by paying the appropriate court or notary fee and getting these signed by a magistrate.
- A person can, at any point during the course of GAS (and even without it as well), go to a lawyer in case they want to change their name and gender in their official documents. The process involves the following steps.

- (i) Getting an affidavit notarised at the court: Such affidavit should mention the change in gender identity (male to female, female to male, or male/female to transgender).
  - (ii) An official gazette notification must be done to notify the change.
  - (iii) Two newspaper advertisements need to be published that include age, date of birth, place of residence, previous official name, and current gender and name.
  - (iv) Filing an application before employer: This application must request for relevant changes in the employee identity card and attach copies of the gender-change affidavit, newspaper advertisements and/or gazette notification.
  - (v) Pursuant to this, applications can be filed before relevant authorities for changes to Voter's ID Card, PAN Card, Bank documents including Debit/Credit Card, Driving License, Passport, Ration Card, etc. These applications must include copies of the affidavit, advertisements and the fresh employee identity card.
  - (vi) Renewal of passport is not yet possible without SRS certificate, contrary to provisions given in the NALSA judgment.
- However, there is no clarity about the process and requirements differ from place to place, case to case, and are often dictated by individual bureaucratic specificities. In the absence of a state protocol and bureaucratic awareness, documents of GAS/GD often end up as the most definite document for gender identity change. Transgender persons who undergo gender-reassignment and who do not, face discrimination and harassment due to such bureaucratic hurdles when attempting to change their name and gender in legal documents, and confusions leading to further anxieties.
  - In West Bengal, in most cases, the Official Gazette still seeks documentation of GAS to publish the change of gender from 'female to male', and does not accept a pre-operation affidavit – despite the directive on the right to gender self-determination without requiring GAS.
  - In some cases surgeons insist on family consent before GAS to avoid future litigations.
  - In the new proposed law legal gender transition will be subject to the mercy and benevolence of the District Magistrate!

### **Legal Status of Transpersons' Sexuality**

On 6 September 2018 Supreme Court of India passed a historic verdict in the Navtej Singh Johar v. Union of India case decriminalising homosexual acts between consenting adults. The judgment is one of its kind and marks the culmination of long years of struggle, strategizing and



perseverance since its first seeds were sown in 1994 when ABVA filed the first petition in Delhi High Court against Sec. 377. Section 377 of IPC was used to persecute more than prosecute the lesbian, gay, bisexual, intersex, transgender and queer population in India.<sup>19</sup>The verdict not only gave back the queer community the right to live and love freely, it also stated that consensual carnal intercourse among adults, be it homosexual or heterosexual, in private space, does not in any way harm public decency or morality. Societal morality cannot overturn the fundamental rights of even a single person and the state cannot interfere in an individual's right to have an intimate relationship with anybody one chooses. The court observed that “the choice of partner, the desire for personal intimacy and the yearning to find love and fulfilment in human relationships have a universal appeal” and the state has no business to interfere in these personal matters.<sup>20</sup> The September 2018 verdict recognizes LGBT persons' entitlement to full constitutional protection, including equality and non-discrimination. This also paves the way for eventually asking for civil-political rights, including anti-discrimination legislation in workplaces, same-sex partnerships, marriage and more.

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<sup>19</sup>Section 377 was introduced in 1864 by Lord Macaulay during the British colonial period. It held that whoever had voluntary carnal intercourse against the order of nature with man woman or animal would be held punishable. Here “against the order of nature” implied any sexual activity that was not peno-vaginal penetration. In other words, giving primacy to reproductive sex among man and woman, the law sought to ban all other sexual acts that were primarily for pleasure and not procreation even if with mutual consent.

<sup>20</sup>In a recent judgment by the Madras High Court in April 2019 the judges ruled that a ‘bride’ under the Hindu Marriage Act shall include any transgender or intersex persons who identifies as a woman. The ruling came on a plea filed by a couple whose marriage was not being registered by state authorities as the bride was a transwoman. <https://www.deccanherald.com/national/marriage-between-man-and-transwoman-is-valid-madras-hc-730260.html> This is the same judgment that banned corrective surgeries on intersex babies.

## CHAPTER 3

### THERAPEUTIC APPROACHES TO GENDER AFFIRMATION

This “Good Practice Guide for Gender Affirmative Care” has been adapted from and follows the principles of –

- 1) The World Professional Association for Transgender Health’s (WPATH) standards of care for health of transsexual, transgender and gender non-conforming people (WPATH SOC 7<sup>th</sup> Version, 2011).<sup>21</sup>
- 2) Good practice guidelines for the assessment and treatment of adults with Gender Dysphoria by Royal College of Psychiatrists, UK (2013).<sup>22</sup>
- 3) Interim National Guidelines – Good practices for sex reassignment surgeries (SRS) for male-to-female transgender people in India, 2011.

#### Age for Gender Affirmative Therapy

This guide is prepared to assist health professionals in assessing and treating Gender Dysphoria of adult individuals aged 18 years or more. The psycho-social supports and interventions are of help to gender non-conforming children and adolescents as well. The health professionals have important roles to play in treating Gender Dysphoria of minors, but this guideline has limited scope to elaborate upon that aspect.

The role of MHPs and psycho-social interventions are important at every stage of transition and for gender non-conforming people of any age group. As per the existing universally accepted guidelines, there is no upper age limit for GAT as such, but in higher age group, SRT is to be done cautiously, after weighing the risks and benefits to the individual.

#### Therapeutic Approaches

As part of Gender Affirmative Therapy, health professionals can assist gender dysphoric individuals with affirming their gender identity, exploring different options for expression of that

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<sup>21</sup>Coleman E, Bockting W, Botzer M, *et al.* 2011. “Standards of care for the health of transsexual, transgender and gender non-conforming people”, version 7.*Int. J.Transgend*;13(4), 165–232.

<sup>22</sup><http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr181.aspx>

identity, and making decisions about medical treatment options for alleviating Gender Dysphoria. Health professionals can also facilitate and assist in establishing support systems for the gender non-conforming individuals and take part in raising awareness in the society to eradicate stigma around the issue.

The treatment for Gender Dysphoria needs to be individualized. While some individuals need both hormone therapy and surgery to alleviate their Gender Dysphoria, others need only one of these treatment options and some need neither. Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others, changes in gender role and expression are sufficient to alleviate Gender Dysphoria.

Gender Affirmative Therapy is holistic and should include input from multiple disciplines such as Psychiatry, Psychology, Endocrinology, Surgery, Urology, Gynaecology, Voice surgery and therapy, Occupational Therapy, Nursing, Social Work and other related professions. The multidisciplinary collaborative work with peer review and supervision are of paramount importance.

There is no absolute necessity for specialists to work together under the same roof. Indeed, individuals may not experience the full benefits of choice and emergent expertise if their options are constrained in such a fashion. Nevertheless, it is desirable that practitioners should establish protocols for working together. In whatever way the multidisciplinary approach is organised, the individual's choice of service provider should not be unreasonably limited, and delivery must not be unreasonably delayed.

### **Consent and Decision-Making**

The idea of empowering people to make informed choices about their own healthcare is a strong principle within modern healthcare thinking. Care should be taken to respect the individual's autonomy for decision-making at all times. 'Informed consent' and 'competence to consent' mean that the individual must comprehend the nature, purpose and possible outcome of the procedure to be undertaken. To arrive at a decision about SRT the person must have the capacity to comprehend the information provided and weigh the risks and benefits of the alternative ways of treatment. The individual should also understand the possible consequences of not receiving the proposed treatment.

Individuals seeking therapy are presumed, unless proven otherwise, capable of consenting to treatment. Consent needs to be seen as an individual capacity and is entirely a personal decision.

Treatment must be client-centred and need-based, recognizing the individual's preferences and circumstances. Treatment must not be prescriptive and should allow clinically safe choices for individuals. Clients should be accorded a substantial role in determining the kinds of treatments that are appropriate for them.

In our socio-cultural context, there are reports of active and passive resistance by the families to gender transition related interventions. Acceptance by family is an important, sometimes vital, factor in the successful rehabilitation of the individual in the new gender role. The role of family can be in providing financial support, psychological and social support, post-transition care, providing shelter so on and so forth. Therefore the treating team needs to be flexible in their approach towards family members of the transgender individual. Wherever possible family's involvement is to be encouraged. However, this should only be implemented if and when the person is comfortable with the family's involvement, and should not be a precondition to treatment. For all practical purposes this guideline considers family in its broadest sense including friends, colleagues, partners, community members, NGO personnel etc.

Being married or having minor children should not be an exclusion criterion of eligibility for GAT. Individual cases need to be sensitively handled with the intention of creating minimal destabilization or conflict in the immediate environment of the concerned individual but the individual's right should be given priority.

Too hurried a decision or going along with the impulsive need to complete the transition might cause regret or complications at a later stage. So the HCPs need to be careful to counsel at every stage, taking necessary time before undertaking any irreversible procedure. Regular follow up and involvement of MHP through the entire stages of transition shall ensure both psychological preparedness as well as good care and establishes the person as a suitable candidate for SRT. One important role of the treating team is to encourage the individual to follow required steps to ensure success of the transition in a safe way, but a person cannot be denied the gender transition service in case of unwillingness to follow the steps. HCPs need to be flexible in their attitude and engage with the person in such a situation in order to address the issues that are causing the unwillingness. Denial of service on this basis might lead to drop out from follow up and create scope for individual becoming victim to unethical practices. However, the HCP should not give in to the unreasonable demands of the individual and clinical judgment should prevail.

Throughout all stages of treatment, the clinician has a responsibility to inform clients of the treatment options, benefits, potential unwanted side-effects and health risks of the treatment, in terms that can be readily understood. The advantages and disadvantages of not undertaking treatment should also be discussed. Client information documentation should be provided in a

timely manner. It is in line with best practice that consent forms for treatment are signed and dated by client and clinician.

### **Addressing the Transgender Individual**

Every single interaction between the client and HCP counts. It is not always possible to know someone's gender based on their name or how they look or sound. When the word transsexual is used to address a person, it should be as an adjective, for example transsexual individual, transsexual people or someone who is transsexual. If personnel, whether medical or administrative, are in any doubt, they should ask the individual discreetly to know how the person wishes to be addressed. Another way can be by addressing people without using gender terms.

Some transgender people might change their name and gender officially on their legal documents and some may not. Either way, it is recommended that health professionals respect the client's preferred name, gender and pronouns by including them on hospital registration forms, prescriptions and other relevant health records.

### **Referral**

Serious concerns have been raised by the team of medical experts preparing this guideline, regarding the lack of knowledge and expertise among most health professionals with respect to GAT specifically in this region. The requirement of only one referral letter from mental health professional for hormone therapy and breast/chest surgery, as recommended by WPATH SOC, was discussed and debated. After much deliberation, the experts opined that it would be better if the individual is assessed by two independent mental health professionals and therefore requirement of two referrals by two qualified MHPs for hormone therapy, breast/chest surgery and genital surgeries, has been proposed in this guideline. Considering various aspects and lacunae in the existing mental health service delivery system of our country, the experts also opined that, of the two referring MHPs, at least one should be a qualified psychiatrist.

It is also preferable, if the first referral is from the client's psychotherapist/psychiatrist, the second referral be from an MHP who has only had an evaluative role with the client.

At every stage of consultation it is the responsibility of the treating medical professional to document in details all processes/treatments/therapies undertaken in their respective prescriptions or medical records. Since GAT is a multidisciplinary approach, this helps in appropriate communication between the treating disciplines. In many cases due to the lack of any dedicated gender clinic the individual is compelled often to travel from one place to another in

order to seek GAT related services. Thus, this record-keeping becomes necessary to help the person get appropriate and safe medical care.

### **Respect Privacy and Confidentiality**

As per medical ethics, like any other individual, if a health professional needs to physically examine a transgender individual for the purpose of clinical assessment, it should be performed only with consent of the individual. To physically examine an individual, privacy and confidentiality must be maintained. If a male clinician needs to examine a FtoM or a MtoF transgender person, in presence of a female attendant, he must ask for consent of the individual beforehand. In case of no consent for the same, the clinician should examine only after ensuring comfort of the individual. Also, maintaining confidentiality of the medical records of the person is of utmost importance.

For a person undergoing any surgical procedure, it is important to maintain privacy and autonomy during procedures like draping and shaving of pubic region. It is often seen that shaving of the pubic region is done by a male attendant in case of a MtoF individual and by a female attendant in case of a FtoM person. This standard protocol can give rise to discomfort and loss of dignity, especially in the case of a MtoF person. While deciding on the gender of the attendant, it is important to take into consideration the wishes of the person undergoing surgery and maintaining optimum privacy and respect for bodily dignity.

When a person is taken to the operation theatre a similar situation might arise when the person is being anaesthetized. Even on the operation theatre table, it is imperative that surgeons, anesthetists and other medical staff present there protect the privacy and dignity of the person who is being operated upon through their actions and conversations during and after surgery. At every step it is important to honour the wishes of the person concerned to be treated as belonging to their preferred gender and not the gender ascribed at birth.

### **Consent for Research**

Though there is need for doing research for the sake of improving services directed at gender-affirmative therapy, the individual with Gender Dysphoria has every right to decide whether to participate as subject of research work. This applies to doing videography or photography of genital and non-genital surgeries as well. Therefore the consent forms for the therapeutic procedures and that for any scientific medical or surgical research should be separate. GAT should not be denied if the client declines to give consent to participate in research in this field.

### **Options for Psychological and Medical Management of Gender Dysphoria**

For individuals seeking care for Gender Dysphoria, a variety of therapeutic options can be considered. The number and type of interventions applied and the order in which these take place may differ from person to person. Treatment options include the following:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity).
- Hormone therapy to feminize or masculinize the body.
- Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, voice, body contouring etc.).
- Psychotherapy (Individual, couple, family, or group).

### **Options for Social Support and Changes in Gender Expression**

In addition (or as an alternative) to the psychological and medical treatment options described above, other options can be considered to help alleviate Gender Dysphoria. Some examples are:

- In-person and online peer support resources, groups, or community organizations that provide avenues for social support and advocacy
- In-person and online support resources for families and friends
- Body hair removal through electrolysis, laser treatment, or waxing
- Breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks
- Voice and communication therapy to help individuals develop verbal and non-verbal communication skills that facilitate comfort with their gender identity
- Occupational Therapy to assist the individual in vocational rehabilitation
- Legal changes in name and gender on identity documents

Transsexual people may need health care throughout their lives. Primary care and health maintenance issues should be addressed before, during, and after any possible changes in gender role and medical interventions to alleviate Gender Dysphoria.

### **Training of Health Professionals and Research**

The HCPs need to engage in continuing education and training in the assessment and treatment of Gender Dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from health professionals with relevant experience; or participating in research related to gender nonconformity and Gender Dysphoria.

As there is a gross lack in research in this area in our country, health professionals and institutions should focus onto more and more research in this field, in order to improve knowledge and implement more safe and effective methods to alleviate Gender Dysphoria.

Ensuring documentation by medical professionals of various therapeutic procedures (related to GAT) undertaken by them would also contribute to future research in this field.

Health professionals need to engage themselves in contemporary discussions and debates on sex, gender and sexuality to be able to think beyond given binary structures of expression, behavior and identity and respond to the needs of transgender/transsexual individuals.

## **CHAPTER 4**

### **MENTAL HEALTH SERVICES FOR GENDER AFFIRMATION**

Transsexual, transgender, and gender-nonconforming people might seek the assistance of a mental health professional (MHP) for various reasons. For example, a client may be presenting for psychotherapeutic assistance to explore gender identity and expression or to facilitate a coming-out process; assessment and referral for feminizing/masculinizing medical interventions; psychological support for family members (partners, children, extended family); psychotherapy unrelated to gender concerns; or other professional services.

#### **Competency of Mental Health Professionals Working with Adults who present with Gender Dysphoria**

The training of MHPs competent to work with adults having Gender Dysphoria, rests upon basic general clinical competence in the assessment, diagnosis, and treatment of mental health concerns. Mental health professionals all over the world can obtain clinical training within any discipline for clinical work, such as psychology, psychiatry, social work, mental health counseling, marriage and family therapy, nursing, or family medicine with specific training in behavioral health and counseling.



The following are recommended minimum credentials for MHPs who can work with and refer for medical and/or surgical intervention for adults with Gender Dysphoria:

- WPATH SOC keeps the minimum qualification from a broader field of mental health practice, i.e. master's degree or its equivalent in a clinical behavioral science field that is granted by an institution accredited by the appropriate national or regional accrediting board. Considering the existing condition of clinical training and practice in the field of mental health in this region, the group of experts for this guideline suggested that the mental health professionals be preferably qualified in the field of Psychiatry or Clinical Psychology. They suggested - A Post-Graduate Degree/Diploma in Psychiatry (DPM/MD) or at least Master degree in Psychology with clinical training, i.e. MA/M.Sc./M.Phil/PhD in Psychology. The MHP should have documented credentials from the relevant licensing board; national medical licensing board (Medical Council of India) for Psychiatry or equivalent authority in Psychology.
- Competence in using the Diagnostic Statistical Manual of Mental Disorders (DSM) and/or the International Classification of Diseases (ICD) for diagnostic purposes.
- Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from Gender Dysphoria.
- Knowledgeable about gender non-conforming identities and expressions, and the assessment and treatment of Gender Dysphoria.
- Continuing education in the assessment and treatment of Gender Dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and Gender Dysphoria.

In addition to the above-mentioned minimum credentials, it is recommended that MHPs develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender-variant clients. This may involve, for example, becoming knowledgeable about local transgender communities and individuals, advocacy, and public policy issues relevant to these clients and their families. Additionally, knowledge about sexuality, sexual health concerns, and the assessment and treatment of sexual disorders is preferred. MHPs who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of Gender Dysphoria.

## **Tasks of Mental Health Professionals Working with Adults who Present with Gender Dysphoria**

MHPs may serve transsexual, transgender, and gender-nonconforming individuals and their families in many ways, depending on a client's needs, for example, as a diagnostician/assessor, a psychotherapist, counselor, family therapist, advocate, or educator.

MHPs should determine a client's reasons for seeking professional assistance. Regardless of a person's reason for seeking care, MHPs should have familiarity with gender nonconformity, act with appropriate cultural competence, and exhibit sensitivity in providing care.

The MHPs who are uncomfortable with, or inexperienced in, working with transsexual, transgender, and gender-nonconforming individuals and their families, should refer clients to a competent provider of such service or, at minimum, consult with an expert peer.

Below are general guidelines for common tasks that MHPs may fulfill in working with adults who present with Gender Dysphoria.

### **Tasks Related to Assessment and Referral**

#### **1. Assess Gender Dysphoria**

The evaluation includes, at least the following,

- Assessment of gender identity and Gender Dysphoria, history and development of gender dysphoric feelings,
- Determining whether the Gender Dysphoria is secondary to or better accounted for, by other diagnoses.
- Assessment of the impact of stigma attached to gender non-conformity on mental health.
- Evaluation of the availability of support from family, friends, and peers.

In order to assess and reach to a diagnosis of Gender Dysphoria, any other possible clinical conditions like schizophrenia or other psychotic disorders, obsessive compulsive disorder, transvestism, fetishism etc. must be ruled out.

It is important to have in-depth understanding of the developmental history of the individual and the psycho-social issues giving rise to the dysphoria. It is necessary to mention here that if a child or adolescent presents with Gender Dysphoria, care must be taken to understand that the minor is in a developing phase and any hurried labeling of and medical intervention thereof can be problematic. Therefore enough time should be given for being certain about the child's gender identity. Supportive therapy and psycho-social interventions are of immense help for alleviating the dysphoria in such cases.

If necessary for clinical assessment, Psychiatrists may also do physical examination of the individual with the person's consent.

The evaluation may result in no diagnosis, in a formal diagnosis related to Gender Dysphoria, and/or in other diagnoses that describe aspects of the client's health and psychosocial adjustment.

## **2. Provide Information Regarding Options for Gender Identity and Expression and Possible Medical Interventions**

- An important task of MHPs is to educate clients regarding the diversity of gender identities and expressions and the various options available to alleviate Gender Dysphoria.
- MHPs may facilitate a process (or refer elsewhere) in which clients explore these various options, with the goals of finding a comfortable gender role and expression and becoming prepared to make a fully informed decision about available medical interventions, if needed. Individual is assisted by MHPs in determining priorities for intervention and decision making through informed discussion. This process may include referral for individual, family, and group therapy and/or to community resources and avenues for peer support.
- The professional and the client discuss the implications, both short- and long-term, of any changes in gender role and use of medical interventions. These implications can be psychological, social, physical, sexual, occupational, financial, and legal.

## **3. Assess, Diagnose, and Discuss Treatment Options for Coexisting Mental Health Concerns**

MHPs should screen for co-existing mental health concerns that might be present along with Gender Dysphoria, such as anxiety, depression, obsessive compulsive disorders, self-harm, history of abuse and neglect, substance abuse, sexual concerns, personality disorders, eating disorders, psychotic disorders etc. These concerns can be significant sources of distress and, if left untreated, can complicate the process of gender identity exploration and resolution of Gender Dysphoria. Psychiatric co-morbidity is a major negative prognostic factor for SRT.

Addressing and managing the co-existing mental health concerns can greatly facilitate the resolution of Gender Dysphoria, possible changes in gender role, the making of informed decisions about medical interventions, and improvements in quality of life.

The presence of coexisting mental health concerns does not necessarily preclude possible changes in gender role or access to feminizing/masculinizing hormones or surgery; rather, these concerns need to be optimally managed prior to, or concurrent with, treatment of Gender Dysphoria.

In addition, clients should be assessed for their ability to provide educated and informed consent for medical treatments.

### **If Applicable, Assess Eligibility, Prepare, and Refer for Hormone Therapy**

MHPs can help clients who are considering hormone therapy to be both psychologically prepared (e.g., client has made a fully informed decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (e.g., has been evaluated by a physician/endocrinologist to rule out or address medical contraindications to hormone use; has considered the psychosocial implications).

It is preferable for the person to be informed about hormone therapy by the endocrinologist/physician to be able to take a fully informed decision. The endocrinologist needs to be in touch with the concerned MHPs to discuss about the plan of hormone therapy for that person, for ensuring preparedness.

In clients of childbearing age, reproductive options sometimes need to be discussed and information regarding fertility and effects of various chemical agents on reproductive cells need to be shared before initiating hormone therapy.

To best support their clients' decisions, MHPs need to have functioning working relationships with their clients and sufficient information about them.

### Referral for Feminizing/Masculinizing Hormone Therapy

Hormone therapy can be initiated with referral from two qualified MHPs (Although the WPATH SOC (7<sup>th</sup> version) recommends referral from one MHP for hormone therapy, but regional medical experts suggest two referrals, as mentioned earlier). One of the two MHPs should be a qualified Psychiatrist as the medical experts suggest. It is also preferable, if the first referral is from the client's psychotherapist/Psychiatrist, the second referral be from an MHP who has only had an evaluative role with the client. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent.

MHPs who refer for hormone therapy share the ethical and legal responsibility for that decision with the physician who provides the service, but should not be held responsible for any physical complication arising out of hormone therapy.

The recommended content of the referral letter (See **Annexure 5**) for feminizing/masculinizing hormone therapy is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;
3. The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;
4. An explanation that the criteria for hormone therapy (See **Annexure 2**) have been met and a brief description of the clinical rationale for supporting the client's request for hormone therapy;
5. A statement that informed consent has been obtained from the client;
6. A statement that the referring professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary; rather, the assessment and recommendation can be documented in the client's chart.

### **3. If Applicable, Assess Eligibility, Prepare, and Refer for Surgery**

MHPs can help clients who are considering surgery to be both psychologically prepared (e.g., has made a fully informed decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (e.g., has made an informed choice about a surgeon to perform the procedure; has arranged aftercare).

For clients of childbearing age, surgeons need to inform them about the effects of various surgeries on the reproductive capacity of the individual before taking the final decision to undertake any operation.

#### Referral for Surgery

The MHP provides documentation, in the chart and/or referral letter, of the client's personal and treatment history, progress, and eligibility.

- Two referrals from qualified MHPs who have independently assessed the individual are needed for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries) as WPATH SOC(7<sup>th</sup> version) recommends.
- WPATH SOC (7<sup>th</sup> version) recommends that one referral from a qualified MHP is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty), but as mentioned earlier, medical experts of this region, suggest two referrals from two

qualified MHPs for breast/chest surgery as well. One of the two MHPs should be a qualified Psychiatrist as suggested by the medical experts.

- For both genital and breast/chest surgeries, it is preferable that if the first referral is from the client's psychotherapist/Psychiatrist, the second referral be from an MHP who has only had an evaluative role with the client. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent. Each referral letter, however, is expected to cover the same topics in the areas outlined below.

MHPs referring for surgery share the ethical and legal responsibility for that decision with the surgeon, but should not be held responsible for any physical complication arising as a consequence of surgery.

The recommended content of the referral letters for surgery is as follows:

1. The client's general identifying characteristics;
2. Results of the client's psychosocial assessment, including any diagnoses;
3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;
4. An explanation that the criteria for surgery (See **Annexure 3 & 4**) have been met, and a brief description of the rationale for supporting the client's request for surgery;
5. A statement that informed consent has been obtained from the client;
6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the client's chart.

### **Tasks Related to Psychotherapy**

A mental health screening and/or assessment as outlined above are needed for referral to hormonal and surgical treatments for Gender Dysphoria. In contrast, psychotherapy, although highly recommended, is not an absolute requirement.

Often projective tests like Rorschach, TAT and other rating scales are used as supportive tools for psychological assessment, but the psychometric tests are neither confirmatory of diagnosis, nor absolute requirement for GAT.

The purposes for Psychotherapy can be in exploring gender identity, role, and expression; addressing the negative impact of Gender Dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

Psychotherapy is not intended to conform a person's preferred gender identity to the gender assigned at birth. Treatment aimed at trying to change a person's gender identity and lived gender expression to become more congruent with sex assigned at birth has been attempted in the past, yet without success, particularly in the long-term. Such treatment is no longer considered ethical.

Typically, the overarching treatment goal is to help transsexual, transgender, and gender-nonconforming individuals achieve long-term comfort in their gender identity expression, with realistic chances for success in their relationships, education, and work. It is important to use clinical wisdom to understand the person in a holistic manner and regular sessions throughout the process of transition are often helpful for adjustment and personal growth in the path.

A psychotherapist should be a co-walker in the whole process of gender transition or gender affirmation for maintaining mental health during different periods. In the process it is imperative to reinforce social support systems and autonomy of the individual, to help in coping and managing anxiety, to assist in maintaining healthy interpersonal relationships, to help in handling social image issues and personal growth. Precisely the trans-person needs to be helped to move towards an existentially meaningful life with affirmation of the desired gender expression, roles and identity and to achieve humanistic goals in life.

Therapy may consist of individual, couple, family, or group psychotherapy, the latter being particularly important to foster peer support. Family therapy may include work with spouses or partners, as well as with children and other members of a client's extended or broader support system. Peer support can reduce social isolation and distress. Peers can play an important role in providing support and encouraging the use of helpful organisations and resources. Because many people may be more comfortable talking to those who have been through similar experiences, they are more likely to trust their help and accept their advice. When faced with a client who is unable to access services, referral to available peer support resources (offline and online) is recommended.

Psychotherapy can also aid in alleviating any coexisting mental health concerns (e.g., anxiety, depression) identified during screening and assessment.

Mental health professionals may work with clients and their families at many stages of their lives. Psychotherapy may be helpful at different times and for various issues throughout the life cycle.

Transsexual, transgender, and gender non-conforming people may face challenges in their professional, educational, and other types of settings as they actualize their gender identity and

expression. Mental health professionals can play an important role by educating people in these settings regarding gender non-conformity and by advocating on behalf of their clients. Finally, harm-reduction approaches might be indicated to assist clients with making healthy decisions to improve their lives.



## CHAPTER 5

### GENDER AFFIRMATIVE HORMONE THERAPY

The person with Gender Dysphoria seeking to develop the physical characteristics of the desired gender require a safe, effective hormone regimen that will suppress endogenous hormone secretion (of biological sex) & maintain sex hormone levels within the normal range for the person's desired gender.

Administration of cross sex hormones to induce feminizing or masculinizing changes is a medically necessary intervention for many transgender individuals with Gender Dysphoria. Some people seek maximum feminization/masculinization, while others experience relief with an androgynous presentation resulting from hormonal minimization of existing secondary sex characteristics.

The age at which to begin treatment with cross sex hormones is codetermined in collaboration with both the person pursuing SRT and the mental health professional (MHP). In a retrospective and cross-sectional study conducted at an endocrine referral center in Kolkata between 2010 and 2015, it has been found the mean age of presentation of Gender Dysphoria is late ( $25.77 \pm 6.25$  years) and many of them may have some co-morbid conditions.<sup>23</sup> Hence, hormone therapy must be individualized based on a client's goals, the risk/benefit ratio, the presence of other medical conditions, and consideration of social and economic issues.

The goals of hormonal therapy are:

- 1) To reduce endogenous hormone levels and, thereby, the secondary sex characteristics of the individual's biological sex
- 2) To replace with cross sex hormone by using the principles of hormone replacement treatment of hypo-gonadal patients.<sup>24</sup> The physical changes induced by this hormone therapy are usually accompanied by an improvement in mental well-being.

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<sup>23</sup>Sanyal D, Majumder A. (2016). "Presentation of Gender Dysphoria: A perspective from Eastern India". *Indian J EndocrMetab*; 20:129-33.

<sup>24</sup>Wylie C, Hembree, Peggy Cohen-Kettenis, et al.(2009). "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline". *J ClinEndocrinolMetab* 94: 3132–3154

### **Referral for Hormone Therapy**

Initiation of hormone therapy may be undertaken after a psychosocial assessment has been conducted and informed consent has been obtained by a qualified health professional. Hormone therapy can be initiated with referral from two qualified MHPs (Although the WPATH SOC recommends referral from one MHP for hormone therapy, but regional medical experts suggest two referrals, as mentioned earlier). One of the two MHPs should be a qualified Psychiatrist as the medical experts suggest. It is also preferable, if the first referral is from the client's psychotherapist/Psychiatrist, the second referral be from an MHP who has only had an evaluative role with the client. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent.

The individual should meet the eligibility criteria for hormone therapy (**Annexure 2**) for initiating the endocrinal treatment.

Eligibility for hormone therapy should not be denied solely on the basis of blood seropositivity for HIV or hepatitis B or C.

Hormone therapy may be contraindicated due to serious individual health conditions.

### **Informed Consent**

The effects of hormone therapy are not always reversible. Feminizing/masculinizing hormone therapy may lead to irreversible physical changes. Therefore care should be taken before taking decision about undergoing hormonal interventions and hormone therapy should be provided only to those who are legally able to provide informed consent. Comprehensive information has to be provided about relevant aspects of the hormone therapy, possible benefits and risks. Obtaining informed consent for hormone therapy is an important task of health providers to ensure that clients understand the psychological and physical benefits and risks of hormone therapy, as well as its psychosocial implications.

### **Competency of Hormone-Prescribing Physicians**

Given the multidisciplinary needs of the people seeking hormone therapy, as well as complexities associated with feminizing/masculinizing hormone therapy, endocrinologists are possibly the most suited physician to undertake this task in our country. While formal training programs on SRT for Gender Dysphoria does not exist in India, hormone providers have the responsibility to obtain appropriate knowledge and experience in this field. Clinicians can

increase their experience in providing feminizing/masculinizing hormone therapy by co-managing care or consulting with more experienced experts in this field.

### **Responsibilities of Hormone-Prescribing Physicians**

1. Treating endocrinologists/physicians should evaluate for Gender Dysphoria (**Annexure1**) and ensure that the eligibility criteria (**Annexure 2**) for hormone therapy have been met.
2. Have the initial discussion on the person's physical transition goals and health history.
3. Physical examination: weight, height, blood pressure, breast, genital, and rectal examination.
4. Risk assessment : thrombo-embolic disease, cardiovascular disease, breast cancer (in feminizing hormone therapy) and cardiovascular disease, osteoporosis, breast cancer (in masculinizing hormone therapy)
5. Relevant laboratory tests: Liver enzymes, plasma glucose, thyroid function test, gonadal hormones and lipid profile should be done for all. Prolactin (in feminizing hormone therapy) and hematocrit (in masculinizing hormone therapy) should be done in addition.
6. Discuss the expected effects of feminizing/masculinizing medications and the possible adverse health effects with the client.
7. Confirm that the person has the capacity to understand the risks and benefits of the treatment and is capable of making an informed decision about medical care
8. Provide ongoing medical monitoring, including regular physical and laboratory examination to monitor hormone effectiveness and side effects.
9. Advice to adopt a healthy lifestyle in regards to body weight, alcohol, smoking and diabetes.
10. Communicate as needed with the mental health professional and surgeon.
11. Provide the client with a brief written statement indicating that the person is under medical supervision and care that includes feminizing/masculinizing hormone therapy (if needed).Some clients may wish to carry this statement at all times to help prevent difficulties with the police and other authorities.

### **Physical Effects of Hormone Therapy**

Feminizing/masculinizing hormone therapy will induce physical changes that are more congruent with the person's gender identity. Most physical changes, whether feminizing or

masculinizing, occur over the course of two years and the changes may be highly variable. The following physical changes are expected to occur:

In FtoM individuals:

- Skin oiliness/acne (starting from 1-6months with expected maximum effect in 1-2 years)
- Facial/body hair growth (starting from 3-6months with expected maximum effect in 3-5 years)
- Scalp hair loss (starting after 12months)
- Increased muscle mass & strength (starting from 6-12months with expected maximum effect in 2-5 years)
- Body fat redistribution with atrophy of breast tissue (starting from 3-6months with expected maximum effect in 2-5 years)
- Cessation of menstruation (take effect in 2-6months)
- Clitoral enlargement (starting from 3-6months with expected maximum effect in 1-2 years)
- Vaginal atrophy (starting from 3-6months with expected maximum effect in 1-2 years)
- Deepened voice (starting from 3-12months with expected maximum effect in 1-2 years).

In MtoF individuals:

- Breast growth (starting from 3-6months with expected maximum effect in 2-3 years)
- Thinning and slowed growth of body and facial hair (starting from 6-12 months with expected maximum effect in more than 3 years)
- Male pattern baldness (no re-growth of hair occurs but hair fall stops from 1-3 months with expected maximum effect in 1-2 years)
- Decreased erectile function (starting from 1-3 months with expected maximum effect in 3-6 months)
- Decreased libido (starting from 1-3months with expected maximum effect in 1-2 years)
- Male sexual dysfunction and decreased sperm production (variable time course)
- Decreased testicular size (starting from 3-6months with expected maximum effect in 2-3 years)
- Increased percentage of body fat (starting from 3-6months with expected maximum effect in 2-5 years)

- Decreased muscle mass & strength (starting from 3-6months with expected maximum effect in 1-2 years)
- Softening of skin (starting after 3-6months).

### **Risks of Hormone Therapy**

All medical interventions carry risks. The likelihood of an adverse event is dependent on: the medication itself, dose, route of administration, age of the individual, associated co-morbidities, family history, and health habits of the person.

Based on the level of evidence, risks are categorized as follows: (i) likely increased risk with hormone therapy, (ii) possibly increased risk with hormone therapy, or (iii) inconclusive or no increased risk.

#### **A. Likely increased risk:**

##### Feminizing hormones

Venous thrombo-embolic diseases

Gallstones

Elevated liver enzymes

Weight gain

Hypertriglyceridemia

Cardiovascular disease (in presence of additional risk factors)

##### Masculinizing hormones

Polycythemia

Weight gain

Acne

Androgenic alopecia

Sleep apnea

Cardiovascular disease (in presence of additional risk factors)

#### **B. Possibly increased risk:**

##### Feminizing hormones

Hypertension

Hyperprolactinemia

Prolactinoma

Type 2 diabetes (in presence of additional risk factors)

Masculinizing hormones

Elevated liver enzymes

Hyperlipidemia

Hypertension (in presence of additional risk factors)

Type 2 diabetes (in presence of additional risk factors)

**C. Inconclusive or no increased risk:**

(may present risk, but the evidence is so minimal that no clear conclusion can be reached)

Feminizing hormones

Breast cancer

Masculinizing hormones

Loss of bone density

Breast cancer

Cervical cancer

Ovarian cancer

Uterine cancer

**Clinical Situations for Hormone Therapy**

1) Initiating Hormonal Feminization/Masculinization:

Hormone therapy must be individualized based on a client's goals, risk/benefit ratio of medications, presence of other medical conditions, and consideration of social and economic issues. A wide variety of hormone regimens have been published and no single regimen has better safety and efficacy comparing to the other.

2) Hormone therapy after castration or mastectomy:

A significant number of subject presents with unplanned, ill-timed prior castration (MtoF) or prior mastectomy (FtoM) by non-qualified persons. <sup>(1)</sup>Consideration of hormone therapy must be based on the client's goals and the risk/benefit ratio of individual subject.

3) Hormone maintenance prior to gonad removal:

After achieving the maximal feminizing/masculinizing benefits from hormones (typically two or more years), the individual remains on a maintenance dose. The maintenance dose is then adjusted for changes in health conditions, aging, or other considerations such as lifestyle changes. The individual should continue to be monitored by physical examinations and laboratory testing on a regular basis.

4) Hormone therapy following gonad removal:

Hormone replacement with estrogen or testosterone is usually continued lifelong after an oophorectomy or orchiectomy, unless medical contraindications arise and adjusted for age and co-morbid health concerns. In MtoF individuals, estrogen therapy may be discontinued after 50 yrs of age.

**Efficacy, Risk Assessment and Clinical Monitoring During Feminizing Hormone Therapy (MtoF)**

Efficacy: The best assessment of hormone efficacy is clinical response and one can measure testosterone levels for suppression below the upper limit of the normal female range and estradiol levels within a premenopausal female range but well below supra-physiologic levels.

Risk: Estrogen is absolutely contraindicated in subjects with previous history of venous thrombotic events, history of estrogen-sensitive neoplasm, and end-stage chronic liver disease. Clinicians should particularly attend to tobacco use, as it is associated with increased risk of venous thrombosis, which is further increased with estrogen use.

Clinical Monitoring: Monitoring needs to be done in every 3-6 months intervals to evaluate the possible presence of adverse effects of medication. Monitoring for adverse events should include careful assessment for signs of cardiovascular impairment and venous thromboembolism (VTE) through measurement of blood pressure, weight, and pulse; heart and lung exams; and examination of the extremities for peripheral edema, localized swelling, or pain.

**Efficacy, Risk Assessment and Clinical Monitoring During Masculinizing Hormone Therapy (FtoM)**

Efficacy: The best assessment of hormone efficacy is clinical response and a good clinical response with the least likelihood of adverse events by maintaining testosterone levels within the normal male range while avoiding supra-physiologic levels. For clients using intramuscular (IM) testosterone cypionate or enanthate, some clinicians check trough levels while others prefer midcycle levels.

Risk: Absolute contraindications to testosterone therapy include pregnancy, unstable coronary artery disease, untreated polycythemia with a hematocrit of 55% or higher and a history of breast or other estrogen dependent cancers.

An increased prevalence of polycystic ovarian syndrome (PCOS) has been noted among FtM individuals and PCOS is associated with increased risk of diabetes, cardiac disease, high blood

pressure, and ovarian and endometrial cancers. Persons at risk of becoming pregnant require highly effective birth control.

Clinical Monitoring: Monitoring needs to be done in every 3-6 months intervals to evaluate the possible presence of adverse effects of medication. Monitoring for adverse events include careful assessment for weight gain, acne, uterine break-through bleeding, cardiovascular impairment and psychiatric symptoms.

### **Hormone Regimens**

A wide variation in doses and types of hormones has been published in the medical literatures and access to particular medications is limited by the individual's geographical location and/or socio-economic situations. Therefore clinician's decision for choosing the kind of molecule and mode of administration depend on multiple factors like availability, affordability, possible complications, contraindications etc.

Some feminizing/masculinizing hormone regimen suitable for Indian population in terms of availability and cost will be described here. However, the healthcare providers should regularly review literatures for updated information and use those medications that are safe and available locally to meet individual client's need.

### **Regimens for Feminizing Hormone Therapy (MtoF)**

#### **FIRST LINE THERAPY**

##### Androgen-reducing medications (Anti-androgens)

Androgen-reducing medications reduce endogenous testosterone levels or activity, and thus diminishing masculine characteristics such as body hair. They minimize the dosage of estrogen needed to suppress testosterone, thereby reducing the risks associated with high-dose exogenous estrogen.

- Cyproterone acetate (50–100 mg per day), is a progestational compound with anti-androgenic properties and cost-effective but potentially hepatotoxic.
- GnRH agonists (triptorelin depot 3.75mg monthly or 11.25mg 3monthly) block the gonadal hormones very effectively. These medications are expensive and available as injectables.
- Spironolactone (100–200 mg per day), an antihypertensive agent, directly inhibits testosterone secretion and androgen binding to the androgen receptor and cost-effective. Blood pressure and electrolytes need to be monitored because of the potential for hyperkalemia.
- 5-alpha reductase inhibitors (finasteride 5mg per day or dutasteride 0.5mg per day) block the conversion of testosterone to the more active agent, 5-alpha-dihydrotestosterone. Beneficial effects are observed on scalp hair loss, body hair growth, sebaceous glands, and skin consistency.



## SECOND LINE THERAPY

### Estrogen

- 1) Oral ethinylestradiol (2.0–6.0 mg per day) is commonly used but associated with high risk of venous thrombo-embolism (VTE).
- 2) Conjugated estrogens is also commonly used but associated with high cost. But use of conjugated estrogen or ethinylestradiol cannot be monitored by measurement of serum levels.
- 3) Transdermal estradiol patch (0.1– 0.4 mg twice weekly) is rarely used due to cost but associated with low risk of VTE.
- 4) Parenteral: Estradiolvalerate (2–10 mg IM injection every week) is also an option. (Presently in India,Estradiol valerate is available in oral tablet form (1 and 2 mg), Estradiol valerate injection is not available.)

## THIRD LINE THERAPY

### Progestins

Progestins use is controversial because of its role on breast is not settled yet and it does not lower serum testosterone and associated with potential adverse effects (depression, weight gain, lipid changes, increase in breast cancer risk). Progestins play a role in mammary development and some clinicians believe that these agents are necessary for full breast development. Progestins are used with cyproterone.

Micronized progesterone may be better tolerated and have a more favorable impact on the lipid profile than medroxyprogesterone.

## **Regimens for Masculinizing Hormone Therapy (FtoM)**

### FIRST LINE THERAPY

#### Testosterone

Testosterone can be given orally, transdermally, or parenterally (IM).

Oral testosterone undecanoate (160–240 mg per day), results in lower serum testosterone levels than non-oral preparations and has limited efficacy in suppressing menses.

Intramuscular testosterone cypionate or enanthate (100–200 mg IM) are administered every 2–4 weeks. Some recipients may notice cyclic variation in effects (e.g., fatigue and irritability at the end of the injection cycle, aggression or expansive mood at the beginning of the injection cycle). Intramuscular testosterone undecanoate (1000 mg) maintains stable, physiologic testosterone levels over approximately 12 weeks and to be administered every 12 weeks.

Daily transdermal preparation (Testosterone gel 1% 2.5–10 g per day or Testosterone patch 2.5– 7.5 mg per day) maintains stable and physiologic testosterone levels but currently not readily available in India.

Transdermal and intramuscular testosterone achieve similar masculinizing results and the goal is to use the lowest dose needed to maintain the desired clinical result.

## SECOND LINE THERAPY

### GnRH agonists

GnRH agonists (triptorelin depot 3.75mg monthly or 11.25mg 3monthly) are highly effective gonadal blockade. These agents can be used for refractory uterine bleeding when testosterone alone (injectable) failed to stop bleeding in patients without an underlying gynecological abnormality. These medications are expensive and only available as injectables.

## THIRD LINE THERAPY

### Progestins

Medroxyprogesterone, can be used similarly (for a short period of time) to assist with menstrual cessation early in hormone therapy. These agents are much cheaper alternative to GnRH agonists and widely used in Indian socio-economic context.

## **Long-term care of transsexual individuals**

Cross-sex hormone therapy confers some risks and the risk is worsened by inadvertent or intentional use of supra-physiologic doses of hormones or inadequate doses of hormones. Hence, a regular clinical and laboratory monitoring is essential. Evaluate every 2-3 months in the first year and then 1-2 times per year afterward to monitor for appropriate signs of feminization/masculinization and for development of adverse reactions.

## **Monitoring of cross-hormone therapy on MtoF transsexual persons**

- 1) Measure serum testosterone and estradiol every 3 months
  - a) Serum testosterone levels should be <55 ng/dl.
  - b) Serum estradiol should not exceed the peak physiologic range for young healthy females, with ideal levels, < 200 pg/ml.
  - c) Doses of estrogen should be adjusted according to the serum levels of estradiol.

- 2) Routine cancer screening (breasts, colon, prostate).
- 3) Consider bone mineral density (BMD) testing at baseline if risk factors for osteoporotic fracture are present (e.g., previous fracture, family history, glucocorticoid use, prolonged hypogonadism). In individuals at low risk, screening for osteoporosis should be conducted at age 60 or in those who are not compliant with hormone therapy.

### **Monitoring of cross-hormone therapy on FtoM transsexual persons**

- 1) Measure serum testosterone every 2–3 months until levels are in the normal physiologic male range:
  - a) For testosterone enanthate/cypionate injections, the testosterone level should be measured mid-way between injections. If the level is >700 ng/dl or <350 ng/dl, adjust dose accordingly.
  - b) For parenteral testosterone undecanoate, testosterone should be measured just before the following injection.
  - c) For transdermal testosterone, the testosterone level can be measured at any time after 1 week.
  - d) For oral testosterone undecanoate, the testosterone level should be measured 3-5 h after ingestion.
- 2) Measure estradiol levels during the first 6 months of testosterone treatment or until there has been no uterine bleeding for 6 months. Estradiol levels should be <50 pg/ml.
- 3) Measure complete blood count and liver function tests at baseline and every 3 months for the first year and then 1–2 times a year. Monitor weight, blood pressure, lipids, fasting plasma glucose (if family history of diabetes) and hemoglobin A1c (if diabetic) at regular visits.
- 4) Consider BMD testing at baseline if risk factors for osteoporotic fracture are present (e.g., previous fracture, family history, glucocorticoid use, prolonged hypogonadism). In individuals at low risk, screening for osteoporosis should be conducted at age 60 or in those who are not compliant with hormone therapy.
- 5) If cervical tissue is present, an annual pap smear examination.
- 6) If mastectomy is not performed, then consider mammograms as recommended.

### **Reproductive Health**

Some transgender people may want to have children. Because feminizing/masculinizing hormone therapy limits fertility, it is desirable for persons to make decisions concerning fertility before starting hormone therapy or undergoing surgery to remove/alter their

reproductive organs. Health care professionals should discuss reproductive options with clients prior to initiation of these medical treatments for Gender Dysphoria.

MtoFpersons should be informed about sperm-preservation options and to consider banking their sperm prior to hormone therapy.

Reproductive options for FtoM clients might include oocyte (egg) or embryo freezing. The frozen gametes and embryo could later be used with a surrogate woman to carry to pregnancy.

## CHAPTER 6

### GENDER AFFIRMATIVE SURGERY

For many people with persistent Gender Dysphoria, surgery is essential and medically necessary to give relief from their psychological distress. For them congruence with their gender identity could be achieved with modification of their primary and/or secondary sex characteristics surgically.

In ordinary surgical practice, pathological tissues of the body are removed to restore disturbed functions, or alterations are made to body features to improve individual's self-image. Some people, including some health professionals, object on ethical grounds to surgery as a treatment for Gender Dysphoria as it arguably alters anatomically normal structures. Health professionals raising such ethical question need to understand how surgery helps alleviate the psychological discomfort and distress of individuals with Gender Dysphoria. Professionals need to listen to their symptoms, dilemmas, and life histories to learn about their distress and the potential for harm if access to appropriate treatment is denied.

While there is a dearth of medical literature in India on the outcome of SRS, follow-up studies from other countries have shown undeniable beneficial effects. A number of studies report extremely high satisfaction with genital surgery done on transgender persons.

A review of more than 80 qualitatively different case studies over 30 years demonstrated that the treatment is effective (Pfäfflin & Junge, 1998)<sup>25</sup>. A study using the post-genital-surgery end-point showed only 3.8% regret rate (Landén *et al*, 1998)<sup>26</sup>. The study revealed that regrets were more likely where there was a lack of family support. Lawrence (2003)<sup>27</sup> found that the most significant factor for regret was a poor surgical outcome.

Factors that help to support successful outcomes are a consistent gender identity and psychological stability before and after surgery, adequate psychological preparation and

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<sup>25</sup> Pfäfflin F, Junge A (1998). "Sex reassignment. Thirty years of international follow-up studies after sex reassignment surgery: a comprehensive review, 1961–1991". *International Journal of Transgenderism*, available at <http://web.archive.org/web/20070503090247/http://www.symposium.com/ijtpfaefflin/1000.htm>.

<sup>26</sup> Landén M, Wålinder J, Hambert G, et al (1998). "Factors predictive of regret in sex reassignment". *Acta Psychiatrica Scandinavica*, 97, 284–9.

<sup>27</sup> Lawrence AA (2003). "Factors associated with satisfaction or regret following male-to-female sex reassignment surgery". *Archives of Sexual Behavior*, 32, 299–315.

transition at an early age (De Cuypere *et al*, 2006)<sup>28</sup>, including properly informed consent about benefits, risks and outcomes. A survey in the UK showed a high level of satisfaction (98%) following genital surgery (Schonfield, 2008)<sup>29</sup>. Two studies on outcomes in women and men showed that they function well on a physical, emotional, psychological and social level (Weyers *et al*, 2009<sup>30</sup>; Wierckx *et al*, 2011<sup>31</sup>).

## **Overview of Surgical Procedures for the Treatment of Gender Dysphoria**

This guideline is neither intended to cover nor is there scope to describe in details, each operative technique, their consequences, risks or complications that might arise. Following is the overview of various gender affirmative surgical interventions –

### **I. Surgeries for Male to Female (MtF) Transgender Persons**

#### **A. MtoF Chest Surgery**

Augmentation Mammoplasty (implants/lipofilling)

#### **B. MtoF Genital Surgeries**

- Penectomy: Removal/amputation of Penis
- Orchiectomy: Removal of testes
- Vaginoplasty: Reconstructive surgery to create a vagina

#### **C. MtoF Non-genital, Non-Breast Surgeries**

Facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation, hair reconstruction, and various aesthetic procedures.

#### **D. Revision Surgeries**

- Clitoroplasty: adjusting the size, shape, location or hooding of the neo-clitoris.
- Vulvoplasty or Labiaplasty: adjusting the size or shape of the labia minora or majora.
- Commisuroplasty: narrowing the superior aspect of the labia majora (the anterior commissure)

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<sup>28</sup>De Cuypere E, Elaut E, Heylens G, et al (2006).“Long-term follow-up: psychosexual outcome of Belgian transsexuals after sex reassignment surgery”. *Sexologies*, 15, 126–33.

<sup>29</sup>Schonfield S (2008).*Survey of Patient Satisfaction with Transgender Services*.Audit, Information and Analysis Unit.

<sup>30</sup>Weyers S, Elaut E, De Sutter P, et al (2009).“Long-term assessment of the physical, mental, and sexual health among transsexual women”.*Journal of Sexual Medicine*, 6, 752–60.

<sup>31</sup>Wierckx K, Van Caenegem E, Elaut E, et al (2011).Quality of life and sexual health after sex reassignment surgery in transsexual men”.*Journal of Sexual Medicine*, 8, 3379–88.

- Deepening the neo-vagina: occasionally the neo-vagina will not be long enough or will contract in size. This is usually the result of inadequate dilating.

## **II. Surgeries for Female to Male (FtoM) Transgender Persons**

### A. FtoM Breast/Chest Surgery

Subcutaneous Mastectomy (removal of breast), creation of a male chest

### B. FtM Genital Surgeries

- Hysterectomy /Salpingo-oophorectomy:Removal of uterus/ Fallopian tubes and ovaries
- FtoM genital reconstruction : Reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty (creation of a micro-penis) or with a phalloplasty (creation of a penis employing a pedicled or free vascularized flap), vaginectomy (removal of vagina), scrotoplasty (reconstruction of scrotum), and implantation of erection and/or testicular prostheses

### C. FtoM Non-genital, Non-Breast Surgeries

Voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures.

### D. FtoM Revision Surgeries

The aim of chest surgery in the FtoM is not just to remove all of the breast tissue, but also to re-contour the chest to create a masculine appearance.

Individuals with larger breasts or poor skin quality have a higher chance of requiring revision surgery. Typical revisions include, but are not limited to –

- Liposuction: To improve contour abnormalities
- Scar revisions
- Excision of skin excess, wrinkling or puckering
- Adjustment of nipple-areola complex position or size

The number and sequence of surgical procedures may vary from client to client, according to their individual clinical needs and available expertise.

Although most of the above ‘non-genital, non-breast surgeries’ are generally labeled “purely aesthetic,” these same operations in an individual with Gender Dysphoria can be considered medically necessary, depending on the individual’s clinical condition and life situation. Before considering for more complicated genital surgery, it is advisable to opt for these surgeries, if appropriate, as that might give a considerable relief to the dysphoria related to gender expression.

### **Referral from MHP for Surgery**

Genital and breast/chest surgical treatments for Gender Dysphoria are to be undertaken only after assessment of the individual and written referral by qualified mental health professionals (see Chapter 3). The person has to meet the criteria for a specific surgical treatment (see Annexure 3&4).

- Two referrals from qualified MHPs who have independently assessed the individual are needed for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries) as WPATH SOC (7<sup>th</sup> version) recommends.
- WPATH SOC (7<sup>th</sup> version) recommends that one referral from a qualified MHP is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty), but as mentioned earlier, medical experts of this region, suggest two referrals from two qualified MHPs for breast/chest surgeries as well. One of the two MHPs should be a qualified psychiatrist as suggested by the medical experts.
- For both genital and breast/chest surgeries, it is preferable that if the first referral is from the client's psychotherapist/psychiatrist, the second referral be from an MHP who has only had an evaluative role with the client. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent.
- The MHP provides documentation, in the chart and/or referral letter, of the client's personal and treatment history, progress, and eligibility (see Chapter 3).
- MHPs referring for surgery share the ethical and legal responsibility for that decision with the surgeon, but should not be held responsible for any physical complication arising as a consequence of surgery.

### **Competence of Surgeons Performing Genital Surgery**

Surgeons who perform surgical treatments for Gender Dysphoria should be licensed urologists, gynaecologists, plastic surgeons, or general surgeons. Surgeons should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. It is desirable for surgeons to be willing to have their surgical skills reviewed by their peers. Surgeons should update themselves by regularly attending professional meetings where new techniques are presented.

Ideally, surgeons should have skill for more than one surgical technique for genital reconstruction so that they, in consultation with clients, can choose the ideal technique for each individual. Alternatively, if a surgeon is skilled in a single technique and this procedure is



either not suitable for or desired by a client, the surgeon should inform the client about other procedures and offer referral to another appropriately skilled surgeon.

### **Roles and Responsibilities of Surgeons Performing SRS**

The surgeon performing SRS should know each client's history and the rationale that led to the referral for surgery. Surgeons must have close working relationships with their clients and other health professionals who have been actively involved in their clinical care. It is necessary for a surgeon to have confidence on the competence of the referring mental health professional(s), and if applicable, the hormone-prescribing physician for the assessment and treatment of Gender Dysphoria as the surgical intervention and outcome of surgery depends on it.

Once a surgeon is satisfied that the criteria for specific surgeries have been met (Annexure 3&4), surgical treatment should be considered and a preoperative surgical consultation should take place. During this consultation, the procedure and postoperative course should be extensively discussed with the client. Surgeons are responsible for discussing all of the following with clients seeking surgical treatments for Gender Dysphoria:

- The different surgical techniques available (with referral to colleagues who provide alternative options);
- The advantages and disadvantages of each technique;
- The limitations of a procedure to achieve “ideal” results; If possible, surgeons should provide a full range of before-and-after photographs of their own clients, including both successful and unsuccessful outcomes;
- The inherent risks and possible complications of the various techniques; surgeons should inform clients of their own complication rates with each procedure.

These discussions are at the core of the informed consent process, which is both an ethical and legal requirement for any surgical procedure. Surgeon should ensure that the client has realistic expectation of outcomes.

All of this information should be provided to clients in writing, in a language in which they are fluent, and in graphic illustrations. Clients should receive the information in advance and be given ample time to review it carefully. The elements of informed consent should always be discussed face-to-face prior to the surgical intervention. Questions can then be answered and written informed consent can be provided by the client. Because these surgeries are irreversible, care should be taken to ensure that clients have sufficient time to absorb information fully before they are asked to provide informed consent.

Clients must be warned that in case of genital reconstructive surgeries there can be several separate stages of surgery and frequent technical difficulties, which may require additional operations. For example, Phalloplasty, using a pedicled or a free vascularized flap, is a lengthy, multi-stage procedure with significant morbidity that includes frequent urinary complications and unavoidable donor site scarring. Complications of phalloplasty may include frequent urinary tract stenoses and fistulas, and occasionally necrosis of the neophallus. In Metoidioplasty the objective of standing micturition cannot always be ensured (Monstrey et al., 2009)<sup>32</sup> and also penetration for sex is usually not possible due to small phallus size.

Surgical complications of MtoF genital reconstructive surgery may include complete or partial necrosis of the vagina and labia, fistulas from the bladder or bowel into the vagina, stenosis of the urethra, and vaginas that are either too short or too small for coitus. While the surgical techniques for creating a neovagina are functionally and aesthetically excellent, anorgasmia following the procedure can occur (Klein & Gorzalka, 2009<sup>33</sup>; Lawrence, 2006<sup>34</sup>).

In case of augmentation mammoplasty, even when desirable size and contour of breast can be achieved, there usually occurs an alteration of sensation. The client must have this expectation of realistic outcome before consenting for the desired surgery.

Consent forms and information sheets, explaining all expected outcomes, including potential complications and risks, must be provided preferably several weeks in advance of surgery.

### **Pre-surgical Screening and Precautions**

For any type of surgery, in general the client must:

- be physically fit for surgery
- be psychologically prepared for surgery
- have realistic goals and expectations of the surgery
- must have a good understanding of the surgical intervention to be performed, its cost, required length of hospitalization, likely complications.

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<sup>32</sup>Monstrey, S., Hoebeke, P., Selvaggi, G., et al (2009). "Penile reconstruction: Is the radial forearm flap really the standard technique?" *Plastic and Reconstructive Surgery*, 124(2), 510–518.

<sup>33</sup>Klein, C., & Gorzalka, B. B. (2009). "Sexual functioning in transsexuals following hormone therapy and genital surgery: A review (CME)". *The Journal of Sexual Medicine*, 6(11), 2922–2939. doi:10.1111/j.1743-6109.2009.01370.x

<sup>34</sup>Lawrence, A. A. (2006). "Patient-reported complications and functional outcomes of male-to-female sex reassignment surgery". *Archives of Sexual Behavior*, 35(6), 717–727. doi:10.1007/s10508-006-9104-9

- should be informed of, and understand, any alternative procedures, and risks and complications of the interventions
- have given their informed consent for the procedures

If the MtoF individual is on estrogen therapy, it should be discontinued three weeks prior to surgery and not resumed at least for two weeks after surgery to prevent thrombosis in major arteries.

Androgen (testosterone) hormones need not be stopped pre-operatively in case of FtoM individual and should be continued for life if there are no contraindications.

Usually pre-operative screening procedures (HIV, HBV, etc.) need to be carried out. Available evidence show that being HIV-positive alone is not a contraindication for genital reassignment surgery, but the general medical condition of the HIV-positive patient should be taken into consideration.

For genital surgical sex reassignment, person has to undergo a urological examination for the purpose of identifying and perhaps treating abnormalities of the genitourinary tract since genital surgical sex reassignment includes the invasion of and the alteration of the genitourinary tract (urological examination is not required for persons not undergoing genital reassignment)

Psychotherapy is not an absolute requirement for surgery unless the initial assessment by MHP leads to a recommendation for psychotherapy. There is a need to be continually under care of mental health professional at every stage of gender transition to ensure better outcome.

### **Living in Desired Gender Role Prior to Genital Surgery**

WPATH SOC (7<sup>th</sup> version) recommends for 12 continuous months of living in a gender role that is congruent with their gender identity as a criterion for some genital surgery, Metoidioplasty or Phalloplasty in FtoM Persons and Vaginoplasty in MtoF Persons (see **Annexure 4**).

This is based on expert clinical consensus that this experience provides ample opportunity for them to experience and socially adjust in their desired gender role, before undergoing irreversible surgery.

The social aspects of changing one's gender role are usually challenging – often more so than the physical aspects. Changing gender role can have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that

people can function successfully in their gender role. Support from a qualified mental health professional and from peers can be invaluable in ensuring a successful gender role adaptation (Bockting, 2008)<sup>35</sup>.

The duration of 12 months allows for a range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, festivals, social events). During this time, clients should present consistently, on a day-to-day basis and across all settings of life, in their desired gender role. This includes coming out to partners, family, friends, and community members (e.g. at workplace, neighborhood and other settings).

Health care providers should clearly document a client's experience in the gender role in the medical chart, including the start date of living full time in identity-congruent gender role for those who are preparing for genital reconstructive surgery.

### **Certificates Related to SRS**

After gender affirmative surgery, the surgeon should provide a certificate to the individual stating the nature of surgery/ies done. This certificate will work as a valid medical document that might facilitate in legal procedures of change of name and gender in identity documents, if opted for after SRS.

### **Postoperative Care and Follow-Up**

Surgeons should provide immediate aftercare and consult with other physicians serving the client.

Long-term postoperative care and follow-up after surgical treatments for Gender Dysphoria are associated with good surgical and psychosocial outcomes (Monstrey et al., 2009<sup>8</sup>). Positive outcomes have been reported in areas of cosmetic appearance, sexual functioning, self-esteem, body image, socioeconomic adjustment, family life, relationships, psychological status and satisfaction.

Follow-up is important for the client's subsequent physical and mental health. Health professionals should emphasize on continuity of care with the hormone-prescribing physician (for clients receiving hormones) and the treating mental health professional.

Postoperative clients should undergo regular medical screening according to recommended guidelines for their age.

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<sup>35</sup>Bockting, W. O. (2008). "Psychotherapy and the real-life experience: From gender dichotomy to gender diversity". *Sexologies*, 17(4), 211– 224. doi:10.1016/j.sexol.2008.08.001

## CHAPTER 7

### GENDER AFFIRMATIVE VOICE TRANSFORMATION

Communication is a very important aspect of gender expression. Voice and communication specialist may assist persons with Gender Dysphoria in developing vocal characteristics (e.g., pitch, intonation, resonance etc.) and non-verbal communication patterns (e.g., gestures, posture/movement, facial expressions) that alleviate Gender Dysphoria and facilitate in desired gender role expression. Voice transformation of persons with Gender Dysphoria can be done through –

- A. Speech and Language therapy
- B. Surgical intervention for changing voice.

#### **A. Speech and Language Therapy**

##### Referral

Speech and language therapists should ideally work as part of a recognised multidisciplinary team including laryngologists. The team should maintain close liaison with psychologists and psychotherapists. Only after a confirmed diagnosis of Gender Dysphoria has been established, will a client be assessed for suitability for voice and communication therapy.

A referral to a speech and language therapist should only be accepted if the therapist is clinically competent in this specialised area.

##### Assessment and readiness for therapy

Therapeutic intervention should be undertaken considering the physical limitations of the client's vocal anatomy enabling change without causing vocal abuse/damage (Dacakis, 2002<sup>36</sup>; Adler *et al*, 2006<sup>37</sup>). Intervention should commence taking into account the person's ability to participate in therapy (Söderpalm *et al*, 2004<sup>38</sup>). It should be consistent with current

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<sup>36</sup> Dacakis G (2002). "The role of voice therapy in male-to-female transsexuals". *Current Opinion in Otolaryngology and Head and Neck Surgery*, 10, 173–7.

<sup>37</sup> Adler RK, Hirsh S, Mordaunt M (2006). *Voice and Communication Therapy for the Transgender and Transsexual Client: A Comprehensive Guide*. Plural Publishing.

<sup>38</sup> Söderpalm E, Larsson A, Almquist S (2004). "Evaluation of a consecutive group of transsexual individuals referred for vocal intervention in the west of Sweden." *LogopedicsPhoniatricsVocology*, 29, 18–30.

research/agreed expert opinion. Any pre-existing voice difficulty should be treated before voice modification (Taylor-Goh, 2005<sup>39</sup>).

Poor prediction factors for such laryngological intervention can be

- Smoking habit
- VF Polyps
- Scarring from voice abuse
- Limited voice range
- Age
- Shorter or thicker neck

Regular therapy should usually commence only when the client is ‘living in role’ or transition is imminent. Case history should include a detailed voice assessment to gain values of both perceptual and objective measures where facilities are available.

#### Therapeutic intervention (general)

The amount of therapy required will be variable and take into account the client’s

- a) Own expectations, e.g. some aspire to be a singer or a professional voice user of the other gender;
- b) Natural vocal ability which can be assessed from the flexibility they show with their natural voice during the therapy;
- c) Commitment to continue with therapy.

Therapy targets should be set through mutual discussion between the therapist and the client before commencement of therapy and can be re-negotiated at any point in the journey. The objective is to achieve a voice which fits into the physique and personality of an individual.

Therapy may be offered on an individual basis or in groups (Chaloner, 2000<sup>40</sup>), with use of biofeedback to support therapy. Different communication styles and situations should be addressed. Activities like playing back audio recording of the voice, pitch matching of the produced voice with the model voice on the acoustic analysis software motivates the client. Therapists should regularly evaluate progress in line with clinical practice guidelines.

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<sup>39</sup>Taylor-Goh S (ed.) (2005).*RCSLT Clinical Guidelines*.Speechmark Publishing.

<sup>40</sup>Chaloner J (2000).“The voice of the transsexual.”*Voice Disorders and their Management* (3rd edn) (eds M Freeman, M Fawcus): pp. 245–67. Wiley-Blackwell.

It is recognised that in some clinics/centres the speech and language therapist may also offer advice on style of dressing and appearance depending on the kind of vocation the client may take up after the change. Counselling/psychotherapy should also be provided by appropriately trained team members.

#### Therapy with women (male to female)

The introduction of estrogen will have no effect on the male voice. Therefore, other factors known to mark the difference between male and female voices have to be enhanced to give the individual a more ‘feminine’ voice. Key communication areas where males and females differ (Oates & Dacakis, 1997<sup>41</sup>; Gelfer & Tice, 2013<sup>42</sup>), for example voice quality, pitch, intonation, prosody, rate, articulation, resonance, language and non-verbal communication are to be focused.

#### Therapy with men (female to male)

The introduction of testosterone in women will lower the pitch of the voice, although the degree and rate of change is variable (Van Borsel *et al*, 2000<sup>43</sup>). Therapy may be offered at this time to help stabilise the voice and laryngeal support musculature that will have been physically altered by the testosterone. However, it is not simply lowering the pitch that will make the voice appear more masculine. Other aspects of the voice/communication need to be addressed during assessment and therapy.

### **B. Surgical intervention**

#### Male to Female

Pitch-changing surgery may be offered but this should only occur after speech and language therapy intervention and should be decided jointly by the laryngologist, psychiatrist, speech and language therapist and the client (Matai *et al*, 2003<sup>44</sup>; Parker, 2008<sup>45</sup>). There are various surgical procedures like cricothyroid approximation, anterior commissure webbing and

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<sup>41</sup>Oates J, Dacakis G (1997). “Voice change in transsexuals”. *Venereology*, 10, 178–87.

<sup>42</sup>Gelfer MP, Tice RM (2013). “Perceptual and acoustic outcomes of voice therapy for male-to-female transgender individuals immediately after therapy and 15 months later”. *Journal of Voice*, 27, 335–47.

<sup>43</sup> Van Borsel J, De Cuyper G, Rubens R, et al (2000). “Voice problems in female-to-male transsexuals”. *International Journal of Language and Communication Disorders*, 35, 427–42.

<sup>44</sup>Matai V, Cheesman AD, Clarke PM (2003). “Cricothyroid approximation and thyroid chondroplasty: a patient survey”. *Otolaryngology – Head and Neck Surgery*, 128, 841–7.

<sup>45</sup>Parker AJ (2008). “Aspects of transgender laryngeal surgery”. *Sexologies*, 17, 277–82.

shortening of vocal folds with or without LASER. This may precede or follow other types of gender-change surgery and should be followed by further voice-therapy review to optimise surgical results (Antoni, 2007<sup>46</sup>). Objective results are variable at present (Wagner *et al*, 2003<sup>47</sup>), although personal satisfaction rates are high (Kanagalingam *et al*, 2005<sup>48</sup>). Thyroid chondroplasty may also be offered to reduce the prominence of the thyroid cartilage for cosmetic appearance (Sandhu, 2007<sup>49</sup>).

### Female to Male

Pitch-changing surgery for this population is not as well developed. There have been attempts to lower the pitch further with surgery e.g. Isshiki type III thyroplasty.

### Support mechanisms and continuing professional Development

Adults with Gender Dysphoria are likely to form a small part of a voice therapist's case-load unless the therapist is attached to a gender clinic. It is therefore essential that access to specialist colleagues and national support networks is available. Regular updating of clinical skills is advised through designated courses, study days and individual learning opportunities.

### Discharge

Discharge will be at the discretion of the speech and language therapist following discussion with the client. Reasons for discharge may include any of the following:

- a) Successful completion of the therapy aims and objectives
- b) No further progress deemed possible
- c) Client is unable to commit to therapy/practice required to achieve therapy goals.

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<sup>46</sup>Antoni C (2007). "The role of the speech and language therapist". *Transsexual and Other Disorders of Gender Identity: A Practical Guide to Management* (ed. J Barrett): pp. 139–54. Radcliffe Publishing.

<sup>47</sup>Wagner I, Fugain C, Monneron-Girard L, et al (2003). "Pitch raising surgery in fourteen male-to-female transsexuals". *Laryngoscope*, 113, 1157–65.

<sup>48</sup>Kanagalingam J, Wood GR, Cheesman AD (2005). "Cricothyroid approximation and subluxation in 21 male-to-female transsexuals". *Laryngoscope*, 115, 611–8.

<sup>49</sup>Sandhu G (2007). "Feminisation of the larynx and voice". *Transsexual and Other Disorders of Gender Identity: A Practical Guide to Management* (ed. J Barrett): pp. 191–8. Radcliffe Publishing.



## Annexure 1

### **Diagnostic criteria: DSM-5**

#### **Gender Dysphoria in Adolescents and Adults 302.85 (F64.1)**

A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of anticipated secondary sex characteristics).
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)

B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

**With a disorder of sex development** (e.g. a congenital adrenogenital disorder such as 255.2[E25.0] congenital adrenal hyperplasia or 259.50 [E34.50] androgen insensitivity syndrome)

Specify if:

**Post-transition:** the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen - namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male; mastectomy or phalloplasty in a natal female).

## **Annexure 2**

### **Criteria for Feminizing/Masculinizing Hormone Therapy**

1. Persistent, well-documented Gender Dysphoria;
2. Capacity to make a fully informed decision and to give consent for treatment;
3. Age of majority(18 years) is reached ;
4. If significant medical or mental concerns are present, they must be reasonably well controlled.

## **Annexure 3**

### **Criteria for Breast/Chest Surgery**

#### **Mastectomy and Creation of a Male Chest in FtM Persons:**

1. Persistent, well-documented Gender Dysphoria;
2. Capacity to make a fully informed decision and to give consent for treatment;
3. Age of majority(18 years) is reached;
4. If significant medical or mental health concerns are present, they must be reasonably well controlled. Hormone therapy is not a prerequisite.

#### **Breast Augmentation (Implants/Lipofilling) in MtF Persons:**

1. Persistent, well-documented Gender Dysphoria;
2. Capacity to make a fully informed decision and to give consent for treatment;
3. Age of majority(18 years) is reached;
4. If significant medical or mental health concerns are present, they must be reasonably well controlled. Although not an explicit criterion, it is recommended that MtF persons undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

## Annexure 4

### **Criteria for Genital Surgery**

#### Hysterectomy and Salpingo-Oophorectomy in FtM Persons and Orchiectomy in MtF

##### Persons:

1. Persistent, well documented Gender Dysphoria;
2. Capacity to make a fully informed decision and to give consent for treatment;
3. Age of majority(18 years) is reached;
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the person's gender goals(unless hormones are not clinically indicated for the individual).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before a person undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these surgical procedures for medical indications other than Gender Dysphoria.

#### Metoidioplasty or Phalloplasty in FtM Persons and Vaginoplasty in MtF Persons:

1. Persistent, well documented Gender Dysphoria;
2. Capacity to make a fully informed decision and to give consent for treatment;
3. Age of majority(18 years) is reached;
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the person's gender goals(unless hormones are not clinically indicated for the individual);
6. 12 continuous months of living in a gender role that is congruent with their genderidentity.

Although not an explicit criterion, it is recommended that these clients also have regular visits with a mental health or other medical professional.

The criterion noted above for some types of genital surgeries—that is, that the individuals engage in 12 continuous months of living in a gender role that is congruent with their gender identity—is based on expert clinical consensus that this experience provides ample opportunity for them to experience and socially adjust in their desired gender role, before undergoing irreversible surgery.

## Annexure 5

### SAMPLE OF A REFERRAL LETTER FOR HORMONE THERAPY BY MHP

1 April 2016

RE: Medical referral

Apurbo (Apurva) Sinha

DOB: 14 November 1990

This letter is written on behalf of the above referenced client for referral and consideration for cross-sex hormone therapy (CSHT), pursuant to the Standards of Care (SOC), 7<sup>th</sup> ed., published by the World Professional Association for Transgender Health (WPATH).

1. Client's general identifying characteristics: The client was born on 14 November 1990 and is 25 years old. Apurbo's preferred pronoun is he. He identifies as an able bodied, Indian FtoM transgender male. He lives at 14/8 Taltala Bazar, Kalyani.
2. Results of the client's psychosocial assessment including diagnosis: The client appears to meet DSM 5 diagnostic criteria for 302.85 Gender Dysphoria.
3. Duration of the referring health professional's relationship with the client, and the type of evaluation, and counseling to date: Apurbo has had three assessment conversations to date.
4. An explanation that the criteria for hormone therapy have been met and a brief description of the clinical rationale for supporting the client's request for hormone therapy: A thorough history of the client's development of Gender Dysphoria has been obtained. He has demonstrated an understanding of the impact of stigma attached to gender nonconformity on mental health, and has evidenced a reliable support system that is available during CSHT.
5. Statement that informed consent has been obtained from the client: The criteria for CSHT for adults, the risks associated with cross-sex hormone therapy, as

well as effects and expected time course of CSHT, as published by WPATH Standards of Care (7<sup>th</sup> ed.) has been reviewed with the client.

6. Statement that the referring health professional is available for coordination of care: The referring health professional will remain available to Apurbo for clinical care.

Thank you for your assistance in this matter. If you have further questions, please do not hesitate to call me or mail me.

Sincerely,

.....

Signature

(Name of the MHP, designation, contact details)

## Annexure 6

### SOME TERMS /IDENTITIES WE MAY WANT TO UNDERSTAND

**Androgynous** –a person expressing gender that has elements of both masculinity and femininity.

**Androsexual/Androphilic** –attraction to men, males, and/or masculinity

**Aravani** – the term for hijras in Tamil Nadu. They identify themselves as women trapped in male bodies, although many aravanis would prefer to be called ‘Thirunangi’.

**Aromantic** –is a person who experiences little or no romantic attraction to others and/or a lack of interest in forming romantic relationships.

**Asexual** – someone who does not experience sexual attraction. Unlike celibacy, which people choose, asexuality is seen as one form of sexual orientation. Asexuality is a self-claimed identity. There is considerable diversity among the asexual community. Asexual people have the same emotional needs as anyone else; each asexual person has experiences pertaining to relationships, attraction, and arousal somewhat differently. Asexual persons might identify as lesbian, gay, bi, or heterosexual.

**BDSM** – Bondage/Discipline, Dominance/Submission, Sadism/Masochism: a combined acronym often used as a catchall for anything in the kink scene.

**Bigender** – a person who fluctuates between traditionally “woman” and “man” gender-based behavior and identities, identifying with both genders (and sometimes a third gender)

**Bicurious** –curiosity about having attraction to people of the same gender/sex (similar to questioning).

**Bisexual** –a person emotionally, physically, and/or sexually attracted to both genders. This attraction does not have to be present simultaneously or be equally split or same across both the genders that the individual is attracted to.



**Butch** – a person assigned gender female at birth having an appearance or other qualities of a type traditionally seen as masculine. ‘Butch’ is sometimes used as a term for lesbians whose appearance and behaviour are seen as traditionally masculine.

**Cisgender** – a person whose gender identity and biological sex assigned at birth align (e.g., man and male-assigned).

**Cisnormativity** – the assumption, in individuals or in institutions, that everyone is cisgender, and that cisgender identities are superior to trans\* identities or people. Leads to invisibility of non-cisgender identities.

**Closeted** – an individual who is not open to themselves or others about their sexuality or gender identity. This may be by choice and/or for other reasons such as fear for one’s safety, peer or family rejection or disapproval and/or loss of housing, job, etc. When someone chooses to break this silence they “come out” of the closet.

**Cross-dresser**– someone who wears clothes of another gender/sex.

**Demisexual** – an individual who does not experience sexual attraction unless they have formed a strong emotional connection with another individual. Often within a romantic relationship.

**Drag King** – someone who performs masculinity theatrically.

**Drag Queen** – someone who performs femininity theatrically.

**Dupli** – a biological man playing both active and passive role in a sexual situation. It is an Indian term.

**Dyke** –a term referring to a masculine-presenting lesbian. While often used derogatorily, it is adopted affirmatively by many lesbians (and not necessarily masculine ones) as a positive self-identity term.

**Fag(got)** – derogatory term referring to a gay person, or someone perceived as queer. Occasionally used as a self-identifying affirming term by some gay men, at times in the shortened form ‘fag’.

**Female marked bodies and male marked bodies** – Bodies which are born with XX chromosome, vagina, clitoris, uterus, and ovaries are female marked. Bodies which are born with XY chromosome, penis, scrotum and testicles are male marked bodies. Female or female marked bodies are also termed as person assigned gender female at

birth (PAGFB) and male or male marked bodies are termed as person assigned gender male at birth (PAGMB).

**Femme** –persons assigned gender female at birth who identifies themselves as feminine, whether it be physically, mentally or emotionally. Often used to refer to a feminine-presenting queer woman.

**Fluid(ity)** –generally with another term attached, like gender-fluid or fluid-sexuality, fluid(ity) describes an identity that may change or shift over time between or within the mix of the options available (e.g., man and woman, bi and straight).

**FtM/F2M; MtF/M2F** –abbreviation for female-to-male transgender or transsexual person; abbreviation for male-to-female transgender or transsexual person.

**Gay** – (1) a term used to describe individuals who are primarily emotionally, physically, and/or sexually attracted to members of the same sex and/or gender. More commonly used when referring to males/men-identified people who are attracted to males/men-identified people. (2) An umbrella term used to refer to the queer community as a whole, or as an individual identity label for anyone who does not identify as heterosexual.

**Gender assigned at birth** – A sex (either female or male) is assigned to every person at birth. This means that a person will be expected to grow up with certain gender expressions that conform to the assigned sex. For example, an infant who is assigned gender male at birth will be presumed to grow up to be a man.

**Genderdiverse people or gender diversity** – It is an umbrella term used to describe gender identities that cover a range of expressions which are diverse and beyond the heteronormative gender binary of male and female. Gender diverse people prefer to have the freedom to change from one gender identity to another or not have any gender identity at all.

**Genderfluid** – genderfluid is a gender identity best described as a dynamic mix of masculine and feminine. A person who is gender fluid may always feel like a mix of the two traditional genders, but may feel more man some days, and more woman other days.

**Gender invariance** – The social pressure of making people conform to the gender-based expectations of society and leaving no scope for deviation from gender norms or not allowing gender variance.

**Gender non-binary** – Gender non-binary people do not believe in the binary of gender which divides human beings into only two genders - male and female. They want to express themselves outside this binary. People who identify as gender non-binary have gender identities which do not fit into the gender binary. Gender non-binary is often used as an umbrella term; gender non-conforming, gender fluid and gender queer persons can be gender non-binary.

**Gender Non-Conforming (GNC)** – (adj.) someone whose gender presentation, whether by nature or by choice, does not align in a predicted fashion with gender-based expectations.

**Gender Normative/Gender Straight** – someone whose gender presentation, whether by nature or by choice, aligns with society's gender-based expectations.

**Genderqueer** – a gender identity label often used by people who do not identify with the binary of man/woman; or as an umbrella term for many gender non-conforming or non-binary identities (e.g., agender, bigender, genderfluid). Genderqueer people may think of themselves as one or more of the following, and they may define these terms differently; may combine aspects of man and woman and other identities (bigender, pangender); not having a gender or identifying with a gender (genderless, agender); moving between genders (genderfluid); third gender or other-gendered; includes those who do not place a name to their gender having an overlap of, or blurred lines between, gender identity and sexual and romantic orientation.

**Gender spectrum** – It is an idea which looks at gender without conforming to heterosexual gender binary. It sees gender as a continuum where man and woman are not polar opposites. They exist in the spectrum which includes intersex people, different non-binary gender identities and expressions. For example, a cisgender woman can be 'masculine' in her behavior and can love to do roles which are considered 'manly' and can still be somewhere in the spectrum. Gender spectrum prioritises the inclusion of identities and a person can be anywhere in the gender spectrum irrespective of their orientation, gender expression or biological sex.

**Gender stereotypes** – Stereotype is a fixed and oversimplified image of a particular notion or idea. So, gender stereotypes are norms which are set by the society - for example, a girl has to behave like a girl and be feminine and a boy has to behave like a boy and be masculine. Any kind of deviation or any other gender expression which does not fit into these two gender stereotypes are unacceptable in the society.

**Gender Variant** – someone who either by nature or by choice does not conform to gender-based expectations of society (e.g. transgender, transsexual, intersex, gender-queer, cross-dresser, etc.).

**Hermaphrodite** – The word "hermaphrodite" is stigmatizing and misleading. Medical literature advocates the use of "intersex", or more recently, DSD (Disorders of Sex Development) in its place. While some intersex people do reclaim the word "hermaphrodite" with pride to reference themselves (like words such as "dyke" and "queer" have been reclaimed by LGBTIQ+ people), it should be generally avoided. Intersex people also contest the use of the terminology “disorders” in DSD and call for the use of Differences in Sex Development as the expansion of DSD.

**Heteronormative** – The idea of normalizing the gender binary and heterosexual orientation through attitudes, biases, social institutions like family, marriage, etc.

**Heterosexism** – The assumption that prioritizes heterosexuality as the only normal sexual orientation over all other kinds of sexual orientation. It propagates discrimination and prejudice against homosexuality and other sexual orientations.

**Heterosexual**– a person attracted to members of the other gender emotionally, physically, and/or sexually. Also referred as straight.

**Hijra** – a word used in South Asia to mean a particular community with its own cultural and professional identity (like begging, dancing at weddings or blessing babies). They even have their own language, known as Hijra Farsi, which is derived from Persian and Hindustani. The word is loosely translated as eunuch in English, a term significant historically but mostly given up now. Not all hijras are necessarily castrated. In general, hijras are born male who reject their masculine identity and identify as women; some hijras undergo an initiation rite into the hijra community called nirwaan, which refers to the removal of the penis, scrotum and testicles. Some are men who cross dress as women as part of the profession. Only a few members are individuals born with intersex variations and identifying as women. There are reports of women too joining the profession.

**Homosexual** – a term used to describe a person primarily emotionally, physically, and/or sexually attracted to members of the same sex/gender.

**Intersex** – someone whose combination of chromosomes, gonads, hormones, internal sex organs, and genitals differs from the two broadly accepted patterns of male or female. It is also known medically as DSD (“Differences/Disorders of Sex

Development”). Formerly known as hermaphrodite the term is now considered derogatory.

**Kinky** – signifies unconventional sexual preferences, thoughts, fantasies and/or behavior, such as fetishism, sadomasochism, or the like.

**Kinnar** –The term for hijras in some parts of India.

**Kothi** – Kothis are seen as a heterogeneous group, because it refers to biological males who show varying degrees of being effeminate. They prefer to take the feminine role in same-sex relationships, though many kothis are bisexual. Some hijras identify as kothi as well, while not all kothis identify as hijra or even transgender. They do not live in separate communities. Kothi is a term which came out from the community itself.

**Lesbian** – (adj.) a term used to describe women attracted romantically, erotically, and/or emotionally to other women.

**LGBTQ/GSM/DSG/+** – initialisms used as shorthand or umbrella terms for all folks who have a non-normative (or queer) gender or sexuality, there are many different initialisms people prefer. LGBTQ is Lesbian Gay Bisexual Transgender and Queer (sometimes people add a + at the end in an effort to be more inclusive); GSM is Gender and Sexual Minorities; DSG is Diverse Genders and Sexualities.

**Lived gender role/ expression** – It is the gender role/ expression which a person performs and follows in their everyday life. It is the experiences and choices of a person and the knowledge that one gains from it. It is a subjective or personal experience.

**Maoga** – a derogatory Indian term used for effeminate men.

**Metrosexual** – a man with a strong aesthetic sense who spends more time, energy, or money on his appearance and grooming than is considered gender normative.

**MSM/WSW** – initialisms for “men who have sex with men” and “women who have sex with women,” to distinguish sexual behaviors from sexual identities (e.g., because a man is straight, it doesn’t mean he’s not having sex with men). Often used in the field of HIV/AIDS education, prevention, and treatment.

**Mx.** – (typically pronounced mix) is a title (e.g. Mr., Ms., etc.) that is gender neutral. It is often the option of choice for folks who do not identify within the cisgender binary.

**Non-normative** – Not adhering to standard expectations or norms. It can be social, cultural, gender norms.

**PAGFB** – acronym of Person Assigned Gender Female at Birth.

**PAGMB** – acronym of Person Assigned Gender Male at Birth.

**Panthi/Parikh/Giria** – the active male sexual partner to a passive/effeminate man. It is an Indian term.

**Pansexual** – a person who experiences sexual, romantic, physical, and/or spiritual attraction for members of all gender identities/expressions

**Polyamory/Polyamorous**– refers to the practice of, desire to, or orientation towards having ethically, honest, consensually non-monogamous relationships (i.e. relationships that may include multiple partners). This may include open relationships, polyfidelity (which involves more than two people being in romantic and/or sexual relationships which is not open to additional partners), amongst many other set ups. Some poly (amorous) people have a “primary” relationship or relationship(s) and then “secondary” relationship(s) which may indicate different allocations of resources, time, or priority.

**Queer** –Originally meaning "strange" or "peculiar", queer came to be deployed pejoratively against those with same-sex desires or relationships in the late-19th century. In the 1970s the term was reclaimed by members of the LGBT community as a political identity. Queer is used as an umbrella term for sexual and gender minorities that are not heterosexual or cisgender.

**Same Gender Loving/SGL** – a term sometimes used by members of the African-American/Black community to express an alternative sexual orientation without relying on terms and symbols of European descent.

**Self-identify** – To assign a particular gender sexual identity to oneself. Gender is not given, it is often chosen. A person might not feel comfortable with the gender assigned to them at birth and might choose to express oneself in a gender of their

preference. A person might also choose to self-identify as belonging to a particular sexual orientation as well.

**Sexism** – discrimination based on sex. In common life any visible act or speech or attitude or theory which treats women as inferior to men, disadvantages women to men, and thus subjugates women and legitimizes the subjugation.

**Socialised gender** – The gender norms which one is taught to follow in the process of socialisation or growing up.

**Spectrum** – A band of colours as seen in a rainbow or, different positions existing on a scale between two extreme points.

**Their/they/them** – alternate pronouns that are gender neutral and preferred by some trans\* people. Some people who are not comfortable/do not embrace he/she use the plural pronoun “they/their” as a gender neutral singular pronoun.

**Third Gender** – (noun) a derogatory term for a person who does not identify with either man or woman, but identifies with another gender. This gender category is used by societies that recognise at least three genders, both contemporary and historic. Its use is discouraged as it indicates a hierarchy among the genders.

**Trans friendly** – Friends or allies of transgender persons. Individuals and institutions can be trans friendly and have an inclusive attitude, create an inclusive space or environment to make transgender people feel comfortable.

**Trans\*/Transgender** – (1) An umbrella term covering a range of identities that transgress socially defined gender norms. Trans with an \* is often used to indicate that you are referring to the larger group nature of the term. (2) A person who lives as a member of a gender other than that expected based on sex assigned at birth.

**Transition(ing)** – this term is primarily used to refer to the process a trans\* person undergoes when changing their bodily appearance either to be more congruent with the gender/sex they feel themselves to be and/or to be in harmony with their preferred gender expression.

**Trans man** – a person assigned gender female at birth who self-identifies as a man.

**Trans woman** – person assigned gender male at birth who self-identifies as woman.

**Transsexual** – a person who identifies psychologically as a gender/sex other than the one to which they were assigned at birth. Transsexuals often wish to transform their bodies hormonally and surgically to match their inner sense of gender/sex.

**Transvestite** – a person who dresses as the binary opposite gender expression (“cross-dresses”) for any one of many reasons, including relaxation, fun, and sexual gratification (often called a “cross-dresser,” and should not be confused with transsexual)

**Two-sex model** – The two-sex model is a historically constructed model coming into dominance at a particular historico-political juncture in Europe. Before the 18<sup>th</sup> Century, the one-sex model of human anatomy, believed that men and women were two different forms of the same sex. At the turn of the 18<sup>th</sup> Century, this model gave way to the two-sex theory of sex differentiation that propagated that men and women were opposite sexes with their anatomy providing justification.