BASICS OF L.G.B.T.I.Q INCLUSION IN HOSPITALS

AUTHOR
BINDUMADHAV KHIRE

MANUAL PREPARED IN COLLABORATION WITH
SAMAPATHIK TRUST (PUNE),
BINDU QUEER RIGHTS FOUNDATION (PUNE),
BHARATI HOSPITAL (PUNE),
KEM HOSPITAL (PUNE)

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AUTHOR's NOTE: The opinions expressed in the manual are my own and collaborators, Samapathik Trust, Bindu Queer Rights Foundation and supporters of the manual may not necessarily be in agreement with any/some/all of them.

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Medical Director Dr. Sanjay Lalwani,
Dr. Jyoti Shetty (Prof. and Head of Dept. of Psychiatry),
Dr. Arvind Panchanadikar (Psychiatrist),
Dr. Manasi Datar (Psychiatrist),
Dr. Varsha Jagtap (Endocrinologist)

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I am grateful to KEM Hospital (Pune) for collaborating with us for working on an LGBTIQ inclusion policy for KEM Hospital. I am thankful to-

KEM Management,
Shirin Wadia (General Administrator),
Taysir Moonim (Psychologist, Mental Health & Psychosocial Services | Programme Lead, Diversity & Inclusion Initiative)
Dr. Sachin Melinkeri (Associate Consultant, Dept. of Medicine)
and all the staff members who gave me the opportunity to work with them on LGBTIQ inclusion.

We had assisted KEM Hospital in arranging two FGDs (Focus Group Discussions) one comprising Transmen- Mx Trinay G, Jay and two other Transmen. The second FGD was with Transwomen- Payal Khalade, Mai Deshmukh and two other Transwomen. I am thankful to all of them for sharing their experience and insight.

We are thankful to Dr. Soumitra Pathare (Psychiatrist) for his inputs.

We are thankful to The Humsafar Trust for their support.

Bindumadhav Khire
President Samapathik Trust (Pune),
Director Bindu Queer Rights Foundation (Pune)

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GLOSSARY [1]

Bisexual, Bi: Bisexual is a person who has the capacity to form enduring physical, romantic and/or emotional attractions to those of the same sex or to those of the opposite sex. People may experience these attractions in differing ways and degrees over their lifetime. Bisexual people need not have had specific sexual experiences to be bisexual; in fact, they need not have had any sexual experience at all to identify as bisexual.

Closeted: Describes a person who is not open about his or her sexual orientation or gender identity. Better to simply refer to someone as not out about being lesbian, gay, bisexual, or transgender.

Coming Out: Coming out actually is a lifelong process of self-acceptance. People forge a lesbian, gay, bisexual or transgender identity first to themselves and then they may reveal it to others. Publicly sharing one's identity may or may not be part of coming out.

Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Statistical Classification of Diseases and Related Health Problems (ICD)
The DSM Manual 5 is published by the American Psychiatric Association and offers a common language and standard criteria for the classification of mental disorders. It is used, or relied upon, by clinicians, researchers, psychiatric drug regulation agencies, health insurance companies, pharmaceutical companies, the legal system, and policy makers. Homosexuality as a mental disorder was removed in DSM III R in 1987. The International Statistical Classification of Diseases and Related Health Problems (ICD) produced by the World Health Organization (WHO), is the other commonly used manual for mental disorders. It is distinguished from the DSM in that it covers health as a whole. While the DSM is the official diagnostic system for mental disorders in the US, the ICD is used more widely in Europe and other parts of the world. The World Health Organization removed homosexuality from (its list of diseases) ICD-10 in 1992.

Gay: The adjective used to describe people whose enduring physical, romantic and/or emotional attractions are to people of the same sex (e.g., gay man, gay people). Sometimes lesbian (n. or adj.) is the preferred term for women. Avoid identifying gay people as "homosexuals", an outdated term considered derogatory and offensive to many lesbian and gay people

Gender: Refers to being "masculine" or "feminine", and corresponding social roles and behavior.

Gender Dysphoria: People whose gender at birth is contrary to the one they identify with are diagnosed with gender dysphoria. Gender dysphoria is manifested in a variety of ways, including a strong desire to be treated as the other gender or to be rid of one's sex characteristics or a strong conviction that one has feelings and reactions typical of the other gender.

Heterosexual: An adjective used to describe people whose enduring physical, romantic and/or emotional attraction is to people of the opposite sex. Another word used for heterosexual is ‘straight’.

Homophobia: Homophobia is a dislike and/or fear of lesbians and gay men. Intolerance or prejudice is usually a more accurate description of antipathy toward LGBTIQ people.

Homosexual: The dictionary meaning of homosexual is a person who is sexually attracted to people of their own sex’.

Intersex: An intersex person is born with sexual anatomy, reproductive organs, and/or chromosome patterns that do not fit the typical definition of male or female. This may be apparent at birth or become so later in life. An intersex person may identify as male or female or as neither. Intersex status is not about sexual orientation or gender identity: intersex people experience the same range of sexual orientations and gender identities as non-intersex people.

LGBTIQ: Acronym for "Lesbian, Gay, Bisexual, Transgender, Intersex, Queer". LGBTIQ and/or GLBTIQ are often used because they are more inclusive of the diversity of the community.

Lesbian: A woman whose enduring physical, romantic and/or emotional attraction is to other women. Some lesbians may prefer to identify as gay (adj.) or as gay women.

MSM: Acronym for men having sex with men who engage in sexual behaviour with men without identifying themselves as `gay' or `bisexual'. This is normally used in the HIV/STI context.

Mx: A title used before a person's surname or full name by those who wish to avoid specifying their gender or by those who prefer not to identify themselves as male or female.

Out: A person who self-identifies as lesbian, gay, bisexual and/or transgender in their personal, public, and/or professional lives.

Queer: The word has multiple meanings. It can be used as an umbrella term for 'LGBTI' communities or it can be used to describe sexuality which cannot be clearly defined / which does not fit into any commonly known sexual/gender pattern.

Sex: Refers to being "male" or "female" as assigned at birth with reference to genitals a person is born with.

Sex Assignment Surgery: Surgery on (adult, consenting) Intersex persons to align their sexual/reproductive organs to their gender.

Sex Reassignment Surgery: Surgery on (adult, consenting) Transpersons (Transwomen or Transmen) to align their sexual/reproductive organs to their gender.

Sexuality: Refers to one's sexual attraction, desire or behavior with respect to another person of the same/opposite or both sexes.

Sexual Orientation: The scientifically accurate term for an individual's enduring physical, romantic and/or emotional attraction to members of the same and/or opposite sex, including lesbian, gay, bisexual and heterosexual (straight) orientations. People need not have had specific sexual experiences to know their own sexual orientation; in fact, they need not have had any sexual experience at all. **The word 'Sodomy' should never be used to describe gay, lesbian or bisexual relationships or sexuality.**

Transgender: A transgender person is someone whose gender expression does not correspond with one's sex assigned at birth. Transgender male to female is referred as transwoman and female to male as transman. When a person is undergoing the sex reassignment process, that state is called transition.

Hijra: Hijras are biological males who reject their "masculine'' identity in due course of time to identify either as women, or "not-men", or "in-between man and woman", or "neither man nor woman". Hijras can be considered as the Western equivalent of transgender (male-to-female) persons but Hijras have a long tradition/culture and strong social ties formalized through a ritual called "reet" (becoming a member of the Hijra community). There are regional variations in the terms used to refer to Hijras; for example, "Kinnars" (Delhi) and "Aravanis" (Tamil Nadu).

Third Gender: The terms 'Third Gender' and 'Third Sex' describe individuals who are categorized (by their will or by social consensus) as neither man nor woman. This term is generally used by Transgenders, Hijaras community members who desire that they be identified as neither male or female.

Every transgender has the right to decide whether they want to be identified as a man, or woman or as third gender.

[1] *Some of the definitions used in the glossary have been taken from SANCHAAR Media Guide: A Recommended Language Manual For Improved Reporting On Sexual Minorities In India (prepared by The Humsafar Trust, HIV/AID S Alliance, Samapathik Trust, Lakshya Trust) and GLAAD (formerly known as the Gay & Lesbian Alliance Against Defamation) Media Reference Guide.*

FOREWORD

CONSULATE GENERAL OF CANADA IN INDIA

Consul General Annie Dubé

"Canada is delighted to support this initiative by Samapathik Trust in collaboration with Bindu Queer Rights Foundation (Pune), KEM Hospital (Pune) and Bharati Hospital (Pune), along with assistance from The Humsafar Trust (Mumbai).

I want to take time at the onset to acknowledge the relentless work done by the medical and mental health experts who have contributed to this manual. In addition, I salute the continuing efforts of countless NGOs, civil society organisations, volunteers and members of the community fighting for equal rights. Supporting the LGBTI community is not just the right thing to do, it's also the smart thing to do.

We certainly hope this will be a very valuable guide for inclusive medical treatment for all."

Consul General Annie Dubé

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BACKGROUND

INTRODUCTION

At least 4% of the world's population comprises of LGBTI [1]**.** This means that India has, at a conservative estimate, 4 million who are LGBTI. Although this is not an insignificant number, the community has faced significant challenges in coming out and demanding their rights in a society that is by and large not very inclusive. The community continues to face prejudice and discrimination in every field. For decades, the community has been demanding that prejudice and discrimination on the basis of our sexual orientation / gender identity has to end. Although the demands have been just and fair the progress in getting these demands addressed has been slow and painful.

NEED FOR LGBTIQ INCLUSION

If the need for the entire exercise is to be reduced to one line, it would simply be **'Freedom from all forms of discrimination'.**

DISCRIMINATION [2]

Discrimination is the unjust or prejudicial treatment of different categories of people, especially on the grounds of race, age, religion, caste, biological sex, gender, sexual orientation. Discrimination faced could be direct or indirect; it could be by association or perception. The different types of discrimination are as follows:

1. **Direct discrimination –** When an employee or job seeker receives less favourable treatment because of a protected characteristic, it is considered to be direct discrimination. Example – not providing additional training for an employee because he is too old.
2. **Associated discrimination –** Treating an employee or job seeker unfairly because of their association with another person who has a protected characteristic constitutes associated discrimination. Example – bypassing a female employee for promotion because she is the mother of a disabled child.
3. **Perceived discrimination –** If an employer treats an employee less favourably because they think or suspect that the employee possesses a particular protected characteristic, it can be counted as perceptive discrimination. Example – an applicant is not given the job because the employer thinks the person is gay.
4. **Indirect discrimination –** When an employer puts in place unjustified practices, provisions or criteria, which are applicable to all staff equally, but which put a few employees or job seekers at a particular disadvantage as compared with those who do not share that characteristic, it is considered indirect discrimination. Example – insisting that all employees put in overtime work to meet the company's goals may put many female employees at a disadvantage as it is mainly women who take primary responsibility for childcare.

All such discriminations go against the tenets of the medical profession.

BARRIERS TO LGBTIQ INCLUSION

(A) MEDICAL BARRIERS

While religion and culture has played a significant role in stifling LGBTIQ voices, archaic laws (Indian Penal Code 377) and pathologising of sexual minorities has also played a major role in perpetuating stigma and discrimination about LGBTIQ.

[1] *WPA Position Statement on Gender Identity and Same -Sex Orientation, Attraction and Behaviours*
[2] *The Equality Act 2010 (UK)*

Vikram Patel (Pershing Square Professor of Global Health at Harvard Medical School and affiliated with the Public Health Foundation of India and Sangath) in his article 'When Science Masks Hate'[1] states, "Freud, who once viewed homosexual behavior in adults as the result of "arrested" psychosexual development, wrote towards the end of his life that "homosexuality is nothing to be ashamed of. It cannot be classified as an illness; we consider it to be a variation of the sexual function". Yet, for the better part of a century, psychiatrists pathologised homosexuality, categorizin g it as an example of a sexual deviance in diagnostic manuals, and attempting to "cure" people of this "disorder". This stance adopted by a discipline of medicine offered a scientific veneer to justify the religiously-inspired prejudice against a significant minority of the population. This medical legitimization of prejudice was a major contributor to the stigma against homosexuality."

LGBT community needs to feel at ease, included and understood in a healthcare setting. Currently they face discrimination due to ignorance and lack of training for care providers.

Dr. Arvind Panchanadikar (Psychiatrist)

Because of their sexual/gender identity, LGBTIQ community has faced discrimination in the healthcare sector for long. Since medical science has not been inclusive of LGBTIQ, their issues have been ignored while formulating medical syllabus. The results in a nutshell are as follows-

ISSUE	CONSEQUENCE
Ignorance of doctors on LGBTIQ issues	Wrong diagnosis, treatment, advice
Prejudice, discrimination by medical staff	Delay in seeking treatment, patient dropout, community seeking treatment of quacks
Patients unaware of LGBTIQ informed and sensitive doctors and LGBTIQ inclusive medical institutions	Trauma, distress, valuable time lost as patients have to take a risk with a doctor (trial and error method)

My son had disclosed to us that he is gay. Since we don't know anything about this issue, we consulted our family doctor. He said, once he gets married to a woman he will start desiring her. We got him married and now we want to get out of this marriage as he has absolutely no desire for her.

A father of a Gay man

There are quite a few doctors who say, "a patient is a patient, we don't care what gender, sexuality they are or what they do". But this isn't quite true. If that had been the case we wouldn't see rampant prejudice and discrimination by doctors, nurses, house assistants in the way male patients with anal STIs are treated or the way HIV+ patients were treated for decades after HIV came to India. In my long experience I have lost count of the harrowing narratives of patients of the way they have been treated by medical staff on knowing they have anal STIs or are HIV+. It is not surprising that patients try to delay seeking treatment or dropout halfway through the treatment.

Yes, he has anaemia, but I am not sanctioning any blood transfusion as we don't want to waste blood on HIV+ people.

Doctor in a Government Hospital
(referring to an HIV+ gay patient that Samapathik Trust had admitted)

[1] *Indian Express. 24th February 2018. https://indianexpress.com/article/opinion/columns/when-science-masks-hate-homosexuality-section-377-5075946/)*

"A doctor told me, 'You are wrong to consider yourself a man. You are a woman live like one.' After contacting Samapathik Trust and meeting Bindumadhav Khire, I was able to reach Psychiatrists who were knowledgeable and sensitive and understood that although my body is female, my gender is male. Now after Gender Assessment I have started hormone therapy"

Mx Trinay G

Such experiences have prevented LGBTIQ community from seeking timely healthcare services. Many Transgenders resort to quacks and religion/superstitious practices to cure STIs or HIV related complications rather than approach an allopathic doctor fearing that the doctor will humiliate them, discriminate against them.

Taysir Moonim
Psychologist, Mental Health & Psychosocial Services | Programme Lead, Diversity & Inclusion Initiative
KEM Hospital Pune

It is to be noted that many hospitals do provide services to LGBTIQ people, without *apparent* discrimination. But is it a conscious practice? No. So, some may question, "There is no discrimination here. So why do we need to do all this?" The simple answer to this is that if we are not consciously aware of the way we treat a client/patient and we believe that there has been no discrimination from our side then there is a high possibility that we are also not consciously aware of the direct or indirect way we are discriminating against them. It is only the client/patient who is aware of the discrimination.

It is to address this widespread issue of discrimination that the healthcare systems need to restructure themselves to ensure that all patients irrespective of their religion, caste, biological sex, sexual orientation, gender identity, race, color and language are treated sensitively, with dignity, without discrimination.

Discrimination makes healthcare accessibility for LGBTIQ community very difficult, making them vulnerable to infections, diseases. We need to use our resources, leverage our strengths to make sure that this community has access to affordable and quality healthcare without any kind of discrimination.

Dr. Sachin Melinkeri
Associate Consultant, Dept. of Medicine, KEM Hospital, Pune

BREAKTHROUGH

As late as 2016, no statement was given by IPS in support of decriminalization of consensual, adult same sex intercourse. It was after the setback received by the LGBTIQ community in the Supreme Court in the IPC377 case that Gay Activist Bindumadhav Khire, in early 2016, approached Dr. G. Prasada Rao (then president of IPS) and Dr. Dinesh Bhugra (then president of WPA) for written statements. In March 2016 these two statements were provided to us. (Annexure A and B). We are thankful to the IPS and its ex-President Dr. G. Prasada Rao and WPA and its ex-president Dr. Dinesh Bhugra for providing the same. These statements have proved to be very crucial in battling homophobia and transphobia in medical setting.

Both the statements make it clear that being gay or lesbian or transgender is a normal variation of human sexuality and not an illness or a disorder. The statements state that these seem to be innate characteristics and attempts to convert or 'cure' these characteristics are unethical and likely to cause harm.

ICD 11 (International Classification of Diseases) and DSM V (Diagnostics and Statistical Manual) does not regard Homosexuality as a disorder or an illness.

In case of Transgenders, ICD-11 defines gender incongruence as a marked and persistent incongruence between a person's experienced gender and assigned sex and is no longer in the list of mental health disorders.

"It was taken out from *(ICD-10 list of)* mental health disorders because we had a better understanding that this was not actually a mental health condition, and leaving it there was causing stigma."

Dr Lale Say, Reproductive health expert at the World Health Organi zation[1]

The Mental Healthcare Act (2017) (India)

One of the first steps taken in prohibition of discrimination on grounds of sexual orientation or gender was The Mental Healthcare Act (2017).

Section 18(2) of The Mental Healthcare Act (2017) prohibits discrimination of patients on the grounds of their sexual orientation or gender.

> *Sec. 18(2) "The right to access mental healthcare and treatment shall mean mental health services of affordable cost, of good quality, available in sufficient quantity, accessible geographically, without discrimination on the basis of gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or any other basis and provided in a manner that is acceptable to persons with mental illness and their families and care-givers."*

One of the objectives of the Act was to make sure that on issues of mental health no person is discriminated because of their sexual orientation or gender identity. We do not want a gay man or a lesbian or a transgender to be discriminated against in anyway by healthcare authorities when providing mental health services.

Dr. Soumitra Pathare
(Psychiatrist who played a significant role in drafting the Act)

All of the above developments are welcome as they will go a long way in preventing coercive measures to 'cure' gays and transgenders.

(B) LEGAL BARRIERS

The Indian Penal Code (IPC) was drafted by Lord Macaulay during the British rule in India and came in force in India in 1860. IPC section 377 deals with Unnatural offences.

IPC377

> *Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with imprisonment for life, or with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine.*
> *Explanation: Penetration is sufficient to constitute the carnal intercourse necessary to the offence described in this section.*

This section suffered from two defects.
(a) it did not consider age of the parties
(b) it did not consider consent of the parties.
On both the above grounds it violated Articles 14, 15, 19 and 21 of the Indian Constitution.

[1] *Transgender no longer recogniz ed as 'disorder' by WHO. 29th May 2019. https://www.bbc.com/news/health-48448804)*

BREAKTHROUGH

In 2001 NAZ foundation India filed a PIL in the Delhi High Court challenging the constitutional validity of section 377 *(WP C NO 7455/2001)*. On 2 July 2009, in a landmark judgment, Delhi High Court found IPC377 violative of articles 14, 19 and 21 of the Indian Constitution and hence was declared unconstitutional to the extent that it criminalized adult, consensual same sex intercourse. The appeal against this judgment in the Supreme Court lead to the Delhi High Court judgment being set aside. In a separate case, in 2017, the Supreme Court of India delivered a landmark judgment stating that 'Right To Privacy' is a fundamental right *(Civil appeal No.494 of 2012)*. Post this judgment many LGBTIQ community members filed Writs under Article 32 of the Indian Constitution stating IPC377 violates their fundamental Right of Privacy. On 6th September 2018 *(WPC 76 of 2016)* the Hon'ble Supreme Court of India struck down IPC377 to the extent it criminalized adult, consensual intercourse between any two persons.

TRANSGENDER IDENTITY

In 2014, the landmark ruling on the PIL *(National Legal Services Authority (NALSA) v Union of India and Others. Writ Petition No. 400 of 2012 with Writ Petition No. 604 of 2013)* , Hon'ble Justice K.S Radhakrishnan and Justice A.K. Sikri gave legal recognition 'Third Gender' to the transgender community. The Hon'ble Court held that the right to choose one's gender identity is integral to the right of leading a life with dignity and therefore falls within the scope of the right to life (Article 21). The Court stated that gender identity is an integral part of one's personality and one of the most basic aspects of self-determination, dignity and freedom. Since, Article 14 is a right enjoyed by 'any person' and Article 15 is gender-neutral, this right applies equally to men, women and transgender people.

Highlights of the NALSA Judgment

- It is not necessary to undergo any medical procedures, including sex reassignment surgery, sterilization or hormonal therapy to be recognized as a Transgender.
- Discrimination on the grounds of sexual orientation and gender identity impairs equality before the law & equal protection of the law and so is violative of Article 14.
- Expressing one's gender through words, dress, action or behavior is included in the right to freedom of expression (Article 19).
- Articles 15 and 16 prohibit discrimination in certain areas based on a list of characteristics which include sex. The reference to "sex" prohibits all forms of gender bias and gender based discrimination.
- Third Gender community be given reservations in education and employment under (socially and Economically Backward Category (SEBC).

TRANSGENDER PERSON's RIGHTS BILL (2019)

The Transgender Person's Rights Bill (2019) prohibits discrimination of Transgenders.

Section 3 (d) *Prohibition against discrimination- No person or establishment shall discriminate against a transgender person on any of the following grounds namely- denial or discontinuation of, or unfair treatment in, healthcare services;*

Note: The Act does not give the right of self determination of identity to Transgenders as directed by the NALSA judgment but vests the right to issue such an identification certificate on the District Magistrate. The Act has no provision of reservations under SEBC. These aspects have been strongly objected to by the LGBTIQ community.

INTERSEX RIGHTS

In the case of Jackuline Mary *(Jackuline Mary v/s Superintendent of Police, Karur Dist, Karur and Ors. W. P. No 587 of 2014 and M.P. No. 1 and 2. Of 2014)* the Hon'ble High Court of Madras stated that the NALSA judgment also applies to Intersex persons. They have the right to choose gender as - male, female or third-gender (transgender).

On the basis of an order of the Madras High Court, the state government of Tamil Nadu banned Sex Assignment Surgeries (SAS) on Intersex babies and children.[1]

MOVING FORWARD

With the reading down of IPC377 and legal recognition of 'Third Gender' two major milestones have been achieved in the LGBTIQ rights movement. Due to these changes, it became easier for companies, institutions, hospitals to formulate LGBTIQ inclusive policies.

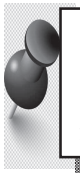
In the healthcare sector, two hospitals in Pune namely- Bharati Hospital (Dhankawadi, Pune) a 831 bed hospital and KEM Hospital (Rasta peth, Pune) a 550 bed hospital have taken the initiative in providing an LGBTIQ inclusive framework. Each of them has opted for a different model. Each of them has collaborated with Samapathik Trust and Bindu Queer Rights Foundation to work on these models.

While there can be many models to choose from, the following two models will be referred to in the rest of the manual.

1. Core Services Model (focus of inclusion is on core units)
2. Systemic Model (the entire system is considered for inclusion at one go)

RAPPORT BUILDING WITH LGBTIQ

While implementing any of the above models it is important that the hospital establish rapport with the LGBTIQ community through advertising, taking assistance of NGOs working with LGBTIQ and implementing various measures like holding mental health and physical health camps for LGBTIQ community. Those who openly identify themselves as LGBTIQ may access these services and those who are in the closet will receive the signal that the hospital is LGBTIQ inclusive.



Before choosing any model, it is desired that the hospital management first understand the concepts of both the models and then take a call on deciding which model to implement. The factors that may impact on this decision are- Access to domain experts, timelines, budget, manpower, hospital layout and hospital specific realities/ particularities.

[1] *'In a first, TN govt bans sex assignment surgeries on intersex infants and children'. Priyanka Thirumurthy. 29th August 2019. Thenewsminute. https://www.thenewsminute.com/article/first-tn-govt-bans-sex-reassignment-surgeries-intersex-infants-and-children-108025*

COMPARATIVE ADVANTAGES AND DISADVANTAGES OF MODELS

Item	Core Services Model	Systemic Model
Administration Go Ahead	Required	Required
Legal Department Involvement	May be required	Recommended *(Refer section LAW on page 50)*
LGBTIQ Domain Expertise	Recommended	Recommended
Gestation Period	Short	Long
Manpower	No dedicated manpower required	Dedicated manpower may be required
Protocol	Minimal Protocol needs to be in place	Detailed Protocol needs to be in place
Confidentiality	May be broken if patient steps out of the core service network	All the staff follows same protocol laid down
Patient Discrimination	May happen when patient steps out of the core service network	All the staff follows same protocol laid down
Staff	Few staff members need to be sensitized	All staff needs to be sensitized.
Staff Training	Minimal awareness/training sessions needed	Induction/training modules need to incorporate LGBTIQ policy & practices
Budget	Very little budget required	May be required (*Refer section Budget on page 52)*
Links	Internal or external referral links related to core services need to be in place.	All staff in hospital follows the same protocol laid down. Where ever relevant, the hospital needs to communicate the protocol to the external links. (*Refer section Links on page 49)*
Documentation	Minimal changes needed	Minimal changes needed
Digitization, Software	Compatibility issues across (in-house or off-the-shelf) Software, Apps, Databases need to be studied and relevant modifications need to be done	Compatibility issues across (in-house or off-the-shelf) Software, Apps, Databases need to be studied and relevant modifications need to be done

Work so far…

This manual is drawn from our experience so far in collaborating on this project. The work on both these models continue and is likely to continue for years. I had the option of writing one manual after both the above models were completely in place or to write one now and do a revision later on. I have opted for the second option as interested hospitals need to do a lot of ground work to make such changes and hence this manual will enable them to start exploring the process early on.

The manual does not suggest which kind of model to use. There could be many more models (than the above two mentioned) each one specifically tailored to that hospital. The manual is meant to assist you in being aware of some of the basic issues related to LGBTIQ inclusion that your hospital will have to take a call on and the options they may have in taking that call.

NOTE ON LGBTIQ INCLUSIVE STAFF POLICY

It would be remiss of the hospital to provide LGBTIQ inclusion for patients, visitors but not have an LGBTIQ inclusive policy for staff which covers equal-opportunity and non discrimination in hiring, promotions, salary, assigning of work responsibilities. **This manual focuses mainly on needs of patients, visitors and non-discriminatory service provision by staff; it does not address LGBTIQ inclusion policy for staff.**

and last but not the least…

WHAT IS IN IT FOR THE HOSPITAL?

This question has been asked often and frankly there was no easy answer. The fact of the matter is because LGBTIQ members are a statistical minority very few LGBTIQ community members will be patients at any given hospital at any point in time. So in terms of business value, unless they are looking for a super specialty service such as SRS or SAS that the hospital offers, the exercise may seem unwarranted from the economic point of view. On the practical point of view I can state that these inclusive policies may be needed for some International Accreditations where LGBTIQ inclusion is one of the measurement criteria. I can also answer this question by stating that laws now warrant some of these changes. While these answers are technically correct, they seem to be designed to address people who are unwilling to make such changes.

So going beyond the legal needs, the questions to be introspected on are-

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- 'Does our staff have the latest medical, legal and social knowledge to effectively interact with LGBTIQ clients/patients?'
- 'Is our perception, attitude and practice in conflict with this current knowledge and understanding?'
- 'What signals are we currently sending out which are prohibiting a LGBTIQ patient from seeking (timely) help?'
- 'What can we do more to make ALL patients seek timely help?'

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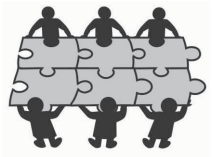
CORE SERVICES MODEL



INTRODUCTION

What is Core Services Model?

This is by far the simplest model aimed to give quick start on LGBTIQ inclusion. Instead of having a go at changing the entire system, this model aims at starting LGBTIQ inclusion at core services level and eventually scaling it up. This chapter provides a template of core services model of LGBTIQ inclusion in a hospital. The following chapter provides a case study of this model being implemented at Bharati Hospital (Pune).

What does Core Services Model mean?

Core Services Model means identification of the core services sought by LGBTIQ community and making these units LGBTIQ inclusive. The following chapter provides a case study of this model being implemented at Bharati Hospital (Dhankawdi Pune).

RECOMMENDED TEMPLATE

- Statement of Intent/Go Ahead from hospital management
- Identification of a person in charge of the Diversity and Inclusion (D&I) Project
- Collaboration with LGBTIQ NGO having domain expertise
- Identification of core services Sought by LGBTIQ
- Grouping of core services
- Core team formation
- Building referral links
- Advertising and referrals
- Implementation and review
- Modification/scaling up of the model

For Teaching Hospitals, one more point needs to be added to the template-

- Dialogue on LGBTIQ with UGs and PGs

Dialogue with UGs and PGs (for Teaching Hospitals)

In teaching hospitals a good way to start the inclusion process is to have a session on LGBTIQ with UGs and PGs. It is important to impart the message of non-discrimination to the students as early as possible. It also sends out the signal to the students that they are expected to be sensitive to **all patients and colleagues** irrespective of their anatomy, sexual orientation or gender.

Statement of Intent/Go Ahead from the Hospital Management

This can be approached in two ways:

(a) The hospital management may prepare a Statement of Intent as the first step in implementing this model. This could cover the following- Need, Objective, Strategy. OR

(b) An informal go-ahead may be obtained from the Medical Director and the formal statement deferred to a later date.

Identification of a Person in Charge of the D&I Project

As a first step the hospital management should identify a person who is willing to lead the project. Alternatively a staff member may *suo motu* express interest in heading the project.

Collaboration with LGBTIQ NGO having domain expertise

Collaboration with an NGO which is experienced in working on LGBTIQ issues is recommended as-

(a) The NGO has the domain expertise required
(b) The NGO becomes a bridge between the hospital and community
(c) Due to its experience in working with the LGBTIQ community, a NGO has a better understanding of the core services desired by the community.

Select an NGO which has in-depth knowledge and experience of the field.

Identification of Core Services Sought by LGBTIQ

The identification of core services can be done in the following ways-

(a) NGO uses its experience to identify and draft a list of core services to be addressed
(b) NGO or Hospital conduct FGDs with LGBTIQ community to identify and draft a list of core services to be addressed
(c) The NGO or Hospital can conduct a small survey in the city/town of the Hospital to identify and draft a list of core services to be addressed. (This option requires budgetary, manpower allocation and is a time consuming task.)

Grouping of Core Services

The core services desired need to be grouped based on the department which predominantly handles the core service. In addition, prioritization may also need to be done on which services should be activated first/receive more focus.

Core Team Formation

Resource persons from the core departments need to be identified to work on the core services selected. The team member selection can be done in the following ways-

(a) Identify doctors who have worked with LGBTIQ and are sensitive and enlist their membership in the team
(b) Identify doctors who have not worked with LGBTIQ but are sensitive and willing and enlist their membership in the team. In this case it is desired that a few sessions on LGBTIQ be conducted to assist their understanding of LGBTIQ issues.

Building Referral Links

The hospital team and NGO has to check whether all the inter-related core services desired/required by the patient can be addressed in that hospital or whether external referrals are needed. If external referrals are needed, these links need to be established. The NGO may be able to help set up such links.

Example 1: If a Hospital provides Gender Assessment but does not have an endocrinologist who provides Hormone Therapy to Transpersons, the hospital will have to build this link with an endocrinologist who is sensitive and has the experience in working with Transpersons.

Example 2: If a Hospital has ICTC but does not have an ART centre, hospital will have to build a link with an ART centre which is sensitive to LGBTIQ community.

Without end-to-end referral links in place, the patient ends up spending a lot of energy in pursuing subsequent steps/treatment and there is a high possibility of the patient dropping out.

Advertising and Referrals

The LGBTIQ inclusive core units have to be advertised. This can be done in the following ways:
(a) Press release
(b) Social media
(c) Work of mouth
(d) NGO resources

Implementation and Feedback

On implementation, the hospital and NGO should monitor the feedback of the patients. The feedback can be sought verbally or in writing. Periodic meeting of the hospital core units team and NGO can help thresh and address the lacune in the model.

A system of feedback in any form- written / verbal should be put in place and needs to be suitably advertised.

Modification/Scaling up of the model

Once the core service model is in place, the model can be scaled up, either by-
(a) Adding more core units to the existing unit OR
(b) Taking the Systemic Model approach

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CASE STUDY: CORE SERVICE MODEL: BHARATI HOSPITAL, DHANKAWADI, PUNE

FOREWORD

Dr. JYOTI SHETTY
(Professor and Head of Dept. of Psychiatry Bharati Hospital, Dhankawadi, Pune)

Considering the recent events viz Indian Psychiatric Society's position statement on Homosexuality dated 2-07-2018, Decriminalization of Section 377 on 6-09-2018, the Transgender (Protection of Rights) Bill 2016 and our experiences as mental health professionals with treating LGBTQ+ individuals, there is a need for the largely "straight" mental health professional community to address the "coming out" of adolescents and young adults and also address our ingrained cultural attitudes and prejudices, even aggressive homophobia in some cases.

After all 10% of the population belong to sexual minorities. The numbers seeking help are increasing, with information online, on social media and an increased awareness in the youth.

There is paradigm shift from the old masculine/feminine binary to a multidimensional gender identity and varied sexual orientation, to allow for individual variation in sexual/gender related behaviours and expression. Heterosexual development has traditionally been seen as the benchmark of sexual development, rather than one of many sexual identities that people develop. Sexual orientation and gender identity are mutually exclusive, and hence persons of any gender identity may have any sexual orientation and vice versa.

Some developmental psychologists also see benefit in widening the range of gender roles taken as normal being a benefit for all. This also has a cascading effect not only on healthy development of sexuality, gender and wellbeing but also reducing stigma, prejudice, abuse and exclusion. Studies support improved health among LGBT+ people in places where greater equality exists. There is a need for competency in health professionals to address the healthcare needs of the LGBTQ+ community. Sensitization programs for undergraduate medical students and postgraduate students in psychiatry and other clinical disciplines will help enhance the same. As also a need for Queer friendly health professionals in the community. Dealing with "coming out" which is a process of understanding, accepting, valuing one's sexual orientation and identity and disclosing it to others is fraught with anxiety, fears, depression. The process also involves family/caregiver counseling.

In view of the above we have a started a LGBT clinic at Bharati Hospital Pune. We have developed a protocol for assessment and intervention as needed for LGBTQ individuals seeking medical and psychological help. A panel of consultants (including psychiatrists, psychologists, endocrinologists, plastic surgeons, dermatologists etc) have been formed to help in intervention for gender affirmation interventions following a set protocol, apart from addressing health needs of the LGBTQ community in a safe space.

ANECDOTAL ASPECT

In September 2017, Dr. Jyoti Shetty (Professor and Head of Dept. of Psychiatry) and Dr. Arvind Panchanadikar collaborated with Samapathik Trust (under 'Being Equal' project) to have a session on LGBTIQ for PG students of Psychiatry at Bharati Vidyapeeth Medical College and Hospital, Pune.

After this session, a similar session was arranged for 2nd, 3rd and 4th year UGs.

As Samapathik Trust started referring LGBTIQ clients to Bharati Hospital Psychiatry OPD, Dr. Jyoti Shetty and Dr. Arvind Panchanadikar approached Samapathik Trust with the idea of having an LGBTI Q inclusive clinic at the hospital.

After Samapathik Trust expressed its willingness to collaborate on this project, an informal go-ahead was given by Medical Director Dr. Sanjay Lalwani.

Eventually after a few rounds of discussions an MOU was signed between Samapathik Trust and Bharati Hospital.

The work on this project is ongoing.

DISCUSSION

Statement of Intent/Go Head from the Hospital Management

Initial discussion with Dr. Jyoti Shetty and Dr. Arvind Panchanadikar set off the process. An inform al go ahead was obtained from Medial Director Dr. Lalwani. No formal Statement of Intent was drafted.

Identification of Person in Charge of the D&I Project

Dr. Jyoti Shetty and Dr. Arvind Panchanadikar undertook this initiative *suo motu*. Dr. Jyoti Shetty became the *de facto* in-charge of the project.

Dialogue with PGs and UGs (for Bharati Vidyapeeth Medical College Students)

Two separate sessions, one for PGs and one for UGs (2nd, 3rd and 4th year) were conducted. These were conducted as the first step even before a call was taken to set up an LGBTIQ inclusive clinic. It was considered imperative that all medical students be sensitized on LGBTIQ issues. The session was facilitated by Dr. Jyoti Shetty.

PG Session Format

Part A
- Introduction of speaker
- Introduction to Sexual minorities- LGBTIQ
- ICD, DSM on LGBTIQ
- IPC377 and NALSA judgment
- Discrimination faced by LGBTIQ patients and consequences
- Non-discriminatory approach as a part of Medical Ethics

Part B
- Experience Sharing by community member

Part C
- Q&A

Note: At the time of the session/s, the final Supreme Court verdict on IPC377 had not been given.

Collaboration with NGO

In all of the above and subsequent steps, Bharati Hospital collaborated with Bindumadhav Khire and all technical support provided by Samapathik Trust and Bindu Queer Rights Foundation was free of cost.

Identification of Core Services Sought by LGBTIQ

Since Samapathik Trust had been working with the community since September 2002, Bharati Hospital used Samapathik Trusts' experience to identify and draft a list of core services to be addressed.

CORE SERVICES IDENTIFIED

Mental Health Services

- Assessment of Sexual Orientation, Gender Identity, Intersex variations.
- Counseling for issues related to Sexual Orientation, Gender Identity, Intersex Variations.
- Hormonal treatment for those having gender different from the biological sex assigned at birth
- Sex Reassignment Surgery
- Sex Assignment Surgery

Proctology

- Examination, diagnosis and treatment for Proctology related issues

STI/HIV/AIDS related diagnosis/treatment services

- STI diagnosis and treatment
- HIV testing and counseling (ICTC- Integrated Counseling and Testing Centre)
- Registration for ART
- TB – Diagnosis and DOTS Treatment
- Opportunistic Infections – Diagnosis and Treatment
- Surgeries of HIV Positive Patients

The above services were the most commonly sought health referrals by the LGBTIQ community with Samapathik Trust.

Grouping of Core Services

The grouping of core services was done as follows.

GROUPING OF SERVICES BY DEPARTMENT

Psychiatry

- Counseling for LGBTIQ community
- Psychiatric support for LGBTIQ community on mental health issues
- Assessment of Sexual Orientation, Gender Identity, Intersex variations
- Counseling for issues related to Sexual Orientation, Gender Identity, Intersex Variations

Endocrinology

- Hormonal treatment

Surgery

- Sex Reassignment Surgery
- Sex Assignment Surgery

Skin

- STIs

Infectious Diseases

- TB
- HIV/AIDS

It was decided that Psychiatry, Endocrinology and Surgery related core services be taken up on high priority.

Core Team Formation

Dr. Jyoti Shetty used her knowledge and experience in enlisting a team to work with LGBTIQ patients/clients. She spoke to various doctors from various departments and prepared a list of doctors for each of the core services chosen. It was agreed that the NGO would make referrals to the doctors specifically listed to ensure non-discrimination.

Building of Referral Links

Bharati Hospital and Samapathik Trust worked out referral links so that for SRS/SAS a team of Psychiatrist, Psychologist, Endocrinologist and Surgeon was available in the hospital.

Advertising and Referrals

A press release of starting an LGBTIQ inclusive clinic was prepared and received publicity in the English press. Samapathik Trust used social media (Facebook), its monthly Support Group Meetings (QueerKatta) to spread the word. In addition to this, an MoU, for referrals, was signed between Bharati Hospital and Samapathik Trust.

MoU

The MoU enabled Samapathik Trust to publicize this LGBTIQ inclusive clinic and refer LGBTIQ clients to the hospital. This benefited both the hospital and the LGBTIQ community. No remuneration is charged by Samapathik Trust for such referrals either to the client/patient or to the hospital. An extract of the MoU is given below.

MoU (FIRST PARTY is Bharati Hospital & SECOND PARTY is Samapathik Trust)

Responsibilities/roles of FIRST PARTY

1. To avoid stigmatization of the clients, the party of the FIRST PART will ensure that the LGBTI clinic will not be a separate clinic but the clinical medical services will be embedded and integrated with regular services. In any case Party of the FIRST PART would not treat the LGBTI patients differently from other patients.
2. To avoid stigmatization, the party of the FIRST PART will not create/provide separate labels, tags, segregation of LGBTI clients nor will there be separate spaces assigned to LGBTI patients.
3. Party of the FIRST PART would not discriminate against the referred client/patients, including but not limited to, medically or financially.
4. Party of the FIRST PART will consider all sexual orientation, gender identities and variations in sexual/reproductive anatomy as normal variants of sexuality and will not directly or indirectly suggest the client otherwise.
5. Party of the FIRST PART will not advice, suggest and coerce referred clients for unnecessary tests, procedures, treatments, counseling, therapy or surgeries.
6. Party of the FIRST PART will treat the clients referred with dignity, respect and sensitivity.
7. Party of the FIRST PART will make appropriate provision with appropriate, conspicuous sign boards for providing directions for restrooms/washrooms for Transpersons.

MoU (FIRST PARTY is Bharati Hospital & SECOND PARTY is Samapathik Trust)

Responsibilities/roles of SECOND PARTY

1. Maintain a list of Referral Linkages including but not limited to party of the FIRST PART.
2. Provide Client referrals to various medical institutions including but not limited to party of the FIRST PART through various means, including but not limited to - One-on-one Befriending Service, Social Contacts, Samapathik Trust Helpline, Advertising, Suitable Online platforms, Suitable Offline platforms.
3. Clients may also directly approach party of the FIRST PART bypassing referral service of SECOND PARTY.
4. The SECOND PARTY shall not charge for any referral either to the party of the FIRST PART or the client referred.
5. The Party of the SECOND PART shall not be liable to pay, share or contribute any compensation or damages for any loss, injury, damage caused to the client/ patient or his/her property before, during or after medical treatment by the party of the FIRST PART and referred by the SECOND PART.
6. The Party of the SECOND PART shall not be liable for any act of the client/ patient referred to the FIRST PARTY, and in any case The Party of the SECOND PART would not be liable to pay or compensate any financial loss, injury, damage caused to party of the FIRST PART by a client referred by the party of the SECOND PART.

Implementation

The system is being currently implemented. So far LGBTIQ clients have approached the clinic mainly for Counseling, Depression, Gender Identity Assessment, Hormone Therapy and Re-assignment surgery. Some of the clients have been referred by Samapathik Trust and in other cases they have approached the clinic directly.

Periodic review of the working

The verbal feedback to Samapathik Trust has been satisfactory. Currently there is no written anonymous feedback system in place.

Modification/Scaling up of the model

The next phase (expected to start in April 2020) is to conduct Focus Group Discussion with staff of various departments on awareness of LGBTIQ communities and their views on LGBTIQ inclusion in hospital policy. The outcome of these discussions will be disseminated to plan ahead.

RECOMMENDATIONS

- A hospital desiring on pursuing this model should focus on Psychiatry Unit as the initial unit for launch of such a project. This is because, with a higher prevalence of mental health issues amongst the LGBTIQ community, LGBTIQ are more likely to seek Psychiatry and Counseling support where they **know** they will be accepted and not be discriminated.

- The second focus should be on Sex Assignment/Re-assignment related units. There are very few hospitals which provide end-to-end services on these issues. Clients are more likely to approach a hospital where all the related services are provided under one roof.

- Periodic awareness/sensitisation sessions, dissemination of the project, experience-sharing is important to identify and address lacunae.

- The Hospital Policy on Sexual Harassment at Workplace should cover instances of sexual harassment of/by Transgenders/Gays/Bisexuals/Intersex/Queer persons who may be patients, visitors, staff, interns, consultants etc. With this objective in mind the policy should be made gender/sex/sexuality neutral. (Please see section on POSH, Pg. 48.)

"… a recently signed memorandum of understanding (MoU) between Samapathik Trust and Bharati Vidyapeeth Hospital is bringing out the better side of the healthcare for Lesbian, Gay, Bisexual, Transgender and Intersex community. Dr Sanjay Lalwani, dean of Bharati Vidyapeeth Hospital, said, "The LGBTI clinic will be available to the patients who now access to the department of psychiatry. This clinic will provide a definite line of counseling and will also benefit our MBBS and MD students – the next generation of doctors. It may help them to consider LGBTI as a specialization in their future medical studies".

City hospital, NGO sign MoU for better LGBTI healthcare. By Sukhada Khandge, Pune Mirror. Jan 29, 2019. *https://punemirror.indiatimes.com/pune/civic/city-hospital-ngo-sign-mou-for-better-lgbti-healthcare/articleshow/67730028.cms*

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SYSTEMIC MODEL

INTRODUCTION

What is a Systemic Model?

The systematic model aims at streamlining hospital policy where relevant and required for LGBTIQ inclusion. This chapter provides a template of Systemic Model of LGBTIQ inclusion in a hospital, based on the systemic model being implemented at KEM Hospital (Pune), of which a case study is provided in the following chapter.

What does it mean?

The systematic model combines a Top-Down and Bottom-Up Model to update and implement the existing policy and practices for LGBTIQ inclusion.

RECOMMENDED TEMPLATE

- Initiation of process by Initiator
- Team Building
    - Identification of Diversity and Inclusion (D&I) Team
    - Collaboration with LGBTIQ NGO having domain expertise
    - Exploratory dialogue with D&I team, NGO domain expert/s
- Statement of Intent from the hospital management
- Budget allocation and framing of timelines
- Discussions with stakeholders
    - Discussion on LGBTIQ inclusion with HODs
    - Focus Group Discussions with LGBTIQ members
    - Dialogue with staff of various departments
- Preparation and internal circulation of D&I Statement
- Identification of external referral links
- Policy
    - Stakeholder inputs
    - Draft of policy
    - Review of policy
    - Approval and dissemination of policy
- Implementation
    - Dry run
    - Pilot Phase
        - Identification of departments/areas for pilot run
        - Pilot phase implementation
        - Revision of policies as required
    - Going Live
        - Hospital wide implementation of policy
        - Revision of policy periodically as required

For Teaching Hospitals, one more point needs to be added to the template-

- Dialogue on LGBTIQ with UGs and PGs

Dialogue with PGs and UGs (for Teaching Hospitals)

In teaching hospitals a good way to start the inclusion process is to have a session on LGBTIQ with PGs and UGs with support from the domain expert/s. It is important to impart the message of non-discrimination to the students as early as possible. It also sends out the signal to the students that they are expected to be sensitive to **all their patients and colleagues** irrespective of their sexual orientation or gender or anatomical variations.

Initiation of process by Initiator

The Initiator (which could be a staff member of the hospital or a third party) has exploratory discussions with the top management of the hospital. Management needs to understand concepts and issues of LGBTIQ community. They need to be given time to understand the issues and the process that needs to be followed to make the hospital LGBTIQ inclusive. Their commitment to the project, understanding of a realistic timeframe and budget are crucial to the success of the project.

Team Building

Identification of D&I Team

Hospital management needs to identify a D&I team to plan, execute and monitor the project. The D&I team can be a separate team dedicated for this project OR it can comprise of existing staff of the hospital which are willing to take up this work in addition to their existing responsibilities. The D&I team need to be aware of LGBTIQ issues and should be comfortable in working on these issues.

Collaboration with LGBTIQ NGO having domain expertise

Collaboration with an NGO experienced in working on LGBTIQ issues is recommended as-
(a) The NGO has the domain expertise required
(b) The NGO becomes a bridge between the hospital and community
(c) Due to its experience in working with the LGBTIQ community, the NGO has a better understanding of the medical issues of the community.

Select an NGO which has in-depth knowledge and experience of the field.

Exploratory meetings with D&I team, LGBTIQ NGO domain expert/s

Through a series of meetings, the D&I team should explore the dimensions of the project with LGBTIQ NGO domain expert/s. This gives them a good idea of the issues involved in terms of timelines, budget allocation, and other technical support they may need from the NGO or other institutions/groups to implement the project.

Statement of Intent/Go Ahead from hospital management

The D&I team should prepare a Statement of Intent as the first step in implementing this model. This should cover - Need, Objective and Strategy.

Time Frame

The D&I team will have to setup a realistic timeline for implementation. For a hospital with 500 to 1000 beds, this would generally be 1.5 to 3 years.

Focus Group Discussions on LGBTIQ inclusion with HODs of various departments

A series of discussions need to be held with HODs, D&I team and domain experts. The topics of discussion involve- definitions of LGBTIQ, medical issues, legal status of LGBTIQ and the reason for LGBTIQ inclusion. The sessions should focus on having the audience express their views and challenges they envision. The most important outcome targeted through these sessions is to enlist their support for the project. An important way of doing this is to have FGDs with LGBTIQ members with the HODs as audience.

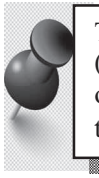
Focus Group Discussions with LGBTIQ members

The object of having focus group discussions is-

(a) Understanding the needs of the Community first hand
(b) Understanding positive and negative experiences faced by the community in healthcare services
(c) Assisting HODs in understanding the issues of the community
(d) Clearing doubts of HODs
(e) Enabling them to introspect on the challenges involved
(f) Enlisting their support

Dialogue with staff of various departments

The next step is to talk to each and every staff member of the hospital on their understanding of the basics of LGBTIQ issues and their views on implementing this project. They should be given space to voice their positive and negative experiences in dealing with LGBTIQ community, their reservations and suggestions.



The policy and protocol revision should also take into account hospital staff which is LGBTIQ (either open or closeted.) So the policy will have to cover non-discrimination and equal-opportunity aspects in hiring, salary, promotions, assigning of work responsibility and zero tolerance of harassment (sexual or otherwise) at workplace.

It is recommended that separate sessions are conducted for various departments. e.g. Social Workers/Psychologists, Doctors, Nurses, House Keeping, Laboratory Technicians, Security, HR, Administration, Ambulance Staff, Medicine Dept. etc. Each department may have unique challenges. So it is important that the LGBTIQ NGO domain expert and D&I team do their homework and draft specific questions in addition to common questions they would be asking in the session. Local language should be used to dialogue with the staff to assist them in communicating comfortably.

It is possible that some staff may have a lot of resistance to LGBTIQ inclusion. Some of them may voice the resistance outright while some of them may prefer to remain silent. Hence, it is advisable to have a feedback system – written or verbal in place.

Since the functioning of the hospital is only as good as its staff, we need to give sufficient time to communicate and address any reservations the staff may have. Their support to this initiative is crucial to the success of this project.

Preparation of D&I Statement

Once all the inputs are in, the D&I should prepare an inclusivity statement. It should highlight the need to be inclusive and the commitment of the hospital to implement the project. The D&I statement should be circulated internally; posters of D&I can be put up in each department in vernacular and English; it can be read at training sessions.

Identification and Mapping of External Referral Links

While the above dialogues are ongoing the D&I team is to initiate the process of-

1. Preparing a list of external referral links and identify areas where there is a potential of causing confusion or incompatibility.
2. Study of Computer Database, Applications, Interfaces- This is extremely important where there is extensive digitization. The ability to adapt in-house and off-the-shelf software, Apps, Databases to the policy change is essential to the success of the project.

Example 1: Referral of a medical claim of a person admitted as a Transwoman (Gender in Admission Form is 'Female') to a Medical Insurance Company in which she has taken a policy under gender Male.

Example 2: Blood sample of a patient who has specified her Gender as Female is sent for testing endocrine parameters to an external laboratory (but the patient is biologically Male)

Example 3: The Computerized Registration System built in-house accepts three options- Male, Female, Other, but the interface of an off-the-shelf software to which the Registration data is sent to, accepts only Male and Female as options.

Stakeholder Inputs

All the inputs, suggestions, reservations received from stakeholders need to be collated and grouped under the following headings- Emergency, OPD Registration, IPD Registration, Diagnostics, Wards, Nursing, Surgery, Security, Ambulance, HR/Administration, Staff, Interns, Consultants, Patients and Visitors, Training, Legal, Documentation, Digitization.

There will be some issues which will be department specific whereas some issues will be common across all the groups. This grouping is useful in revising the existing policy.

Draft of Policy

Once the draft policy is prepared it can be reviewed with stakeholder inputs. It is recommended that the legal department review the policy.

Approval and Dissemination of Policy

It is recommended that an open house dissemination of the policy be held to enable the staff to understand it, clear their doubts. This opportunity should be used to explain to the staff the reason for creating a certain procedure/option, reason for change in infrastructure (if any) and the trade-offs arising out of it.

Implementation

Dry Run

Recruit volunteers (Transmen, Transwomen, Intersex, Queer identified) to walk through the following scenarios as if they were patients.

OPD

- Patient comes to OPD- gets a case paper- wants to do a urine and blood test- goes to diagnostics dept- goes to specimen collection washroom to give urine sample- then goes to the blood lab.- gets a blood test done- collects results- meets a doctor for diagnosis.
- Patients comes to OPD- gets a case paper- goes to diagnostics dept. – gets a chest xray done – gets an abdominal sonography done- collects results- meets a doctor for diagnosis.

- Patient comes to OPD- gets a case paper- meets a doctor for diagnosis- has to get admitted.
- Patient comes to OPD- gets a case paper- meets a doctor for diagnosis- has to have a minor procedure done- gets it done- gets discharged.
- Patient comes to OPD- gets a case paper- meets a doctor for diagnosis- is referred with a note to an outside facility for checkup/diagnostics
- Patient needs to use washroom
- LGBTIQ relative/friend of patient needs to use washroom

Emergency

- A conscious patient is to be brought by ambulance to the hospital and carried to Emergency. Patient gets admitted and registration form is prepared.
- An unconscious patient is to be brought by ambulance to the hospital by strangers and is carried to Emergency. Patient gets admitted and registration form is prepared.
- An unconscious patient is to be brought by ambulance to the hospital by Transgender community and is carried to Emergency. Patient gets admitted and registration form is prepared.

IPD

- Patient comes to/brought to IPD- is registered- admitted to General Ward - patient has LGBTIQ relative/friend with him/her
- Patient comes to/brought to IPD- is registered- admitted to General Ward - patient has non-LGBTIQ relative/friend with him/her
- Patient comes to/brought to IPD- is registered- admitted to Semi-Private Ward
- Patient comes to/brought to IPD- is registered- admitted to Private Ward
- Patients comes to IPD- is registered- admitted to General Ward - sent to diagnostics- gives urine sample, blood sample, gets a chest xray and abdominal sonography done.
- Patients comes to IPD- is registered- admitted to General Ward - is unable to go to the washroom- needs to use urine pot, bedpan.
- Patient needs to use washroom. Is able to go to the washroom but needs assistance.
- Patients comes to IPD- is registered- admitted to General Ward - needs sponging and changing.
- Patient is referred to outside facility for checkup/diagnostics
- LGBTIQ relative/friend of patient needs to use washroom
- LGBTIQ relative/friend needs to stay overnight

D&I Team, relevant HODs/staff could observe and learn without interfering or assisting. The feedback from volunteers, doctors, staff, D&I Team, HODs should be collated, disseminated and used by the D&I Team to locate and address lacunae in the policy.

Pilot Run

Implement the system in all the departments simultaneously. When it comes to General Wards select the Wards for pilot run. It would be beneficial to have a effective, discrete feedback system (written or verbal) in place. The feedback from doctors, staff, patients, HODs should be collated, disseminated and used by the D&I Team to identify and address lacunae in the policy.

Go Live

Implement the system in all the departments simultaneously, including all the General Wards. Periodic meeting of the hospital team and NGO is recommended to identify and address the lacunae in the policy. It would be beneficial to have an effective, discrete feedback system (written or verbal) in place.

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CASE STUDY: SYSTEMIC MODEL – KEMH, RASTA PETH, PUNE

By Taysir Moonim

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FOREWORD

SHIRIN WADIA
(General Administrator, KEM Hospital, Pune)

"Diversity and Inclusion has tremendous value at all hospitals. We are proud that this exemplifies our values and mandate here at KEMH Pune. We have always cared for LGBTIQ patients, as we do all patients – however, the value of a formally mapped out Diversity and Inclusion (D&I) Initiative like this is that we can now do so with awareness, and thus more conscious, informed intent. This allows us to take deliberate, considered and effective steps to be inclusive and sensitive in our care and services that improves the healing, work and lives of our patients, visitors and employees.

We hope to be a standard bearer and provide a call to action to all hospitals in this endeavour by making what is well known as a 'gray area' a little less gray, and the steps to achieve this, a concrete actuality.

Moreover, we realise that this work has relevance not only as a model for other hospitals in India, but we also believe that as a general framework, it can offer deep and practical learnings and a starting point to motivate any organisation, company and industry on the cusp of becoming intentionally inclusive, to begin their work here, and begin now."

What is a systemic model approach?

The systematic model aims to introduce holistic structural changes in the hospital's functioning as a whole system, rather than a targeted intervention involving a set of people or services. These changes may include specific policy, administrative and infrastructural changes – such that, in this context, the objective and requirements of the Diversity and Inclusion initiative can officially be sustainably met and supported to successfully provide **inclusive healthcare services delivery** at a multi-specialty tertiary care hospital. The hospital's healthcare professionals and other staff would anchor this service delivery to individuals from diverse backgrounds and vulnerable, marginalised communities who visit the hospital.

The Diversity and Inclusion (D&I) Initiative at KEMH involves several protected characteristics for non-discrimination including protection towards minorities of sex, gender, sexuality (herein LGBTIQ community).
In this chapter, we solely focus on our work with regard to the LGBTIQ community.

A systemic approach combines a top down and bottom up (also called a grass-root or community driven) engagement.

What does this mean?

We began by identifying stakeholders -internal stakeholders (within the hospital),as well as external stakeholders (the LGBTIQ leaders/ influencers & the community) in Pune, Maharashtra. We then reached out to them to take such work forward. Within the hospital, this means that the Diversity & Inclusion team has worked to create, gain and sustain not only the support of the management ('top down'), but also across all tiers of service employees (from the 'ground up'),while taking the hospital through a transition to the desired changed state *i.e.* inclusion. As hospital staff, these are all people who will have to take up and deliver D&I through their interactions & services, in their respective roles, and thus an indispensable core, audience and community of what it means to be and become an inclusive hospital.
Outside the hospital, we have reached out to LGBTIQ allies such as the NGO, Samapathik Trust Pune to consult in a formal/ informal capacity.

A few merits of the systemic approach we have used, are that:–
(a) It recognises the commencement and transition period as an important part of the project to prepare, learn, mobilise in the community of hospital staff,
(b) It relies on function and leader specific feedback on what changes can be made and delivered realistically in their specific area of impact, i.e. the 'parts' of the whole, and
(c) It permits us to keep reviewing and streamlining this initiative at a macro level, such that it becomes a community driven inclusive initiative that grows because it is relevant, sustainably incorporated into daily work, social and behavioural functioning.

Below, we share the broad framework we have utilized at KEMH Pune. We hope this will be useful to other hospitals in taking diversity and inclusion work forward as an informed, conscious and deliberate engagement. We believe the steps can be flexibly adapted according to each hospital's particular rea lities and requirements.

FRAMEWORK

1. Initiating the groundwork

- Identification and appointment of a Diversity and Inclusion (D&I) Leader/ 'Champion' for the Hospital who will spearhead and drive the initiative end to end. This could be an existing staff member whose role and values align with the work; or the appointment of a new staff member for a role created for this purpose could be made– either would suffice.
- Making a case for inclusion: onboarding of Hospital Management for their support
- Exploratory discussions and approach with a city/ state based LGBTI NGO to collaborate as a community based stakeholder and subject/domain expert to deliver primary awareness sessions to Management and other key staff members. Advised but optional step.

- Conducting the first awareness sessions, as above, to initiate the dialogue across the senior stakeholders of the hospital, collect feedback and assess levels of interest & buy-in to commence.

2. Introducing a hospital specific framework

Programme:

- Planning: define SMART goals, and assess and map out what resources (financial, time commitments, paperwork, printing requirements, training needs etc.), infrastructural changes (eg. washrooms for trans patients), stakeholders (which staff members are crucial for its success) and implementation will be required to achieve it
- Review with management and gain understanding, approval& support of hospital management and key stakeholders

Policy:

- In lieu of a policy, KEMH Pune first prepared a **D&I *Statement of Intent*** for formal internal circulation and visibility. This is widely shared and displayed across the hospital in various forms.
- This Statement of Intent acts as an interim policy which can be critiqued, engaged with by all, reworked as per hospital requirements and ground realities in the course of programme implementation. Changes, if any, can be incorporated and formalized as a policy once the initial programme is completed.
- The timeline is the defining characteristic of the interim status of this text. e.g. KEMH Pune has set a timeline of 1 – 3 years as a learning initiative to do primary level and foundational work. During this interim stage, we aim to complete various preparatory measures – such as assessing, formulating and defining what the KEMH policy & standardised practices will be by the completion of this period.
- On completion of the programme's initial objectives, the organisation (hospital) would be able to formally chart out what administrative and other decisions it is making with regard to its commitment to the Diversity & Inclusion mandate, accordingly draft &publish the policy and guidelines for this purpose &sustained, consistent implementation.

Diversity and Inclusion at KEMH Pune

Happiness and belonging make a huge difference in a person's life and their healing.

We are proud to expand our mandate and vision here at KEMH Pune with the launch of our Diversity and Inclusion Initiative. We are sharing this statement of intent with you, our colleagues and stakeholders in this process, as the first step in building a workplace and healthcare environment where everyone can thrive. This will lead to new conversations that may be difficult and uncomfortable; active problem solving in teams, on the floor and in the wards, thus guiding us on to pathways of equal, safe and fair access for all colleagues, patients and visitors at KEMH Pune. We hope and trust that you will take these steps with all of us.

The foreword for the internally circulated Diversity & Inclusion Statement of Intent [1]

[1] *InfoKEM Newsletter Vol 43 (Jan 2019) can be found at:* http://kemhospitalpune.org/upload/newsletterdetails/January-2019-min.pdf

3. Implementation: Conducting Awareness and Sensitisation Sessions

- As it is a sensitive and new subject, it involves trust. If working with an external trainer from a community NGO, the D&I programme in-charge must ensure they are introduced to the Hospital management or a suitable supervisory point of contact who represents the Management & Board. The trainer should understand and align to the hospital's requirements.
- Keeping patient needs, experiences in mind when designing each step is important
- Ensure that management is involved and comfortable with the direction and steps taken as per policy and via programme implementation at each step along the way, as well as possible implications and consequences of the same for the organisation are regularly discussed (e.g. how soon does the hospital wish to make it public that they are LGBTIQ sensitised and ready?)
- Planning and strategising with HR and L&D departments for awareness sessions is necessary to arrange logistics and for effectiveness of training hours utilised.
- At KEMH Pune, multiple awareness and sensitisation sessions were organised by the D&I programme lead to share and discuss the case for inclusion at the hospital, and proposed steps openly with all, and with the NGO representative and subject expert on LGBTIQ community co-facilitating as the subject speaker about the community and introducing the legal, medical and social context for them. Target employee groups consisted of:-
  - **Leaders:** HODs of various clinical and administrative departments, as well as their deputies, managers, floor supervisors
  - **Staff members:** staff of various departments (e.g. Administration, Human Relations, Reception, Admissions/ Enquiry/ Billing Counters, TPA, Doctors, Nurses, Social Workers, Psychologists, Lab Technicians, Security and Housekeeping)
- **Focus Group Discussions (FGDs) with Transgender individuals** were also held to understand their healthcare experiences and their needs and choices in a healthcare context. In the audience, several leaders & administrators were present to gain exposure and personally interact with the volunteer transmen & women who came to share their personal journeys.
- Below we have described how we conduct (a) a staff awareness session, and (b) an FGD.

4. Implementation: Other steps

As a part of phased implementation, identify phases according to priority and practicality:

- Identification of specific patient or employee areas where LGBTIQ patients are most likely to visit, especially to start with (e.g. which OPDs or wards?)
- Identification of which staff need to be sensitised first
- Hence, defining the order of the rollout of awareness sessions across the hospital
- Assessing existing organisational policies and practices with regard to Diversity and Inclusion objectives & requirements, and working to align them with their process owners and associated executives responsible to implement/ apply them for streamlined and accountable changes and outcomes
- Assessing capacity building, visibility and exposure initiatives as a part of engagement and onboarding various stakeholders
- Ensuring an open and two sided dialogue at all times: all stakeholders – internal ones such as staff members, external ones such as patients, visitors, employees who may be LGBTIQ or allies, and any partnering NGO – should be able to share reviews and feedback for policy stances or action steps taken.
- Collect feedback to measure effectiveness and reception/suggestions/ objections regularly
- Collaborate with other departments such as Human Relations (HR) to understand function specific applications for D&I: e.g. how to incorporate and sustain fairness and equity across processes like recruitment, selection, appraisal, promotion, partner benefits, insurance, etc.
- Review and evaluate progress on programme objectives at regular intervals up to completion.

ANECDOTAL ASPECTS

How to begin.

Keeping KEMH Pune Framework Point 1. "*Initiating the ground work*" in mind – we must mention that the hospital did not initiate D&I or appoint someone to begin such an initiative – although we recommend hospitals do so.

The Diversity and Inclusion Initiative at KEMH Pune began because Ms. Moonim as an individual/ employee advocated the need and value to the hospital and took up an organisational approach and problem solving approach with it. Ms. Moonim currently anchors and spearheads the D&I Initiative. However, it is equally important to mention that the proposal of this initiative was well met by the hospital's management. They were receptive to first considering and building their understanding of the relevance and need to ensure providing inclusive healthcare services as presented, and have since lent their unstinting support, resources, involvement and voices unequivocally to making it a reality, gi ving it visibility and keeping it going across the hospital.

So as much as the hospital identifying a D&I leader is important, if they don't, we do encourage and urge individuals to step up and choose be that person. '*You'* could bring this added value to your hospital, and create solutions for both the hospital and the LGBTIQ Community. We describe this start in a few steps below, to encourage healthcare and administrative professionals to take up the work.

How it was initiated –

- Ms. Moonim's core organizational role as a psychologist and counsellor is to provide Mental Health Services for staff and students. She also takes up special HR projects, organizational change and development, awareness & capacity building initiatives pertaining to her role – such that she works on community mental health applications through establishing organizational policy &standards. These additional systemic aspects of her work (D&I being such an initiative) charted out by her are then initiated with KEMH Management and undertaken in addition to her core role and responsibilities at KEMH Pune, with initial informal go-aheads. This entry point opens up the scope to work with negative experiences of discrimination and harassment, within a broader framework of psychological health and safety.

- **"When in doubt, we take our time or take the plunge. But we don't stop**". Once conceptualized, she approached the General Administrator for approval. Initially it was given tentatively to begin enquiry and to check the feasibility and receptiveness of moving ahead, if at all. This has been a consistent dialogue throughout in the last two years. The General Administrator and others have put their weight behind the initiative at each step.

- She then approached a mentor, Parmesh Shahani (Godrej India), and through him was connected to Mr. Ashok Row Kavi and Mr. Vivek Raj Anand of The Humsafar Trust, Bombay, who work with healthcare. Subsequently, she was introduced by them to Mr. Bindumadhav Khire, President of the Samapathik Trust, Pune, for a local collaboration. Parmesh also shared key resources such as the UNHRC Standards of Conduct for Businesses, The In & Out Indian LGBT Workplace Climate Survey 2016 by MINGLE and the Godrej India Culture Lab's Trans Inclusion Manifesto.

- She then discussed the ideas she had in mind to take forward at the hospital with Mr. Khire and asked if he would support the initiative she had in mind as a community link, representative, educator and as an LGBTIQ activist himself. He promptly agreed to this and in fact, through the Samapathik Trust offered to provide technical support free of cost - since at the time there was no specific budget for manpower, consultancy or implementation at KEM Hospital for this initiative. This gave her integral support from the community and a steadfast ally with whom to take forward the exploratory work at KEMH Pune with a certain impetus and focus.

- At the hospital, a doctor (our Hon. Associate Consultant, HIV Medicine, Department of Medicine) is also a supporter, advocate and an integral part of the Diversity and Inclusion Initiative. As a clinician himself, his experiences and understanding of the medical& personal needs & experiences of this population adds to our understanding from a doctor's perspective.

This trio (a Psychologist, Doctor and the General Administrator), thus forms the internal consulting team that coordinates taking the Diversity & Inclusion work forward at KEMH Pune.

Once these initial steps were in place and approved, Ms. Moonim presented a proposal for inclusive healthcare service delivery and made the case *for the value of diversity and inclusion* at the hospital to various internal stakeholders from across the hospital. It was thoroughly discussed with a view to understand, and eventually well received by most at the hospital. A brief summary of the responses in this regard were:
(a) They believed it will improve equitable access to healthcare by all in society,
(b) It is 'high time' an especially vulnerable community with unique needs can avail of the basic right to healthcare,
(c) This is an objective in keeping with our ethos of being a 'hospital with a heart', and of practicing healthcare, period
(d) There are certain social and cultural barriers in the way of this access currently that we as a hospital can particularly help to bridge.
(e) This work is such that it needs to be done with care and understanding; we need to train our staff, and we need to take our time to get it right.

KEMH Pune was on that day and continues to be ready to participate and learn to the best of our ability in this D&I Initiative. As various staff and leaders have stated in the course of our ongoing work, this exemplifies not only the principles and values of KEMH Pune, but also the underlying tenets of the care giving, healthcare services and medical professions. This attitude on the part of so many of KEMH's staff is significant, and it is of course only with everyone's consensus and willingness to act, that this work can really move forward.

Since the KEMH Pune initiative has been framed and led by an individual, and depends on many others to make it succeed, this required domain expertise as well as a good working knowledge of the organisation's departments & functioning to be developed by from that individual. Ms. Moonim studies case studies and models of work done locally and globally – whether at corporates or in hospitals, international standards and guidelines, research, etc. to devise and assess how to best create *the right model* (in policy, planning & implementation)*for KEMH Pune*. One cannot forget or ignore the organisation's workplace culture, values or grounded reality - the wider social, cultural factors that influence its workforces, and of course, the business of running a hospital – so one has to work *with* all of this in mind, rather than against it.

CASE DISCUSSION

Important Considerations:

1. Disclosure, Privacy and Confidentiality – Keep considerations across documentation, records & interactions (clinical and general), storage & digitization of the same in mind

2. Use the local language, idiom and culturally relevant references for the staff in awareness and sensitisation work

3. Plan awareness and sensitisation sessions for specific groups. Not only is it easier in a known group to invite perspectives, for staff to share their experiences and put forward common concerns, queries and reservations, but it is key to building a two way dialogue. Groups can be determined by the employee group level or it could be department/ function specific. During sessions -

a. Assess and respond to the existing understanding about the LGBTIQ community in staff members, as well as the receptivity and/or the bias/ resistance of staff members to such an initiative; and invite their views on implementing such a project.
b. Give staff members space to voice their personal positive and negative experiences and thoughts about the LGBTIQ community

How A Typical Awareness Session is Conducted at KEMH Pune

As advised by the KEMH HR and General Administration team, separate sessions are conducted for various departments; e.g. Social workers / psychologists, doctors, nurses, housekeeping staff, laboratory technicians, security, HR, administration, etc. as each department may have unique challenges, and hence, a unique set of concerns or queries to be raised & discussed.

So it is important that the Diversity & Inclusion team, or/and the session speaker do their homework to be able to contextualize session content for the upcoming discussion.

- General Introduction (of the speaker, & the Diversity & Inclusion Initiative)
- Brief Audience Handout: To self-assess knowledge & attitudes towards gender, sex, sexuality. This was used as a brief, initial reflective exercise for audience members before the session started
- Quick introduction to LGBTIQ
- NALSA Judgment and Transgender Bill
- Inviting sharing of staff's experiences about Transgenders
- Presenting the need for LGBTIQ inclusion at a Hospital
- Requesting their views on the following points -
  1. Transgender and Intersex identification in OPD and IPD
  2. Ward admission to Transgenders and Intersex (with focus on General Ward)
  3. Use of Washrooms, Toilets by Transgenders
  4. Preference of Staff, if any, with regard to the handling duties such as sponging, cleaning, changing of clothes, diapers, providing bedpan
  5. Issues related to clinical examination, or diagnostic tests
  6. Security of patients, visitors, staff
  7. Handling difficult patients
  8. Comfort level of patients, visitors, staff
  9. Other issues they may foresee with regard to their specific tasks/ responsibilities/ role/ department

The sessions were conducted by BindumadhavKhire (in Marathi language) and Taysir Moonim (in Hindi language). The sessions ended with a feedback form being provided to the employees, which they were to fill up and submit. Participants were encouraged to share their reservations about certain proposed changes.

At the end of the session, participants are encouraged to discuss these issues amongst themselves in the coming weeks, be more aware when an LGBTIQ patient is under their care, and are also encouraged to reach out to Taysir directly to discuss this privately and in more detail.

4. Existing LGBTIQ Staff and incoming new employees would also benefit from such an initiative as awareness and tolerance increases in the workplace environment. Additionally, one part of the D&I Initiative is certainly oriented to work with HR & Administration in applying D&I principles in selection, recruitment, salary, workplace safety, performance & learning, retention, exit, etc in an employee's lifecycle as well, i.e. to be an proactive and inclusive employer. It may be highlighted here that the policy and protocols established or/and adapted in this regard must also take into account, existing hospital staff who may be LGBTIQ and their preference for identity disclosure or to maintain & protect their privacy.

5. Diversity & inclusion – The initiative can be presented at all employee inductions/ incoming student orientations so new staff & students are aware of the workplace culture and expectations.

6. In our experience, the FGDs we conducted were a breakthrough moment for us in helping our hospital staff personally invest and understand the value of the initiative. Here is a brief note on the FGDs –

Conducting Focus Group Discussions (FGD)s with LGBTIQ members

The objective of having focus group discussions is-

(a) Understanding the needs of the Community first hand
(b) Understanding positive and negative experiences faced by the community in healthcare services
(c) Assisting HODs in understanding the issues of the community
(d) Clearing doubts of HODs
(e) Enabling them to introspect on the challenges involved
(f) Enlisting their support

The following procedure was used for the FGDs:

- The Samapathik Trust gave out a call-out to volunteers from the community to enlist in the focus group.
- A panel of 4 members was created for each group (i,e, Transmen and Transwomen).
- The HODs, supervisors, unit social workers and administrators of various departments were invited to be members of the audience.
- Requested no photos, videos and recording to be done of the session by audience members
- De-identification of panelists was offered; however most refused as they were happy to participate in this exercise and be known to those they were speaking to in the audience
- A set of questions for a themed discussion and sharing of narratives by the panel was prepared by Taysir and delivered through the FGD by Bindumadhav Khire, who chaired the panel
- After introductions, each of the panelists was given time to narrate their life story and experience with healthcare providers
- They were then asked various questions related to how the hospital could function taking their needs, as well as personal choices/ preferences into account
- Each member of the panel was allowed to voice his/her opinion even when the opinion was in conflict with other panelists
- The audience was allowed to ask questions to the panel to clarify their doubts
- The FGD ended with a vote of thanks
- These FGDs provided a lot of information for us. There were a lot of moments when it was clear myths were being busted, experiences of vulnerability in a healthcare context were personally relatable and personal connections were made between audience members and those on the panel.
- Members of the audience also personally/ directly asked several questions; this further facilitated such connections and understandings.

7. The KEMH Pune's existing Prevention of Sexual Harassment (POSH) policy is gender neutral. It covers any inappropriate sexual behaviour and harassment between two individuals regardless of gender/ sex/ sexuality, and it is inclusive of same sex harassment. This policy was instated in KEMH Pune before the D&I initiative began. It further serves as a measure of safety offered at the hospital that also protects people who are LGBTIQ, as we continue to expand our mandate in keeping with our values of equality, fairness& non-discrimination.

8. After a baseline of effective sensitisation sessions at the hospital has first been conducted, it is a worthwhile exercise to then run a pilot (a small targeted simulation or sample) in certain sections of the hospital, under observation. After the simulation is successfully completed, feedback can be collected from the staff as well as volunteer LGBTIQ members – (a) to assess readiness of the hospital's process flow (b) the level of accommodation of LGBTIQ members and their experience (c) any feedback or suggestions to be incorporated. You will realise that each specific area of the hospital such as Emergency, OPDs, IPDs, Diagnostics, etc – have their own specific process flows, modes of interactions, documentation, teams and subculture – and hence, may have unique aspects to resolve &work with, in creating inclusive practices and spaces.

Snapshot of Impact

At this time, we have completed Phase 1 of our awareness and advocacy work with 631 staff members, in 21 sessions conducted across August 2019 – January 2020, at KEM Hospital.

ANALYSIS

As per our understanding and observations of various operational challenges, we have compiled some 'learnings by doing'. We have presented these tabulated as checks and balances for the systemic approach. Please find them enlisted below –

LEARNINGS BY DOING OF THE SYSTEMIC APPROACH

CHECKS	BALANCES
Capacity building: The hospital is better informed & prepared to respond to the needs of LGBTIQ patients with awareness and sensitivity	x Capacity building requires knowledgeable trainers who can delve into the group/ department/ hospital contexts for effective training material x Admin staff, D&I and trainer will have coordinate to develop understanding of what those needs are
x Reduces discrimination against LGBTIQ Patients/ Visitors/ Employees, x Puts in place feedback and redressal mechanisms to address any incidences of the same and takes up the responsibility to be accountable in this regard	x Anticipate incidents when things go wrong and prepare for those
Since it puts in place an organizational policy	Needs time to draft, review by stakeholders, gain consensus, iterate and publish
Since it is a holistic approach, a detailed and considered plan was required to be put in place	x Long gestation period x Important to understand which specific areas or departments of the hospital may have unique concerns/ challenges/ barriers in this work, and how and when to resolve those.
Review, supervision and course corrections/ realignments are possible, because it is a phased project that collects feedback to iterate itself, where necessary	x Requires a D&I team to be self-assess/ review work x Requires a supervisor who will also develop some knowledge in this area to be able to competently review & support work x Requires experience and skill in hospital policy & administration to execute the same smoothly at the organization
Encountering stigma/reluctance / resistance	x It is possible that some staff may have a lot of resistance to LGBTIQ inclusion. Some of them may outright voice it, some of them may prefer to remain silent. x Since the success of this mandate rests upon it's delivery by hospital staff, it is important work to solicit such concerns, and address any reservations the staff may have. x It is important to understand and assess when such resistance may pose a significant roadblock, to know when & how to respond to the same.
Identifying external referral links Not all hospitals will have all medical services or surgeries available for LGBTIQ patients. Eg. Sex Assignment Surgery/ Sex Reassignment Surgery / Mastectomy / Plastic surgeries for oral/ maxillofacial desired changes, vaginoplasty, etc.	In this case, the hospital will need to utilize its knowledge and resources, to become aware of: x What specific treatments/ surgeries required or wanted by the LGBTIQ community, that are or can be made available at the hospital, and x What may available but not safe x Identifying what city based services may be available and safe, that patients can be reliably provided an external referred to, on their enquiry.

COMMUNITY STAKEHOLDER RELATIONSHIP

The expertise and support of the community NGO was most required in the following areas:

1. As knowledge partners and trainers, for the delivery of awareness and sensitisation sessions in the local, culturally aligned language and idiom (here, Marathi) for ease and inclusion across all levels of staff.

2. To consult with the D&I programme lead on matters such as assessing the relevance, desirability and practical use of proposed/ intended changes conceptualized by the hospital to better reasonably accommodate LGBTIQ members across the spectrum, as per the ground reality of their varied needs for the intended audience.

3. To become informed & aware of the specific healthcare issues or systemic gaps which affect the micro-minorities (gender/ sex/ sexuality) which could be directly or indirectly related to providing better and more inclusive healthcare services to them as solutions. E.g. (a) what are the other private/ public/ formal/ informal healthcare services locally available to them, if any? (b) What kind of discriminatory or unsafe experiences do they have in healthcare facilities, that your hospital can learn from and proactively cognize and prevent?

4. To be the bridge between the hospital and the community, e.g. to provide support for trusted outreach to the community to form the FGD groups of trans-people for interactive sessions with hospital leaders. Community linkage and involvement is integral as they are the stakeholders and the intended beneficiaries of such a programme. The NGO/ CBO is uniquely situated as a resource to do this effectively, as they both represent and already have a relationship with the LGBTIQ community.

5. To assess and review usage of appropriate and acceptable terms of reference in English/ local language for spoken use in sessions, in written format, etc.

RECOMMENDATIONS

While the following points *are not at this time, actions taken* at KEMH Pune due to the stage at which our initiative is, we do recommend the following steps could also be taken within the scope of the systemic model approach –

1. Board members could also be reached out to, to build awareness & sensitisation, as this will help them to understand issues and needs of the LGBTIQ community; as well as clarify queries/ doubts about proceeding with such an organizational change/ development initiative. An additional benefit may be that members of the board are also likely to be associated with other industries/ organisations/ NGOs and this dialogue can influence an entire network of organisations positively. However, for the purpose of the immediate organisation concerned - This is recommended, but not wholly necessary, if you do already have management's unequivocal intent, support, commitment and involvement to proceed with a Diversity and Inclusion initiative.

2. If the hospital feels it is necessary or has concerns about the exact steps to take, or the commitments they are making, they may always have in-house legal counsel or an external legal consultant present at meetings, to review and advise them on policy or programme steps to be taken along the way. It may help for legal counsel to have or develop knowledge/ expertise in the following areas of law (diversity and inclusion, human resources, labour laws, human rights). KEMH Pune consulted with legal counsel at select junctures, as deemed suitable.

3. If resources are available, and depending on the organizational model, scale and need of the hospital, management may find it advisable to assign more than 1 dedicated staff to the project. Possible roles may that of D&I coordinators for specific functions – customer service executives, TPA (Insurance), social workers or administrators – who are aware of, are at ease & able to interact and respond on the basis of the specific needs of LGBTI individuals, at the point of service delivery, as well as respond to escalated complaints for grievance redressal.

4. If timelines and budgetary concerns are an issue, it is best to use a project management approach where both parameters are defined, and due allocations made before commencing work & roll outs, lest it halt the same if it is unexpectedly or suddenly not available.
As stated earlier, expenses may include training, printing, designing and printing signboards (for washrooms), creatives and making infrastructural changes to build inclusive and accessible washrooms.

5. If it is a teaching hospital, we suggest the UG and PG residents, interns, observers, nursing students could also be covered with awareness and sensitisation sessions; this aligns them to an organizational objective and can inform their own equality driven, discrimination free and safe work ethics and practices, from an early stage in their careers, to go forward.

6. If suitable for the hospital and keeping privacy, safety &confidentiality considerations in mind (*Is the location discreet or public? How often is mail collected? Who collects and reads the feedback/ suggestions?*), you may consider having a Suggestions box in an accessible place and have the staff deposit their anonymous suggestions in the box. Otherwise, feedback can be collected via conversations with a specific Point of Contact (such as the D&I Programme Lead), or digitally at a particular email ID, if all staff uses email communication.

7. As necessary, please consider updating the labour union, as well as hospital vendors, of these changes in policies & practices so (a) they too can adapt, align in time, (b) participate effectively in adhering to the social, behavioural and business standards of the hospital, with understanding, and (c) give feedback about their experiences. This also builds value at scale through the network effect via advocacy at an organizational level.

Taysir Moonim (Psychologist | Mental Health & Psychosocial Services Programme Lead | Diversity & Inclusion Initiative KEM Hospital Pune)

Access to healthcare, education, social and economic survival is a basic human right.

But this is not available to many LGBTIQ people, particularly transgender people. In a typical Indian hospital, how many Indian doctors, nurses and other staff will feel comfortable disclosing they are LGBTIQ even to their colleagues at the workplace, much less to patients/ visitors? Or to speak about or bring their spouses/ partners to professional social events?
How many LGBTIQ patients come to the hospital? Are all the medical services LGBTIQ people may need available and accessible at every hospital/ clinic? How many feel comfortable disclosing to their doctors and nurses that they are LGBTIQ, especially in a clinically relevant context or to seek healthcare information, patient counselling, specific treatments and surgeries?
We learned a large number of LGBTIQ patients actually don't prefer to come to private hospitals too much. So where do they go to in Pune or even in India, if at all, where they can be sure their particular problems will be met with understanding and solutions? What is the quality of care they will receive? Can they afford that care? Do they avail of insurance? When they are sick and vulnerable, do they receive the assurance of a positive, safe and friendly environment in waiting rooms, changing rooms, elevators, lobbies and clinics? Are they recipients of an uncomfortable gaze or touches or are they treated with care, respect and regard?

What do we have to do, as a hospital, to be and become inclusive?
Here, we can work on two key objectives: access to inclusive and affordable quality healthcare, and providing jobs in a safe workplace.

We started with the big questions. This has led us to many insights and solutions.
We keep asking questions.
We're listening and learning as we continue our work.

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OPERATIONAL ISSUES

TRAINING

COMPETENCE BASED MEDICAL EDUCATION (CBME)

From 2019, a Competence Based Medical Education (CBME) has been rolled out for the undergraduate students with training in Attitude Ethics and Communication (AETCOM) being an essential part of the training. The module of AETCOM can be modulated to include LGBTIQ issues apart from undergraduate psychiatric lectures on the same. In addition to this, sessions where LGBTIQ community members address and dialogue with the audience is essential in sensitizing them.

AWARENESS AND SENSITI SATION SESSIONS FOR STAFF

Most staff including doctors lack training on LGBTIQ issues. It is generally a practice of a hospital to have sessions on various related topics for Nurses, House Assistants and Technicians. This schedule should also include session/s on LGBTIQ with a focus on sensitivity, non-discrimination and removal of misconceptions.

Training should be given to security staff or if security has been hired through a third party it should be ensured that security is sensitive and at the same time firm in dealing with people (irrespective of their gender/sexuality) who are aggressive or who demand special treatment.

Training on LGBTIQ should also be given to the members of the Internal Committee to understand sexual harassment issues related to LGBTIQ.

Human nature being curious, it is important that the staff satiates its curiosity by openly and frankly discussing their opinions, experiences, queries about LGBTIQ community during the training sessions rather than questioning the patient or physically checking the anatomy of LGBTIQ patients (especially those patients who are Intersex or those who have or are undergoing SRS or SAS).

It is advised that separate sessions be conducted for various departments as each department will have special concerns and issues that need to be addressed. For e.g. a Receptionist who prepares an OPD case paper will have different issues and concerns than a Lab Technician.

TECHNIQUES/PROCEDURES

Special training should be provided to Nursing Staff and House Assistants on working with patients who have been admitted for SAS/SRS. Training on post-op care of SAS/SRS patient (e.g. catheterizing a post-op patient who has undergone a Penectomy, aftercare of Vagina after a Vaginoplasty etc.) should be imparted to at least a set of staff who are generally expected to work with SAS/SRS patients.

QUEUE FOR OPD CASE PAPER

Currently most government and private hospitals do not have a separate queue for Transgenders for getting a case paper. They stand in either the Male or Female queue.

Although there is no written policy, my experience is that, whenever I have accompanied Transgenders to Sassoon Hospital (Government Hospital in Pune), they have been able to directly approach the case paper window bypassing the queue and are given preference. This is possible only in cases where the person can be visually identified as a Transwoman.

Bindumadhav Khire

OPINION
A policy of separate queue for Transgenders and persons who do not identify as male or female should be put in place. Considering the relatively few Transgenders coming to the Hospital each day, it makes administrative and economic sense, to have one person managing both the Female queue and Transperson/Non-binary queue or Male queue and Transperspon/Non-binary queue.

Biological Sex Identification

Biological sex refers to the sexual/reproductive anatomy with which the person was born.

When a person comes to the OPD for a case paper or IPD for admission, the person has to give name, biological sex.

OPINION
As a first step, it will be easier for hospitals to start with just three options.
Sex: [Male] / [Female] / [Other]
Specific Details (if any) : _____
The Specific Details cell should be added to allow the patient to provide more details related to Sex.

Gender Identification

If the hospital decides to differentiate between sex and gender a new question of Gender has to be added. There are many categories of gender. But it is seen that too many options can be daunting for a hospital which is beginning to take baby steps in LGBTIQ inclusion.

OPINION
As a first step, it will be easier for hospitals to start with just three options.
Gender: [Male] / [Female] / [Other]
Specific Details (if any) : _____
The Specific Details cell should be added to allow the patient to provide more details related to gender.

Addressing the Patient

It is assumed that the patient will be called as per his/her/their gender identification. Note that some non-binary persons prefer to be called as 'they'/'them' rather than 'him'/'her'. During discussions with nurses and house assistants (at KEM Hospital) some have mentioned that they prefer to call the patient by surname instead of first name or as '*patient*' and thereby avoid use of gender. Some of them use the Marathi form of respect in addressing patients- *'tumhi', 'tyanna'* which are gender neutral forms of address.

OPINION
The answer to the question 'should Biological Sex and Gender be combined?' is **'**No'. These should be kept separate. Having said this I am aware that many hospitals club Sex and Gender into one.

Sex: [Male] / [Female] / [Other].

In such cases it becomes important for the doctor to take proper history of the patient or the patient on his/her own volunteer all relevant medical history. For Example a patient identifying herself as female, admitted as a female, may have been born a biological male.

EMERGENCY ADMISSIONS

In emergency admissions, the patient may not have the ability to inform about their sex/gender. They may get admitted by strangers, relatives who may intentionally/unintentionally state the inappropriate Sex/Gender. So provision has to be made to change the sex/gender on the admission when the patient is able to communicate or the error is realised.

In cases where the patient is unable to communicate but has a legal document the hospital may devise a policy whereby a specified legal document (especially Aadhar Card) is used as a baseline for registration. There may be cases where there are multiple documents each stating a different sex/gender. In such cases a hierarchy needs to be defined to register sex/gender.

OPINION
The priority for assigning gender could be as follows

1. Patient's wish
2. Aadhar Card
3. Opinion of the relative/person giving consent while admitting patient
4. In all other cases the doctor examining the patient is to take a call

HISTORY

It is of the utmost importance that proper and complete history be taken. History taking has to be handled delicately and with respect. To elicit compete and correct information, the doctor need to have good communication skills. e.g. some Transgenders take hormone medications by purchasing the pills over the counter without consulting a doctor. If they believe that they will be castigated for this, they will not volunteer the information or lie if confronted.

OPINION
The desire of disclosure of complete history by the patient to the doctor, is at times in conflict with demand from some Transpersons who state that post transition their biological history is nobody's business. Out of medical necessity, being transparent about their medical history will be in the patient's interest.

CONFIDENTIALITY

Where ever the patient is able to communicate, there will be some instances where the patient will request that their biological sex/gender/surgery or HIV status not be disclosed to relatives/friends. The hospital will have to respect this confidentiality as far as possible.

There may be some exceptions to this. For example should this confidentiality be maintained from the accompanying person who is signing the consent form and taking responsibility of the patient? The hospital will have to work with the legal department to frame issues related to confidentiality and list scenarios where exceptions will have to be made.

To what extent would the hospital be liable for confidentiality of data? especially in cases where the patient's data needs to be sent to some other institution? For e.g. a patient identified as Intersex is sent by the hospital for a test at an external diagnostic centre.

WARDS

The issue of allocation of a patient to a ward is of importance for Transgenders and Intersex patients.

ICU

Generally, there is no segregation by sex or gender in the ICU.

Minor Procedures Room

For Minor OPD Procedures some hospitals have a special unit. Generally there is no patient segregation by sex/gender in such unit.

Private/Semi-Private Wards

Both Surgical and Medical Wings generally have Private, Semi-Private and General Wards. The general wards are sex segregated. There is no sex segregation in private, semi-private wards. If the patient is to be admitted to a private or a semi-private room, the patient has reasonable privacy and has access to a separate washroom.

General Ward

The privacy concerns for general wards is generally addressed with curtains placed around the bed as and when needed. In the FGDs conducted at KEM Hospital, Pune most Transmen and Transwomen did not consider this as sufficient. During FGDs and discussion with KEM staff, the following options came up.

(1) Separate ward for Transgenders

The reasons cited were-

- Transpersons feel uncomfortable in male/female wards
- Privacy screens in General Ward do not give sufficient privacy
- Adjoining patients feel uncomfortable having Transpersons in the adjoining bed
- Transpersons generally have transperson visitors which may cause disturbance to others.

I feel that transgenders should be assigned a separate ward, I wont feel comfortable in either male or female ward.

Mai Deshmukh (Transwoman)

(2) No Separate ward for Transgenders
Some transpersons voiced the opinion that the patient should have the right to decide whether they want to be admitted to the male or female ward.

There is no need for separate ward for transgenders, we should have the right to choose between male or female ward

Payal Khalade (Transwoman)

(3) Conditional
(i) Transwomen who have had SRS be admitted to female ward, but other transwomen to male ward.
(ii) Transmen be admitted to female ward irrespective of whether they have had SRS or not. (Reason: some transmen stated that they would feel unsafe in Male ward).
The Conditional option is problematic as some Transwomen who have not undergone SRS may feel unsafe in the male ward.

Special Cases: SAS/SRS
For privacy reasons, the hospital may consider a policy that mandates a semi-private or private room for Intersex/Transgenders who are undergoing SAS/SRS.

RESERVATION OF BEDS FOR TRANSGENDERS

'Transgenders seek reserved beds in Sassoon Hospital'. By Vicky Pathare, Pune Mirror. 18 .3.2019. (https://punemirror.indiatimes.com/pune/ civic/transgenders-seek-reserved-beds-in-sassoon-hospital/articleshow/68455944.cms)

If a hospital desires to implementing this or similar policy the following issues need to be addressed:

1. What is the objective of reserving beds for transgenders?
2. How does it address the problem of privacy, comfort and safety?
3. What logic is adopted to arrive at the number of beds being reserved? (in the above news reported – 5 beds)
4. How would the following case be dealt with- If a bed reserved for transgenders is unoccupied, all other beds are occupied and a new non-Transgender patient get admitted and needs a bed?
5. Will the number of reserved beds be for the whole hospital or for each unit? e.g. Surgical, Medical, Psychiatric, Infectious diseases, Burns Unit etc.?

WASHROOMS

Hospitals generally have Male and Female washrooms. For specimen collection there may be an All Gender and Disability Friendly washroom. It is seen that, washrooms which are disability friendly are surprisingly few, if at all present.

Hospitals have two broad categories of Washrooms -
(A) Washrooms for Staff
(B) Washrooms for Patients / Relatives / Visitors

The hospital has a choice of utilizing/altering a couple of the existing ones to make them gender neutral and disability friendly OR making new ones which are gender neutral and disability friendly. The washroom should contain a Western Style Toilet. The washroom should have enough maneuvering room inside for a wheelchair (The wheelchair mentioned are the folding wheelchairs. The old wheelchairs which are made of metal are wide, tall and bulky and may not be usable for this purpose as they may not go in through the door.) A ramp may be required depending on the setup. The washroom should have the appropriate signboard on the door.

(A) Washrooms for Staff

Washrooms for TIQ (Transgender, Intersex, Queer identified) Staff

Generally there are separate male and female washrooms reserved for staff. Considering that the hospital may have TIQ staff, a beginning may be made where there is at least one separate washroom which is gender neutral and disability friendly. Then depending on the size of the hospital, the number of buildings, number of floors in a building, distance between the buildings, additional gender neutral and disability friendly washrooms may be provided.

(B) Washrooms for Patients / Relatives / Visitors

(i) OPD

TI (Transgender, Inter sex) Patients/Visitors

A small beginning can be made by having **at least one** washroom which is All Gender and Disability Friendly for TI OPD patients, visitors. Then depending on the size of the hospital, number of buildings and floors having OPD, number of floors in a building, distance between the buildings, additional gender neutral and disability friendly washrooms may be provided.

Specimen Collection Washroom

Generally there are either two separate washrooms-
(a) Male and Female washrooms OR
(b) there is only one washroom – All Gender washroom

In cases where there are separate male and female washrooms for specimen collection, an additional washroom which is All Gender and Disability Friendly needs to be created.

(ii) IPD

General Ward

Each hospital has its own practice, but generally, in female general wards, only (female) patients and female relatives are expected to use the washrooms; there are separate washrooms for visitors outside the wards. But this rule may not always work. Example: If the female patient is accompanied by a male relative in the Female Surgical General Ward, he uses the washrooms in the ward (which technically are meant for females only).

In the beginning, each of, at least one male medicine general ward, one male surgical general ward, one medicine female general ward, one female surgical general ward should have one washroom which is gender neutral and disability friendly. It is assumed here that the TI (Transgender, Intersex) patient/s will get admitted to these specific wards.

PATIENT HYGIENE

The general practice is that female House Assistants address the toilet needs of female patients and male House Assistants address the toilet needs of male patients. But this may not always be true; to some extent it depends on staff availability. For changing the beds-sheets, sponging the patient, attending to bed sores there is generally a team comprising of a nurse and house attendant which could be a combination of male/female.

It is seen that male House Assistants prefer to serve males and Transwomen who have male organs and female House Assistants prefer to serve females and Transmen who have female organs.

OPINION
The patient should be given the choice of selecting the gender of the staff for providing these services. The patient should also note that while all efforts will be made/should be made to respect this preference, it may not always be possible as it depends on staff availability.

NOTE OF CONCERN
There have been rare cases where, when a transgender is admitted, the accompanying transgenders insist in taking care of the patient. Transgenders may not have the knowledge and experience in handling the patient in certain circumstances, especially surgical cases and patient with an infectious disease. Patient and accompanying transgenders need to be politely but firmly explained that it is not in the patients interest nor is it in their interest to undertake activities which they are not professionally trained for.

All staff needs to be inculcated into the practice that they have to serve any patient that needs care-taking service. They may have their preferences but there should be no denial of the service or delay in providing the service because of their reservation about the gender/sexuality of a patient.

DIAGNOSTICS AND BASELINE MEASURES

For laboratory tests (especially Endocrine tests) we currently have only male and female baselines for comparison of sample test results. The challenge lies in knowing which baseline to compare with in case of a patient having gender specified as [Other] or [Transgender]. If complete and correct history is not available to the technician / doctor, there is a high possibility of wrong interpretation of the findings.

So, the laboratory technicians should be sent information on biological sex at birth, gender, SAS/SRS status, hormone therapy details. If the sex at birth varies from gender expressed / if there is history of SAS/SRS / if the patient is Intersex / if the patient is on harmone therapy then the doctor in charge of the patient/endocrinologist should interpret the findings based on the complete history.

SAFETY AND SECURITY

POLICY ON SEXUAL HARASSMENT

The hospital's staff and patient's relationship is a fiduciary relationship. In any relationship which is unequal, there is a chance of abuse. As seen from KEM Hospital Pune's policy, it is hence of paramount importance that a gender neutral policy against sexual harassment which applies to staff, consultants, interns, patients, visitors should be in place, with zero tolerance towards sexual harassment.

Prevention of Sexual Harassment At Workplace- Although currently the The Sexual Harassment of Women at Workplace (Prevention, Prohibition, and Redres sal) Act, 2013 covers only women, the staff training on this Act should also cover same sex harassment and sexual harassment of/by LGBTIQ and a clear signal should go out that irrespective of sex, gender, sexual orientation of the victim or perpetrator sexual harassment of any staff, patient, visitor will be strictly dealt with.

Internal Committee for Sexual Harassment

Hospitals have an Internal Committee to deal with sexual harassment of women at workplace. The scope of the policy should be widened and made gender neutral. A strong and clear signal has to go out to everyone that **'there will be zero tolerance to sexual harassment at workplace, by anyone, with anyone'.** This will assist in keeping the patients and staff safe. e.g. **Such a Sex/Gender/Sexual Orientation neutral policy on Sexual Harassment is in place in KEM Hospital.**

EXAMINATION

For the safety of female patients, hospitals generally have a policy that when a female patient is being examined or is undergoing a diagnostic procedure (e.g. Sonography, X-Ray) one female staff or relative is present. The scope of this policy should be widened and made Gender/Sex neutral. This will ensure the safety of the patient and the staff.

Some staff may be concerned that if a transperson is in a private ward, the staff would be open to sexual harassment from the patient. Similar concern is expressed by transpersons too that they are vulnerable to sexual harassment from staff. This scenario is applicable to all patients and all staff irrespective of their Gender/Sex. So measures for prevention of sexual harassment and redress should not be looked at from the narrow prism of a specific gender or specific sex/sexuality.

Bindumadhav Khire

In my long experience, I have come across instances where technicians, doctors have made sexual advances towards feminine gay men and transgenders. I have also come across instances where transgenders have made sexual advances towards doctors. I feel that the policy of zero tolerance towards such practices should apply to ALL.

CCTVs

It is in the interest of overall safety to have CCTVs installed in corridors, stairs, parking and isolated areas.

MANAGING AGGRESSION

There are a few isolated instances where Transgender visitors have displayed aggressive behavior, were very rude to doctors and refused to listen to instructions, ignored visiting hour schedule. It is to be noted that similar instances also occur with visitors/relatives/patients who are not Transgenders. In matters of discipline the same rules apply to everyone and hence training the security, in ways of dealing with visitors and patients who refuse to follow rules or expect special treatment, plays an important role.

A Security Guard

If I encounter an aggressive Hijara group of visitors, I politely explain the situation to their leader. Once the leader agrees with your stand the rest of the group follows the leader. I have never had an occasion where the situation has gone out of control and I had to call additional security.

LINKS

1. ADMINISTRATION

With the addition of the third option [Other] / [Transgender] as gender identifier, it is imperative for Administration, Legal, Personnel department to modify its policies accordingly. The addition of the third option raises certain compatibility issues in the following interactions.

a. Hospital ⟷ Staff
b. Hospital ⟷ Patients/Relatives
c. Hospital ⟷ Third Party

a. HOSPITAL ⟷ STAFF

The policies related to Staff will have to cover the following scenarios when designing policies-

- Person who gets employed in the hospital, is Out about his/her sexuality to the Admin. Dept. but is Closeted to the rest of the staff.
- Person who gets employed in the hospital and is Out to all at the time of joining
- Person who gets employed in the hospital, is in the Closet at the time of joining but later on Comes Out as Gay/Lesbian/Bisexual
- Person who gets employed in the hospital, is in the Closet at the time of joining but later on Comes Out as Transgender or Intersex
- Person who gets employed in the hospital, is in the Closet at the time of joining but later on Comes Out as Transgender or Intersex and starts transition
- Person who gets employed in the hospital, is in the Closet at the time of joining but later on Comes Out as Transgender or Intersex, starts transition and completes it

In the last three instances (especially the last two instances), adjustment and acceptance issues for both the employee concerned and other staff need to be carefully studied and addressed in the policy especially on issues related to gender address, clothing, gender related privileges/perks etc.

b. HOSPITAL ⟷ PATIENT/RELATIVES

The issues related to this section have been covered in the 2 models of inclusion, but an important issue that needs to be underlined is that as far as possible the LGBTIQ inclusion policies with respect to gender identification, non-discrimination, prevention of sexual harassment should be uniform for staff, patients/relatives.

c. HOSPITAL ⟷ THIRD PARTY

(a) REPORTING DATA TO GOVERNMENT

In certain instances the hospital is expected to report certain data to the government- medical, economic or statistical data. The government systems (online or offline) may not have the [Transgender] / [Other] option and compatibility issues may arise.

> **Example 1:** If patient details of a Dengue case is being reported to the Municipal Corporation, and the Municipal Corporation report format does not have option for [Transgender] / [Other].
>
> **Example 2:** Filling out PCPNDT forms for a Transman.
>
> **Example 3:** Birth Certificate / Death Certificate

(b) COLLABORATION WITH THIRD PARTY

All relevant policies need to be shared with each collaborating party. The onus on sharing the relev ant policies to third party lies with the hospital.

2. LAW

Although the NALSA judgment and Transgender Person's Rights Act, 2019 provides a third option 'Transgender', as of February 2020 very few Acts have this change reflected in them / are unclear about their applicability to Transgenders. Hence it is recommended that the legal department be consulted on policy before it is made operational.

Example 1: Workman's Compensation Act, 1923
Definitions section 2(d) does not cover 'other' or 'transgenders' under 'dependants'.

Example 2: Maternity Benefit Act, 1961
The application of this Act to a person identifying himself/herself as a Trans gender is a grey area.

3. INSURANCE

An important thing of concern is that the patient's claim should not be rejected on account of mismatch of sexual/gender identification in their legal documents, hospital records and insurance records.

Most transgender's don't have medical insurance and in cases where they do have, most are listed as either male or female based on their biological sex assigned at birth.

When a hospital records sex/gender of the patient as [Transgender] / [Other] compatibility issues with Medical Insurance companies may arise if the patient has a medical insurance. For example, if a patient has a medical insurance policy where the gender is listed as 'Male', and the hospital records show patient's gender as 'Female' or 'Transgender' the hospital and the insurance company will have to have a mechanism in place which allows this mismatch and does not reject the patient's claim due to such mismatch.

Under NO circumstances should a patient's medical insurance claim be rejected for a mismatch in sex, gender identification.

4. OTHER EXTERNAL LINKS

In addition to those listed above, there are many other external links and collaborations that the hospital works with e.g. Police (filing FIRs), specialized diagnostic facilities / laboratories, contractual firms for security / parking / ambulance services etc. For all such external links, compatibility issues have to be worked out.

It is important that all the external links be identified and listed. The D&I team / Personnel / HR / Admin will need to have meeting/s with core linkage staff of linked institutions, identify issues and potential areas of conflict and identify mutually acceptable solutions.

5. DIGITIZATION

With most medium and large hospitals increasingly going in for digitization of patient records, it is important that software/database compatibility issues be studied in detail. D&I should involve IT personnel when protocol is being created / revised.

There may be many Software Programs, Apps used in a hospital of which some may be designed in-house or designed by an external agency for that specific hospital and some which may have been purchased off the shelf. Change in protocol especially of sex / gender identification has to pass the test of compatibility with all the existing Software Programs and Apps.

If the hospital database accesses an external institution database (e.g. government database) or vice a versa the external software interface links too need to be compatible with the changes being done to the hospital software.

DATA CONFIDENTIALITY
One of the biggest concerns is protecting data of the patient. From the point of preparation of case paper / admission file, care will have to be taken to see that the data is not stolen for studies, research, marketing or misused in any other way. Data leaks of LGBTIQ patients (especially Transgender / Intersex patients) can have serious consequences for the patient and hospital.

BUDGET

This will depend on various factors, namely –

- Number of training sessions
- Domain expertise sought
- Dedicated manpower if any
- Structural changes required if any (e.g. adapting a couple of washrooms to make them gender neutral and disability friendly)
- Adaptation of existing digital systems to the new policy

SUBSIDY

While, so far, hospitals are under no obligations to provide any financial relief in billing to Transgenders, those who are a Charitable Hospitals in Maharashtra or those who receive grants from the Maharashtra State Government have an obligation to provide free of charge certain percentage of beds to patients whose income falls Below Poverty Line (BPL) and provide concessional rates for beds to patients who belong to the vulnerable classes. These clauses may be used to provide financial relief to transgenders in appropriate cases. Appropriate advertising of these subsidies through notices and posters need to be made in local language and posted at prominent places in the hospital.

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ABOUT SAMAPATHIK TRUST AND BINDU QUEER RIGHTS FOUNDATION

SAMAPATHIK TRUST
Trustees: Bindumadhav Khire, Nitin Karani, Tinesh Chopade

Samapathik Trust was founded in September 2002 by Gay activist Bindumadhav Khire. For the past 17+ years Samapathik Trust has worked on issues of advocacy and health of LGBTIQ community. Samapathik Trust was awarded a Survey grant in 2005 by Pathfinder International to do a MSM/TG survey in Pune. In 2008, Samapathik Trust started implementing Pathfinder International's 'Targeted Intervention (TI) Project', for The Humsafar Trust, funded by Bill and Melinda Gates Foundation (BMGF). In April 2012 the project was handed over to MSACS and till mid 2014 Samapathik Trust was funded by MSACS to carry out TI activities in PMC, PCMC region. In addition to the above TIs Samapathik Trust has also implemented other non-government funded projects which are listed below.

NON TI PROJECTS	COMMENT
Surveys	1. Designed and implemented Survey and Mapping exercise for enumeration of MSM/TG in Pune and PCMC for Pathfinder International (2005). 2. Designed and implemented a pilot Survey of Transgenders / Hijras / Jogtas/ Aradis attending 2 Jatras (Fairs) (2014).
Empowerment and Advocacy	1. Pehchan Project This project worked on empowering Trangenders through training, workshops and assisting them in procuring various legal documents.
One Year Advocacy Projects	1. INFOSEM Small Grants Project (2012) for dialogue with various stakeholders – media, counselors, doctors, community. 2. UMAJ- Innovation Grant Project (2014) for sessions/dialogue with various stakeholders - media, counselors, doctors, community. 3. DIVA - Small Grant Project (2016) for dialogue with various stakeholders. Funded by VIIV and The Humsafar Trust. 4. SAMVAD - Small Grant Project (2016-2017) Funded by BARTI (Dr. Babasaheb Ambedkar Research and Training Institute) to dialogue with the Police staff at various Police Stations
One Year Community Outreach Projects- Being Equal Phase 1 Being Equal Phase 2	Two small grants project (Year 2018-2019 and 2019-2020) on working with community and mainstreaming of community issues. Funded by VIIV. Bindumadhav Khire was the consultant to The Humsafar Trust for project implementation.

- Samapathik Trust has been the organizer of-
  - the annual LGBTIQ Pride Walk in Pune from 2011 to 2018.
  - 'Mooknayak' the annual LGBTIQ Marathi Literary Festival for 2 years.
  - the annual 'Advait Pune' International Queer Film Festival at NFAI (Pune) for 5 years.
- The trust has for the first year (2019) brought out the annual Marathi Diwali Ank (magazine) called 'Samapathik' dedicated to LGBTIQ issues.

BINDU QUEER RIGHTS FOUNDATION
Directors: Bindumadhav Khire and Tinesh Chopade

Bindu Queer Rights Foundation was founded on 1st March 2019 for the purpose of working on LGBTIQ awareness, sensitization, training, consultancy and providing financial support to LGBTIQ groups in India and abroad.

In 2019 the foundation started running the Bindumadhav Khire Queer Seed Fund Initiative (which was previously run for 2 years by Bindumadhav Khire as an individual) which provides seed funds to LGBTIQ groups in India.

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ANNEXURE A

The Indian Psychiatric Society's Position Statement on same-sex attraction, orientation, behaviour and life style

Modern medicine and psychiatry, since the 1970's, have abandoned pathologizing same-sex orientation and behavior.[1] The World Health Organization accepts same-sex orientation as a normal variant of human sexuality.[2] The United Nations Human Rights Council values Lesbian, Gay, Bisexual and Transgender (LGBT) rights.[3]

India's Supreme Court recently issued a ruling against human rights by reinstating a law that bans gay sex by restoring section 377 of the Indian Penal Code.[4]* The prevalent circumstances and recent controversies in India suggests the need for clarity and hence this position statement.

The Indian Psychiatric Society recognises universality of same sex expression, across cultures. It holds the position that homosexual orientation per se does not imply any objective psychological dysfunction or impairments in judgement, stability and vocational capability. The Indian Psychiatric Society considers same-sex attraction, orientation and behaviour as normal variant of human sexuality.[5] It recognises the multi factorial causation of human sexuality, orientation, behaviour and lifestyles. It acknowledges the lack of scientific efficacy of treatments, which attempt to change sexual orientation and highlights the harm and adverse effect of such therapies.[5]

Indian Psychiatric Society acknowledges social stigma and consequent discrimination of people with same sex orientations[5-6]. It recognises that the difficulties they face are a significant cause for their distress and calls for the provision of adequate mental health support.[5-6]

Indian Psychiatric Society supports the need to de-criminalise same-sex orientation and behaviour and to recognise LGBT rights to include human civil and political rights[6]. It supports efforts at seeking the repeal of section 377 IPC as the 19th century law has no place in a 21st century democracy.* It supports the legal recognition of same sex relationship, civil unions and marriage, adoption and parenting.[6] It also supports anti bullying legislation anti-discrimination, student, employment and housing laws, immigration equality, equal age of consent law and hate crime laws providing enhanced criminal penalties for prejudice-motivated violence against LGBT people.[6] The Indian Psychiatric Society supports government efforts and encourages parliament to leave a lasting legacy of progress by repealing Section 377 IPC.*

Dr. G Prasad Rao
President Indian Psychiatric Society.

1st March 2016

**In 2018 (two and half years after this statement was released), the Hon'ble Supreme Court of India read down IPC377 to exclude adult, consensual intercourse from its purview.*

References:

[1] American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, III rd edition. Washington, DC: APA 1980.

[2] World Health Organization. International Classification of Disease 10: Classification of Behavioral and Mental Disorders. Geneva: WHO, 1992.

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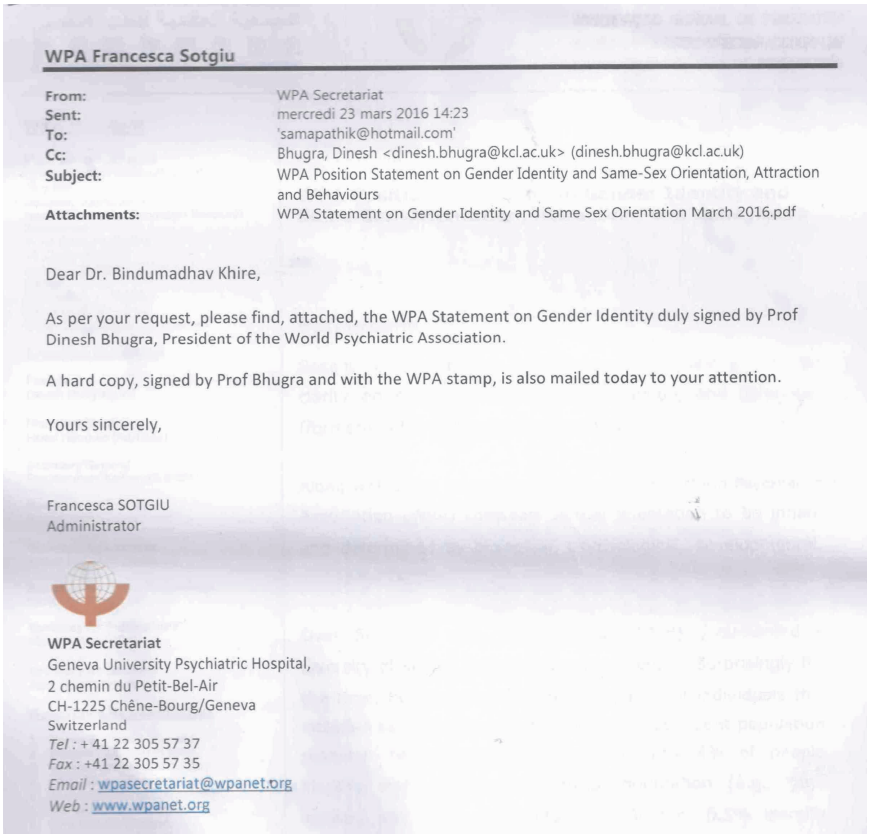
ANNEXURE B

WPA Position Statement on Gender Identity and Same-Sex Orientation, Attraction and Behaviours



WPA Francesca Sotgiu

From: WPA Secretariat
Sent: mercredi 23 mars 2016 14:23
To: 'samapathik@hotmail.com'
Cc: Bhugra, Dinesh <dinesh.bhugra@kcl.ac.uk> (dinesh.bhugra@kcl.ac.uk)
Subject: WPA Position Statement on Gender Identity and Same-Sex Orientation, Attraction and Behaviours
Attachments: WPA Statement on Gender Identity and Same Sex Orientation March 2016.pdf

Dear Dr. Bindumadhav Khire,

As per your request, please find, attached, the WPA Statement on Gender Identity duly signed by Prof Dinesh Bhugra, President of the World Psychiatric Association.

A hard copy, signed by Prof Bhugra and with the WPA stamp, is also mailed today to your attention.

Yours sincerely,

Francesca SOTGIU
Administrator

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WPA Position Statement on Gender Identity and Same-Sex Orientation, Attraction and Behaviours

Background

Recent controversies in many countries suggest a need for clarity on same-sex orientation, attraction and behaviour (formerly referred to as homosexuality).

Along with other international organizations, World Psychiatric Association (WPA) considers sexual orientation to be innate and determined by biological, psychological, developmental and social factors.

Over 50 years ago, Kinsey et al (1948) documented a diversity of sexual behaviours among people. Surprisingly for the time, he described that for over 10% of individuals this included same-sex sexual behaviours. Subsequent population research has demonstrated that approximately 4% of people identify with a same-sex sexual orientation (e.g., gay, lesbian and bisexual orientations). Another 0.5% identify with a gender identity other than the gender assigned at birth (e.g., transgender) (Gates 2011). Globally, this equates to over 250 million individuals.

Psychiatrists have a social responsibility to advocate for a reduction in social inequalities for all individuals, including inequalities related to gender identity and sexual orientation.

Despite an unfortunate history of perpetuating stigma and discrimination, it has been decades since modern medicine abandoned pathologizing same-sex orientation and behaviour (APA 1980). The World Health Organization (WHO) accepts same-sex orientation as a normal variant of human sexuality (WHO 1992). The United Nations Human Rights Council (2012) values lesbian, gay, bisexual and transgender (LGBT) rights. In two major diagnostic and classification systems (ICD-10 and DSM-5), same-sex sexual orientation, attraction and behaviour are not seen as pathologies.(WHO 1993, APA 2013).

There is considerable research evidence to suggest that sexual behaviours and sexual fluidity depend upon a number of factors (Ventriglio et al 2016). Furthermore, it has been shown conclusively that LGBT individuals have higher than expected rates of psychiatric disorders (Levounis et al 2012, Kalra et al 2015) and once their rights and equality are recognized these rates start to drop (Gonzales 2014, Hatzenbuehler et al 2009, 2012, Padula et al 2015)

People with diverse sexual orientations and gender identities may have grounds for exploring therapeutic options to help them live more comfortably, reduce distress, cope with structural discrimination, and develop a greater degree of acceptance of their sexual orientation or gender identity. Such principles apply to any individual who experiences distress relating to an aspect of their identity, including heterosexual individuals.

The WPA believes strongly in evidence-based treatment. There is no sound scientific evidence that innate sexual orientation can be changed. Furthermore, so-called treatments of homosexuality can create a setting in which prejudice and discrimination flourish, and they can be potentially harmful (Rao and Jacob 2012) The provision of any intervention purporting to "treat" something that is not a disorder is wholly unethical.

Action

1.The World Psychiatric Association (WPA) holds the view that lesbian, gay, bisexual and transgender individuals are and should be regarded as valued members of society, who have exactly the same rights and responsibilities as all other citizens. This includes equal access to health care and the rights and responsibilities that go along with living in a civilized society.

2.The WPA recognizes the universality of same-sex expression, across cultures. It holds the position that a same-sex sexual orientation per se does not imply objective psychological dysfunction or impairment in judgement, stability or vocational capabilities.

3.The WPA considers same-sex attraction, orientation and behaviour as normal variants of human sexuality. It recognizes the multi-factorial causation of human sexuality, orientation, behaviour and lifestyle. It acknowledges the lack of scientific efficacy of treatments that attempt to change sexual orientation and highlights the harm and adverse effects of such "therapies".

4.The WPA acknowledges the social stigma and consequent discrimination of people with same-sex sexual orientation and transgender gender identity. It recognizes that the difficulties they face are a significant cause of their distress and calls for the provision of adequate mental health support.

5.The WPA supports the need to de-criminalize same-sex sexual orientation and behaviour and transgender gender identity, and to recognize LGBT rights to include human, civil and political rights.* It also supports anti-bullying legislation; anti-discrimination student, employment and housing laws; immigration equality; equal age of consent laws; and hate crime laws providing enhanced criminal penalties for prejudice-motivated violence against LGBT people.

6.The WPA emphasizes the need for research on and the development of evidence-based medical and social interventions that support the mental health of lesbian, gay, bisexual and transgender individuals.

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The writing group was led by professor Dinesh Bhugra and constituted Drs Kristen Eckstrand (USA), Petros Levounis (USA), Anindya Kar (India), Kenneth R Javate (Philippines)

Geneva March, 2016

Dinesh Bhugra

President
World Psychiatric Association (WPA)

*****_In 2018 (two and half years after this statement was released), the Hon'ble Supreme Court of India read down IPC377 to exclude adult, consensual intercourse from its purview._

ADDITIONAL READING

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