WORKING TOGETHER

Bridging the Gap Between Medical Practitioners and LGBTIQA

FOR FREE DISTRIBUTION

BINDUMADHAV KHIRE

WORKING TOGETHER

Bridging the Gap
between
Medical Practitioners
and
LGBTIQA

Bindumadhav Khire

Published by: Bindumadhav Khire

WORKING TOGETHER

Bridging the Gap
between
Medical Practitioners
and
LGBTIQA

Bindumadhav Khire

ISBN Paperback: 978-93-5620-586-4
Published by: Bindumadhav Khire
Printers: Pratima Offset (Kothrud, Pune)
Published in India. First Edition. May 2022

Contact: bindumadhav.khire@gmail.com

I have written *WORKING TOGETHER: Bridging the Gap between Medical Practitioners and LGBTIQA* to assist medical practitioners, psychologists in delivering quality healthcare services to the LGBTIQA community.

Disclaimer

This book has been prepared for general information only. It is not to be substituted for medical or legal advice or taken as medical or legal advice. While every effort has been made to avoid any mistake or omission, this publication is being sold on the condition and understanding that the authors, collaborators, publishers, and printers would not be liable in any manner to any person or institution by reason of any mistake or omission in this publication or for any action taken or omitted to be taken or advice rendered or accepted based on this work. All disputes are subject to the exclusive jurisdiction of Courts, Tribunals, and Forums at Pune City of the State of Maharashtra only.

Price: ₹ 250/-

NOTE OF THANKS

I am thankful to the following persons for sharing their experiences with me.

- Sourabh ~ Bisexual
- Sumedh ~ Asexual
- Damini ~ Transwoman
- Nikki ~ Transwoman
- Preesha ~ Transwoman
- Vijaya ~ Transwoman
- Joe ~ Transman
- Reese ~ Transman
- Siddharth ~ Transman
- Trinay ~ Transman

I am also thankful to many others who have shared their experiences but do not wish to be named.

I am deeply grateful to Dr. Bhooshan Shukla (Child and Adolescent Psychiatrist, Pune) for guiding me on this book and granting permission to use some part of the Chapter 'The Three-Dimensional Spectrum' from the book 'Basics of Sex, Gender, and Sexuality' (authors Dr. Bhooshan Shukla, Bindumadhav Khire; published by Dr. Bhooshan Shukla, 2021).

I am deeply thankful to Dr. Varsha Jagtap (Endocrinologist, Pune), Dr. Ashish Davalbhakt (Cosmetic Surgeon, Pune), Dr. Sanat Pimpalkhare (Gynaecologist and Obstetrician, Pune), Dr. Bhooshan Shukla (Child and Adolescent Psychiatrist, Pune), Dr. Arvind Panchanadikar (Psychiatrist, Pune), Dr. Umesh Nagapurkar (Psychiatrist, Nashik), Dr. Mridula Apte (Psychologist, Pune) for providing valuable insights.

I am grateful to Dr. Kanchan Pawar, Dr. Jyoti Shetty (Professor & Head Dept. of Psychiatry, Bharati Vidyapeeth (DTU) Medical College & Hospital, Pune), Dr. Manjiri Datar (Associate

Professor Psychiatry, Bharati Vidyapeeth Medical College, Pune), Dr. Arvind Panchanadikar, Dr. Devavrat Harshe (Associate Professor, Dept of Psychiatry, D. Y. Patil Medical College, Kolhapur), Dr. Kaustubh Joag (Psychiatrist, Pune), Dr. Bhooshan Shukla, Dr. Mridula Apte, and Dr. Aparna Pawar (Baramati), for reading the initial draft and providing valuable suggestions.

I am thankful to Dr. Manjeet Santre (Professor & Head Dept. of Psychiatry, PCMC's Post Graduate Institute Yashwantrao Chavan Memorial Hospital, Pimpri, PCMC, Pune) for undertaking a technical review of the book.

My understanding has increased from the presentation by Dr. Armaan Pandey (Psychiatrist and Schema Therapist, Mumbai) in the expert panel discussion "From Gender Dysphoria To Euphoria" at IMA's (Nashik) 'SEXICON' (2021-2022) seminar. I am thankful to him.

I am thankful to Bharati Vidyapeeth (DTU) Medical College & Hospital (Pune) and KEM Hospital (Pune) for giving me the opportunity to work with them on LGBTIQA inclusion at their respective workplaces.

I am thankful to Chandrashekhar Begampure for the cover design and layout and Shobhna S Kumar for copyediting and proofreading.

Last but not least, I am thankful to Adv. Ashish Sonawane (Co founder 'Nyay-Neeti Strategic Legal Consulancy LLP' for the legal guidance.

Bindumadhav Khire
May 2022

TABLE OF CONTENTS

INTRODUCTION

Why this book?

When a youth from the LGBTIQA community in India faces issues related to his/her/their gender or sexuality, they either approach a psychiatrist or psychologist or, in a few cases, their family doctor or gynaecologist. At times the family doctor or the gynaecologist takes matters into their hands and decides the next course of action for the individual. Some family doctors and gynaecologists thoughtfully refer the individual to a psychiatrist or psychologist.

Although many family doctors say they don't see LGBTIQA persons this is not entirely true. Many LGBTIQA community members do not trust their family doctor with issues of gender and sexuality. The LGBTIQA community is all around us. We are just not aware of them; we have not developed the rapport and trust for them to open up to us. E.g., 3% of all men are estimated to be gay. Considering the population of India, this is a large number.

On referral to a psychiatrist/psychologist, they conduct a clinical assessment and recommend the next course of action. For individuals with depression and other mental illnesses, the psychiatrist provides medications and may recommend counseling or therapy.

In suspected cases of Gender Dysphoria (GD), the psychiatrist makes a detailed clinical assessment and interviews relevant persons who know the individual (e.g., family members). The clinical psychologist conducts assessment tests. The psychiatrist evaluates the results and provides a GD certificate.

After obtaining the GD certification, transpersons who want to transition approach the endocrinologist to start Gender Affirming Hormone Therapy (GAHT). After starting GAHT, a

transperson who desires to undergo gender affirmative surgical intervention approaches the plastic surgeon for surgical transition.

So, medical practitioners with various physical and mental health expertise are involved in the healthcare of LGBTIQA individuals. But studying the chain of referrals, I realized that very little cohesive information or guidebooks in the public domain bring all these threads together. I could not find any Indian publications that documented the journey from the LGBTIQA person's point of view from the time of deciding to approach a family doctor or psychiatrist/psychologist to the point the individual steps out of a clinic or hospital at peace with himself/herself/themself.

During this journey, LGBTIQA persons meet many outstanding professionals, while seeking diagnosis and resolution. But, many also meet professionals who are uninformed about these issues and, worse, are insensitive to LGBTIQA persons.

Over the past two decades, I have heard a wide range of experiences narrated by LGBTIQA community members. I understand that a few medical practitioners are knowledgeable, unbiased, and sensitive to LGBTIQA person's needs and circumstances. But, many community members have also experienced extremely distressful, traumatic, homophobic/transphobic behaviors at the hands of medical practitioners. Needless to say, the absence of LGBTIQA affirmative training in the medical curriculum is a significant lacuna, though not the only one.

During this long period, I have also met many LGBTIQA community members who have unrealistic expectations from medical practitioners. E.g. Despite being told that homosexuality or Gender Dysphoria (GD) is not a

disorder/disease, some community members (and their parents), stubbornly continue to demand a 'cure'.

Many transpersons are so desperate and impatient to undergo transition that they do not take time to understand the short-term or long-term consequences of the transition. Many transpersons seek resolution from quacks or resort to unsupervised medications, leading to health risks.

In addition to these problems, many LGBTIQA community members have incomplete and, at times, incorrect scientific information, which gets passed on from one community member to another.

So, I am aware that a significant gap exists between the medical practitioners who are unaware or at times insensitive about LGBTIQA issues and the LGBTIQA community and their parents who have misconceptions or unrealistic expectations.

Many medical practitioners desire to, but do not know how to, work with LGBTIQA persons. So, it falls on them to educate themselves. To do so, the material on LGBTIQA issues, as they are understood in the current environment, needs to be easily available in India.

WORKING TOGETHER: Bridging the Gap between Medical Practitioners and LGBTIQA is my humble attempt to collate and make accessible, information and experiences shared by LGBTIQA friendly and inclusive medical practitioners and LGBTIQA community members, and my own experiences in the field.

> **Dr. Mridula Apte (Psychologist):** *"We all need to constantly update ourselves not just about research literature about the community, but also about legal matters and new policies.*

I 'listen' to our LGBTIQA clients more- they are my best teachers. Their experiences guide me well. I allow a great deal of ventilation. I validate their experience and do not dismiss or trivialize it. I make it a point to sensitively deal with adolescents who report being bi-curious/questioning.

At times I find it useful to help the client focus on other aspects of their personality to get a fuller and comprehensive picture of themselves. This helps raise self-esteem and decrease depression."

Who is this book for?

I have written this book primarily for family doctors, psychiatrists, psychologists, counselors, endocrinologists, gynaecologists, dermatologists, urologists, plastic surgeons, and the LGBTIQA community of India.

I assume the readers know the basic issues related to the three-dimensional spectrum of- Sex, Gender, and Sexuality. For those unfamiliar, I have explained the concept, in brief, in the first chapter. Still, I suggest that, if possible, readers should first go through the book 'Basics of Sex, Gender, and Sexuality' before reading this one.

While writing this book, I am aware that terms, knowledge, and understanding in this field evolve rapidly. The knowledge herein may be outdated sooner or later. But this is what I know for today, and I shall continue to be open-minded about the newer understanding of sex, gender, and sexuality as it evolves.

Prefix and Pronouns

There is an evolving terminology with regards to the honorific desired by non-binary individuals and those who don't wish to be identified by gender. E.g. the gender-neutral honorific 'Mx'.

Some non-binary individuals desire the use of the pronouns 'they'/ 'them' instead of 'he'/'him' or 'she'/'her'. In addition, quite

a few, new pronouns (called neo-pronouns) have been created. For the sake of simplicity, I have not devolved into these linguistic issues.

Important Note

The cost of Assisted Reproductive Technology procedures, Gender Affirmative Hormone Therapy (GAHT), transition surgeries stated in this book are estimates only. The LGBTIQA person must inquire about the expected cost with the concerned medical practitioner/team when planning transition.

ABBREVIATIONS

AFAB	Assigned Female At Birth (A transperson who has been assigned the female gender at birth)
AMAB	Assigned Male At Birth (A transperson who has been assigned the male gender at birth)
DD	Differential Diagnosis
DSM-V	Diagnostic and Statistical Manual of Mental Disorders. 5th Edition.
GD	Gender Dysphoria
GAHT	Gender Affirming Hormone Therapy
ICD-11	International Classification of Diseases. 11th Revision.
ICTC	Integrated (HIV) Counseling and Testing Centre
IEC material	Information-Education-Communication material
IPC	Indian Penal Code
IPS	Indian Psychiatric Society
MSM	Men who have Sex with Men
NGO	Non-Governmental Organization
STI	Sexually Transmitted Infection
TG	Transgender
VD	Venereal Diseases (STIs)
WPA	World Psychiatric Association

TERMS USED

TERMS ASSOCIATED WITH BIOLOGICAL SEX

Biological Sex	Is used to represent a person's anatomical/gonadal/chromosomal sex.
Intersex	An intersex person is born with sexual/reproductive anatomy and/or chromosome patterns that do not fit the typical anatomy of a male or female. This may be apparent at birth or become so later in life.
Sex Reassignment Surgery (SRS)	Surgical intervention on an intersex baby, to remove sexual/reproductive organs which are not congruent with the gender chosen by the parents/shape the sexual/reproductive anatomy of the intersex baby to make it congruent with the gender chosen.

TERMS ASSOCIATED WITH GENDER IDENTITY

Gender	Refers to being 'masculine' or 'feminine' and corresponding social roles and behaviors.
Gender Identity	Refers to self-identification through self-experience as a male or female or both or neither.
Agender	A person who does not experience either male or female gender identity.
Cisgender	A person whose biological sex is in sync with the person's gender identity. e.g., the body of a male and gender identity of a

	male; the body of a female and gender identity of a female.
Transgender	A person whose gender identity is different from their biological sex.
Pangender	A person whose gender identity is not limited to one gender. i.e. a person who experiences multiple gender identities (pan=multiple).
Genderqueer	Used by individuals who characterize their gender identity as neither male nor female, as both, or as somewhere in between.
Gender Fluid	It refers to change over time in a person's gender identity or gender expression, or both. The change might be in expression, but not identity, or in identity, but not expression. In certain cases, both expression and identity might change together.
Transsexual	A term used in varying contexts. Sometimes it is used interchangeably with transgender. At times it is used to denote transgenders who have undergone transition. Some transpersons find the word offensive and hence the use of the word is to be avoided.
Gender Dysphoria	A medical term denoting a person who strongly and consistently indicates gender identity different from their biological sex. Gender Dysphoria includes a strong desire to be treated as per self-gender identification and a desire

	to be rid of one's biological sex characteristics.
Transphobia	Dislike and/or fear of transgender persons.
Non-binary	Non-binary is an umbrella term that describes a gender identity that is neither exclusively male or female.
Dead Naming	A transgender person will have a birth name given by their family. As they realize that they experience a gender other than the one given at birth, some decide to change their name according to their gender experience. The name assigned at birth is no longer used and is a 'dead name'. The use of the dead name (‘dead-naming’) should be avoided. Calling the person by the dead name can be hurtful, insulting.
She-male	A term primarily used in pornographic industry to describe a transwoman with male genitalia combined with female secondary sex characteristics e.g. breasts developed through hormone therapy/ breast implants. So the appearance of the top half is female, and the bottom half is male. Many transpersons regard the term 'she-male' as offensive and hence the use of the word is to be avoided.

TERMS ASSOCIATED WITH SEXUAL ORIENTATION

Sexual Orientation	The scientifically accurate term for an individual's enduring physical and emotional attraction to members of the

	same and/or opposite sex or neither. It includes Lesbian, Gay, Bisexual, Heterosexual (Straight), and Asexual orientations.
Asexual	('ace' for short) A person who does not feel sexual attraction to a person of any gender.
Bisexual	A person who can form enduring physical and emotional attraction to men and women. Bisexual persons may experience this attraction in differing degrees over their lifetime.
Heterosexual/ Straight	A person whose enduring physical and emotional attraction is to people of the opposite sex only.
Homosexual/Gay	A person whose enduring physical and emotional attraction is to people of the same sex only.
Lesbian	A woman whose enduring physical and emotional attraction is to other women only. Aka Gay woman.
Butch Lesbian	A woman whose enduring physical and emotional attraction is to other women only and presents and behaves in a masculine manner. Her gender identity remains female.
Femme Lesbian	A woman whose enduring physical and emotional attraction is to other women only and whose appearance and behaviors are traditionally feminine.
Pansexual	A person who is sexually attracted

	towards people regardless of their biological sex or gender identity.
Homophobia	Dislike and/or fear of Gays and Lesbians.
Biphobia	Dislike and/or fear of Bisexuals.

OTHER COMMON TERMS

Closeted	A person who is not open about his/her/their biological sex, sexual orientation or gender identity.
Coming out	Revealing your biological sex, gender identity or sexuality to someone.
Queer	At times, it is used as an umbrella term to include the entire LGBTIA spectrum. Sometimes, it means a person who does not fit the traditional binary gender/sexuality framework. At times, it implies someone who is questioning their gender/sexuality.
LGBTIQA+	L-Lesbian, G-Gay, B-Bisexual, T-Transgender, I-Intersex, Q-Queer, A-Asexual. '+' indicates other sexually and gender diverse people.
DSM-V	Diagnostic and Statistical Manual of Mental Disorders. 5th Edition. It is an authoritative guide to the assessment and diagnosis of mental disorders published by the American Psychiatric Association.
ICD-11	International Classification of Diseases.

11th Revision. It is a globally used diagnostic tool for epidemiology, health management, and clinical purposes. It is maintained by World Health Organization (WHO).

OVERVIEW

Introduction

Dr. Bhooshan Shukla: *"A person's sex, gender, and sexuality are three distinct parts of the same person. Given below is a simplified overview so that it is easily understood. Admittedly, it may not be 100% accurate."*

- The anatomy of a person defines Biological Sex.
  - o Gonads of boys and girls and their functioning. Whether the individual has testes or ovaries, this is the Gonad dimension.
  - o Whether the individual has XX sex chromosomes or XY sex chromosomes, or some other pattern of sex chromosomes, this is the Genotype dimension.
  - o Presentation of the external genitalia, this is the Phenotype dimension (physical dimension).
- Gender Identity is the self-identification of gender by a person.
  - o After attaining puberty, whether the person identifies self-gender as male or female or both or none is the Gender Identity dimension.
- Sexual Orientation is discovered and may evolve.
  - o After puberty, whether the person is sexually attracted to men only or women only or both men and women or neither is the Sexual Orientation dimension.

The three dimensions of Biological Sex, Gender Identity, and Sexual Orientation are not related to one another. A majority of people have unity in all these dimensions. It means the individual's chromosomes, genitalia, gender identity, and sexual orientation are congruent. This uniformity or congruence is being male or female.

None of these dimensions is discrete; each of these dimensions is a continuum. Medical science is aware that there are many grey areas in these dimensions, so many a times even specialists do not know much about these grey areas. In fact, no one should claim that he/she/they know everything about these complexities.

Many biologically *male* persons experience the world as a *male* (gender identification is male) and only experience sexual attraction for *women*. Therefore, their biological sex/gender/sexuality identity is represented on the three-dimensional graph as: Male(biological Sex), Male(gender identity), sexual attraction for Females. These persons are also known as cisgendered heterosexual men. The term *cisgendered* means their biological sex and gender identity is consistent with society expectations. I.e., anatomically male and gender identity male or anatomically female and gender identity female.

Many biologically *female* persons experience the world as a *female* (gender identification is female) and only experience sexual attraction for *men*. Therefore, their biological sex/gender/sexuality identity is represented on the three-dimensional graph as: Female(biological Sex), Female(gender identity), and sexual attraction for Males. These persons are also known as cisgendered heterosexual women (Ref. Figure 1).

Similarly, there are infinite other possibilities.
Eg1: Biological Sex: *Male*, Gender Identity: *Male*, Sexually Attracted to: *Men*. I.e., Gay.
Eg2: Biological Sex: *Male*, Gender Identity: *Female*, Sexually Attracted to: *Men*. I.e., Transwoman who is sexually attracted to men.
Eg3: Biological Sex: *Intersex* (ambiguous genitalia), Gender Identity: *Genderqueer*, Sexually Attracted to: *Females.*
And so on…

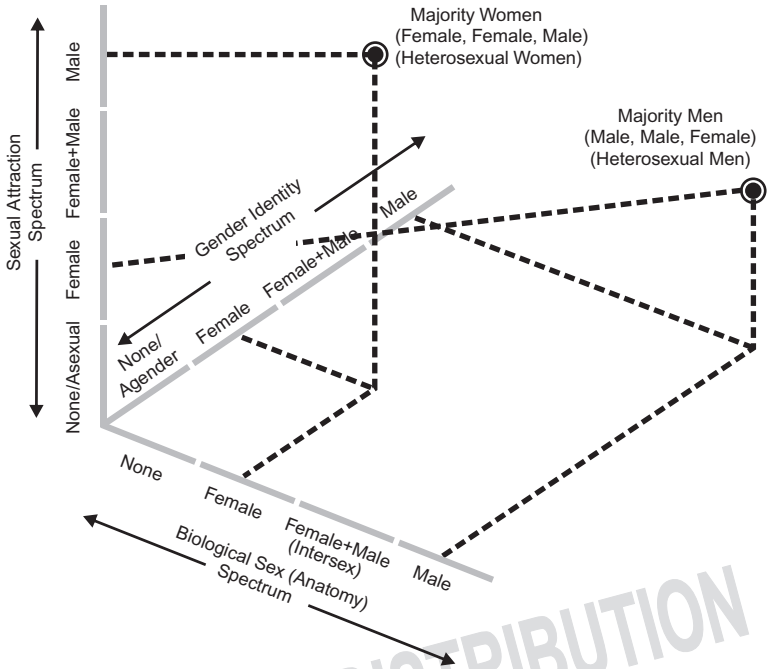


Figure 1: Cisgendered, heterosexual men and women mapped on the three dimensional graph of Biological Sex, Gender Identity, and Sexual Attraction

In some cases, persons self-identify as Gender Fluid. Gender fluidity refers to a change of gender identity and/or gender expression over time. So, it needs to be remembered that, while for the sake of understanding, we simplify the sex, gender, and sexuality of a person as a point on a three axis-plot, in reality, it is more complex for some persons.

What is Normal?

As far as sex, gender and sexuality are concerned, cisgendered heterosexual males and cisgendered heterosexual females are the majority. Tragically, our society interprets that, cisgendered, heterosexual persons, who are a majority population, is the only normal. I.e. their behaviours dictate what the rest of society must follow or imitate.

The implication is that anyone not part of the majority, i.e. not identifying as either of the two binaries nor behaving as per sexual and/or gender norms is abnormal. And hence any anatomical variation, gender identity at variance with the gender assigned at birth, and sexual orientation other than heterosexual have been considered an abnormality, a disorder.

Medical Understanding

Medical science has long considered being gay or transgender a disorder that needs to be 'cured'. Various inhuman experiments have been done on innumerable gay and transgender people to 'straighten' them, without success. This perception started to change in the mid-seventies.

Homosexuality

- In 1973, the American Psychiatric Association removed homosexuality from its official list of mental disorders.
- In 1975, the American Psychological Association supported the (above) stand of the American Psychiatrist Association.
- In 2013, DSM (5th Edition) removed homosexuality from its list of disorders.
- The latest version of ICD (11th Revision) (maintained by WHO) has removed homosexuality from its list of disorders.

Discrimination Against Homosexuals[1]

[Adopted by the APA Council of Representatives on January 24-26, 1975]

1. The American Psychological Association supports the action taken on 15th December 1973 by the American Psychiatric Association, removing homosexuality from that Association's official list of mental disorders. The American Psychological Association, therefore, adopts the following resolution:

Homosexuality per se implies no impairment in judgment, stability, reliability, or general social and vocational capabilities; Further, the American Psychological Association urges all mental health professionals to take the lead in removing the stigma of mental illness that has long been associated with homosexual orientations.

2. Regarding discrimination against homosexuals, the American Psychological Association adopts the following resolution concerning their civil and legal rights:

   The American Psychological Association deplores all public and private discrimination in such areas as employment, housing, public accommodation, and licensing against those who engage in or have engaged in homosexual activities and declares that no burden of proof of such judgment, capacity, or reliability shall be placed upon these individuals greater than that imposed on any other persons… (abridged)

Gender Dysphoria

- The term 'Gender Identity Disorder' that was used in DSM (4th Edition) was changed to 'Gender Dysphoria' (Code 302.85) in DSM (5th Edition) (year 2013).
- The latest version of ICD (11th Revision) has redefined 'Gender Identity Disorder' (used in the 10th Revision- Code F64.9) to 'Gender Incongruence'. It has moved Gender Identity Issues from the Chapter Mental, Behavioural and Neurodevelopmental Disorders to Conditions Related to Sexual Health (Chapter 17)- Gender Incongruence (Codes HA60-HA6Z).

This is acceptance of evidence that gender diverse identities are not conditions of mental ill-health.

Legal and Medical Developments in India

In 1984, ABVA (AIDS Bhedbhav Virodhi Andolan (Delhi)) filed a Public Interest Litigation (PIL) on the constitutional validity of Section 377 IPC (which criminalized adult consensual same-sex intercourse).[2] The petition was not followed up.

In 2001, another PIL was filed in the Delhi High Court by Naz Foundation (India) Trust on the constitutional validity of Section 377 IPC.[3] On 2nd July 2009, the Delhi High Court ruled that Section 377 IPC was unconstitutional to the extent it criminalized adult, consensual, same-sex intercourse. Conservative and religious bodies appealed the decision.

In 2013, independent of the Indian Psychiatric Society (IPS), thirteen psychiatrists from all over India filed an Intervention, in the Supreme Court, on behalf of the gay community. Six of them were from Pune- Dr. Devendra Shirole, Dr. Bhooshan Shukla, Dr. Arvind Panchanadikar, Dr. Soumitra Pathare, Dr. Kaustubh Joag, and Dr. Raman Khosla.

From 2001 to 2013, at no point did the IPS file any mental health intervention on the adverse impact of Section 377 IPC on the mental health of the gay community.

On 11th December 2013, the Supreme Court of India reversed the Delhi High Court Judgment of 2009, effectively re-criminalizing adult, consensual same-sex behaviors.[4] This was a significant setback for the LGBTIQA community.

In March 2016, responding to my (Bindumadhav Khire) written request, the former president of the IPS, Dr. G Prasad Rao, and the former president of the World Psychiatric Association (WPA), Dr. Dinesh Bhugra, promptly provided me with written position statements of the professional bodies on sexual orientation.[5][6]

The highlights of these official statements, paraphrased below, are:

- Gay, Lesbian, Bisexual sexual orientations are normal variants of human sexuality and probably innate.
- Any attempts to change a person's sexual orientation (e.g., from gay to straight) or gender identity is unethical. No such 'cures' are possible.
- People whose identities lie outside the cisgendered, heteronormative norms, i.e., LGBTIQA, have a larger than average prevalence of mental health issues. The frequency and severity go down in an accepting and inclusive environment.
- Society must make efforts to understand and accept their sexuality and gender and create a conducive environment where LGBTIQA persons can flourish.

Soon after, the former president of IPS, Dr. Ajit Bhide, too provided a written statement supporting the reading down of Section 377 IPC to exclude adult, consensual same-sex intercourse from its purview.

On 6th September 2018, a five-judge Constitution Bench of the Supreme Court unanimously declared that Section 377 IPC was unconstitutional to the extent it criminalized consensual, adult same-sex intercourse.[7] This is a landmark judgment for gay rights.

Current Medical Stand

The bottom line is that medical practitioners have to focus their work on understanding sex/gender/sexuality, educate the LGBTIQA individual, and help them accept it.

Parents of gay and lesbian persons often insist on 'curing homosexuality.' It is not possible to do so, and any such hopes and expectations must be laid to rest as soon as possible.

Similarly, in the case of Gender Dysphoria, the only way to

alleviate the individual's distress is to assist them in accepting their gender. Further, if they so desire, the medical practitioner must help the individual in the transition process, after the individual reaches the age of majority (has completed 18 years of age).

Medical practitioners also play an important role in educating and assisting the LGBTIQA person's parents in accepting their sex, gender, and sexuality as natural and not insist on a traditional form of family, e.g., heterosexual marriage, etc.

Statistics

In India, there have been no reliable statistical surveys done to determine the percentage of the population who identify as LGBTI. Statistics quoted below are estimates across the world.

- around 3% of all men are gay; 1% of all women are lesbians.[8]
- around 1 in 11,000 men identify as other gender.[9]
- around 1 in 30,000 women identify as other gender.[9]
- less than 2 out of every 10,000 births are intersex births.[10]

References

[1] Conger, J.J. (1975). Proceedings of the American Psychological Association, Incorporated, for the year 1974: Minutes of the annual meeting of the Council of Representatives. American Psychologist, 30, 620-651.

[2] ABVA (AIDS Bhedbhav Virodhi Andolan) v/s Union Of India and Ors. WP (C) No. 1784/1994.

[3] Naz Foundation (India) Trust v/s Govt. of NCT of Delhi and Ors. WP (C) No. 7455/2001.

[4] Suresh Kumar Koushal and Anr v/s Naz Foundation & Ors Civil Appeal No. 10972/2013 arising out of SLP (C) No. 15436/2009.

[5] The Indian Psychiatrist Society's (IPS) Position Statement on Same-sex Attraction, Orientation, Behavior, and Lifestyle. March 2016. The Position Statement is provided in appendix A of the book: Basics of Sex, Gender, and Sexuality. Authors Dr. Bhooshan Shukla and Bindumadhav Khire. Published by Dr.

Bhooshan Shukla. 2021.
[6] The World Psychiatrist Association (WPA) Position Statement on Gender Identity and Same-Sex Orientation, Attraction, and Behaviours. March 2016. The Position Statement is provided in Appendix B of the book: Basics of Sex, Gender, and Sexuality. Authors Dr. Bhooshan Shukla and Bindumadhav Khire. Published by Dr. Bhooshan Shukla. 2021.
[7] Navtej Singh Johar v/s Union of India. WP (Crl) No. 76/2016.
Judgment dated 06th September 2018.
Coram: Hon'ble Dipak Misra, CJI, and Justices A. M. Khanwilkar, Rohinton F. Nariman, J, Dr. D. Y. Chandrachud, Indu Malhotra.
[8] Shorter Oxford Textbook of Psychiatry. Michael Gelder, Richard Mayou, Philip Cowen. 4th Edition. Chapter 19.
... Subsequent estimates suggest that a more accurate figure may be nearer 3% of men and 1% of women are exclusively homosexual. (Gagnon and Simon, 1973; Laumann et al, 1994).
[9] Kaplan and Sadock's Synopsis of Psychiatry. 11th Edition. Wolters. Kluwer. Chapter 18. Gender Dysphoria.
The estimated cases of Gender dysphoria in adults emanate from European hormonal/surgical clinics with a prevalence of 1 in 11,000 male-assigned and 1 in 30,000 female-assigned people. DSM-5 reports a prevalence rate ranging from 0.005 to 0.014 percent for male-assigned and 0.002 to 0.003 percent for female-assigned people.
[10] How common is Intersex? Dr. Leonard Sax. Journal of Sex Research. August 2002.

PART I: FRAME OF MIND

THE LGBTIQA PERSON

> **Transman**: *"I wanted to get a Gender Dysphoria assessment done but was terrified of approaching a psychiatrist. Whom should I approach? Would the doctor be trans-friendly? Would he be knowledgeable about the issue? Would he make fun of me? Humiliate me?"*

Introduction

When a gay or transgender person steps into a clinic, they are carrying a lot of baggage. Some of it is related to their sexuality or gender, some related to their previous experiences at the hands of other doctors.

The LGBTIQA Person

An LGBTIQA individual has some unique and hostile stressors in addition to the general stressors that impact all of us. (Meyer's Minority Stress Theory)[1] These stressors are-

1. Internal stressors (internalized homophobia): E.g. Am I abnormal? Am I a sinner? Am I a pervert? Etc.
2. External stressors: Experiencing direct and indirect discrimination based on sexuality/gender or perceived sexuality/gender. E.g. Denial of medical treatment on the basis of sexual orientation, gender identity Etc.
3. Victimization stressors (expectation of rejection): Should I reveal my sexuality/gender to a person? What will happen if I do so? Will I face humiliation, discrimination, violence?

To understand these stressors, let's try to step into and understand a typical gay or transgender person's closeted world.

Gays and Lesbians

As the gay boy/girl reaches adolescence, they start feeling sexual attraction for members of their own sex. While their classmates and friends share obscene jokes and ogle at members of the opposite sex, gay adolescents feign sexual interest in the opposite sex. Many are intuitively aware that telling others about their sexual attraction would be unwise. They learn to

keep the secret and take the first step of living a hypocritical, dual lifestyle.

For some adolescents, same-sex attraction is a passing phase. For others, it is not so, and as years go by, realization dawns that their sexuality is here to stay. And they are afraid. Afraid of what life has in store for them. Fearful of how society will treat them if the secret gets out. Homophobic comments, and jokes, from friends, family members, negative portrayals of gay men in films, television and media feed into this vulnerability. They start feeling ashamed of themselves, hating themselves.

Many gay persons come from a conservative background, where any non-heteronormative gender/sexuality is swiftly punished. Some who come from a background of religious dogma regard themselves as sinners. They are extremely insecure and vulnerable.

> **Gay male:** *"Mai Muslim hu.. Hamare dharm me gay hona haram hai. To mai aap ko mera asli naam nahi bataunga."* (I am a Muslim. Being gay is a sin in our religion, so I will not reveal my identity to you.)

In addition to these stressors, if they are feminine, they face ragging and bullying in school; at times, sexual assault too.

All of this adversely affects their mental health. They know that it would deeply hurt their parents if they came to know the truth. So, with this guilt gnawing at them day in and day out, they become obsessed with their sexuality. Carrying this burden which they cannot share with anyone, each day becomes a nightmare.

The consequences of this hostile environment are varied. For some, it leads to severe depression and suicide ideation. Some try to die by suicide. Many lose interest in their hobbies, studies, and career. Some take refuge in drug use.

Some carry internalized homophobia and may be extremely hostile to gay persons. This hostility in words and actions is intentionally expressed to distance themselves from the gay community.

Many gay men, afraid of facing the consequences of coming out to their parents and society about their sexuality, marry and settle down in a heterosexual relationship. That is the beginning of a nightmare. Imagine the trauma if they are unable to have intercourse with their wife. Imagine the trauma if they are able to have intercourse with their wife- they will have to be physically and emotionally intimate, for decades, with a person whose touch is revolting. In the case of a lesbian, after the marriage, the husband is, to put it bluntly, raping her; she unable to say that the male touch is repellent. Imagine the trauma if you were in their shoes.

If gay men seek same-sex relations and their partner comes to know of their identity, they risk being blackmailed. I have come across hundreds of cases where gay men have been blackmailed. Despite my willingness to accompany them to the police station, most are too ashamed and terrified to approach the police. And so stressors pile up, one upon the other.

Transpersons

Transpersons with Gender Dysphoria (GD) may feel at a very early age that they are in the 'wrong body', although they are unable to understand its implications. They try to dress, talk, behave in the manner of their experienced gender and not in the manner the society expects them to (i.e., the gender assigned to them at birth). Noticing this change, parents try to discipline and punish them, to 'correct' them.

This is especially true of boys whose gender expression is female.

> **An angry *tritiyapanthi*'s father:** *"mazha ghari chakka janmala alai."* (We have a eunuch born in our family)

Boys with feminine gender expression are very vulnerable to teasing, ragging, bullying, and sexual assault. Frustrated at this inhumane treatment, most drop out of school.

Many boys whose gender identity is not male eventually leave their hostile family environment to join the Hijra community. Out of the mainstream, their only means of livelihood are asking for alms (*Mangti*), dancing at weddings and blessing the groom. Some become sex workers. Having insufficient knowledge of safe sex issues, some end up getting infected with HIV.

There are a few exceptions, where the transperson and their parents approach an LGBTIQA aware and sensitive psychiatrist. Under the psychiatrist's sensitive guidance, the parents make efforts to understand and accept the transperson and eventually provide support for transition.

The masculine behavior of girls whose gender identity is male (transmen) is initially ignored. In fact, some may find support from their fathers- "he is my 'boy'". But as the person reaches adolescence, the mother starts fretting that its high time their daughter starts behaving like a woman. Instead, the 'daughter' is distressed with the monthly menstrual cycle, distressed at the growing breasts. The mother tries to explain the process of nature, to the daughter but this does not solve the problem, and finally, the mother approaches the family doctor.

Approaching the Medical Practitioner

When a non-LGBTIQA person approaches a medical practitioner, they place a lot of trust in the medical practitioner. They assume that the medical practitioner is an expert in the field and has experience treating other patients with similar ailments. Therefore, the professional's advice is considered authoritative and sacrosanct.

When it comes to an LGBTIQA person, this trust is not always implicit. Some LGBTIQA persons and their families completely trust the medical practitioner and follow their advice to the T. If the doctor gives a wrong advice and the LGBTIQA person (and

parents) follow it, it leads to incalculable harm. The most common of such wrong advice is the 'heterosexual marriage 'cure".

I have come across cases where the youth shows a lot of courage in coming out as gay to his family. The family consults their family doctor, who advises them,

> *"Get him married; everything will turn out all right. Once he gets intimate with his wife, he will forget all about men."*

And on this sage advice parents marry him to a woman. Later on, they hear of me from someone and approach me. They are deeply upset that the marriage is not working.

> **Parent:** *"We spoke to our family doctor. We trusted him, took faith in his advice and got my son married. Now, it's six months after marriage, but my son cannot have sex with his wife. She has gone back to her parents."*

Many medical practitioners strongly believe that a male is sexually attracted to another male because they have not had the heavenly pleasure of being with a woman. On similar lines, they also believe that a female is sexually attracted to another female because she hasn't yet had the heavenly pleasure of being with a man. And so, they wrongly believe that heterosexual marriage is the cure of all 'such ills'. Medical practitioners, psychologists, counsellors should strictly refrain from giving such disastrous advice.

While some LGBTIQA persons trust the medical practitioner, there are many who harbour deep suspicion. This is especially so, if they visit the doctor for the first time.

> **Gay male:** *"I wanted treatment for my depression but kept on procrastinating. Is the psychiatrist gay-friendly? Should I disclose my sexuality to the doctor?"*
> (He procrastinated for six months before mustering the courage to approach a psychiatrist.)

Unless the medical practitioner makes efforts to send out inclusive signals in a disarming way, the distrust continues, and there is a higher likelihood of the LGBTIQA person dropping out. In turn, this may result in the individual getting into the 'trial-and-error' approach- approaching different medical practitioners, which is time-consuming and expensive.

Establishing Trust

Dr. Kanchan Pawar: *"Medical practitioners should note that it is not easy for the LGBTIQA person to open up and talk frankly or candidly about their sexual preferences/gender identity in the first visit due to a lack of trust and rapport. They might initially 'tailor' their responses to sound 'more acceptable'. For example, they might not state that they like to cross-dress privately or are bisexual. It is vital to put the person at ease, ensure them upfront about privacy and confidentiality, and make them aware that intimate questions will be asked. It is of utmost importance that queries posed by doctors be answered honestly for an accurate diagnosis. LGBTIQA persons might open up in the second or third consultation after sufficient rapport has been built up. So it is essential to keep an open mind."*

Prejudice and Discrimination

For many closeted LGBTIQA persons, the medical practitioner is the first person they disclose their secret to. And so, in this first outing, they are at their most vulnerable. It is unimaginably devastating for the individual if they face discrimination or are treated insensitively. The number of instances where LGBTIQA persons have faced this trauma is too many to list here. A couple would suffice.

Transwoman: *"The doctor asked me to take my clothes off in front of everyone in the OPD. I refused. He said, 'How will I know the cause if you don't?' The female doctors standing around him started laughing. I removed all my clothes. In the end, as I was about to leave, the doctor commented, 'He is not a 'giver' but a 'receiver''. You have no idea of the shame I felt at the time. I was humiliated and terrified of approaching a doctor after that experience."*

Gay male: *"I heard him (a renowned 'sexologist') give a public talk. He made LGBT inclusive statements, and I thought he was inclusive. But when I met him at his clinic, he said I was abnormal, and he could make me straight."*

Transman: *"He (psychiatrist) said, 'You have come for a GD certificate. Tell me, how do you have sex with a woman?' I was shell-shocked and tried to explain to him how my gender assigned at birth was distressing for me. Still, he insensitively kept on asking the same thing over and over. later on, when my parents approached him to find out whether my gender identity could be changed to a woman, instead of taking my side, he said, 'It's doable.' This was such a traumatic experience for me. Why do doctors torture the tortured?"*

With such experiences, the LGBTIQA person

- drops out, or
- anxiously approaches another medical practitioner and in this way, is statistically more likely to encounter another unaware/phobic medical practitioner, or
- buckling under pressure from parents pretends to be 'cured'

With such traumatic experiences, their self-esteem takes a further beating. They hate themselves even more and are more likely to end up with severe depression or suicide ideation. Building on their experiences, the LGBTIQA community has

started building informal databases on which medical practitioners are to be strictly avoided.

Positive Feedback

When a medical practitioner treats the LGBTIQA person with sensitivity, dignity, and respect, it becomes one of the most defining moments in the LGBTIQA person's life. Here is a medical practitioner who accepts them as normal, does not discriminate against them, accepts them as they are, and is a sensitive witness to their ordeal.

Many LGBTIQA persons make it a point to thank me for referring the person to the 'right' medical practitioner (especially when they are emotionally exhausted after repeated bad experiences). Some of them make it a point to refer their LGBTIQA friends to that medical practitioner.

Lesbian: *"Sir, you referred me to the right doctor. He was so sensitive and understanding. Frankly, I was anticipating a bad experience, and this came as a pleasant surprise."*

Gay male: *"He (doctor) is quite cool... and well aware. I took my dad to meet him. He has spoken to my dad. My dad continues to be unhappy, but he is no longer pushing me to marry a woman. What a relief."*

Transwoman: *"The psychiatrist was very knowledgeable. She was so patient and accepting. I relaxed and felt I could share everything with her without fear. If anyone from the trans community asks for a reference, I will definitely refer the transperson to this doctor."*

Gay male (with anal warts): *"Sir, I was so ashamed of going to the doctor(Dermatologist) you had recommended. I was worried he would mistreat me. But he was not judgmental at all. He provided treatment and*

gently stated that I should undergo an HIV test and practice safe sex (use of condoms). So can you give me a referral to a good (non-judgmental) HIV testing centre for a HIV test?"

References

[1] Meyer Ilan H. Minority stress and mental health in gay men. Journal of Health and Social Behaviour. 1995, Vol.36 (march):38-56.

PARENTS OF LGBTIQA PERSONS

Parent: *"Amhi tuzha sathi yevhda kela, tuzha kadun aaj var amhi kadhi kahi magitla nahi. Yevhdhi ekach magni ahe, ki tu lagna kar."* (We have done so much for you. Todate, we have never asked anything from you. Our only wish is that you marry.)

Introduction

I cannot overemphasize that parental support to an LGBTIQA youth is an extremely important factor in their wellbeing. In my extensive experience in this sector, I have seen that youths with parental support are far happier, and more content than those who face rejection or consistent denial from their parents. So wherever possible, working with parents is as important as working with the LGBTIQA person.

LGBTIQA Unaware Parents

Mother of a Gay youth: *"But how can he be gay? I had bathed him when he was a baby. He has male organs".* (She was under the impression that gay men have ambiguous genitals, i.e., they are intersex.)

As society and laws become more LGBTIQA inclusive, medical practitioners are more likely to see cases where the LGBTIQA youth is very comfortable with his/her/their gender/sexuality. The youth comes out to the parents, but the parents cannot comprehend the issue, and so they approach a medical practitioner for guidance.

Many parents are from a generation where LGBTIQA issues were never discussed or reported in the press. They are likely unaware of the LGBTIQA spectrum. With changes in law and a more liberal media, these issues are slowly getting mainstreamed in recent times.

So, it is crucial to explain to parents the three dimensional representation of Sex, Gender, and Sexuality and assist them in understanding where their child fits in this representation. They should be given time to understand this and think it over. More

than one session may be required for this.

Misunderstanding about LGBTIQA issues are prevalent in our society. Many parents only understand three terms- Male, Female, and Hijra. As far as the term Hijra is concerned, some parents define it as 'not men' but cannot explain the meaning. Some believe they have ambiguous genitals. Some believe they have no genitals at all. Some have not thought about it at all. If parents are from tribal areas, there is a possibility that they may not even know the term Hijra.

Stages in Acceptance

From the day of the birth of the child, parents traditionally plan the future of their child. They assume and expect their child to be cisgender and heterosexual. So their dreams about their child are tailored accordingly. When their son or daughter comes out as gay or transgender, it shakes their very foundations.They suddenly find their world turned topsy turvy, their dreams in tatters. They grieve for their child; they grieve for their dreams which will forever remain unfulfilled. It takes some time, for them to come to terms with reality.

As we are aware, the Elisabeth Kubler-Ross scale of grief outlines five stages-

- Denial (this is not true, this is not happening),
- Anger (why me, why has fate singled me out?),
- Bargaining (searching for means to change- 'Conversion Therapy'),
- Depression (coming to the conclusion that there will be no change)
- and finally Acceptance (I accept him/her/they from the bottom of my heart).

Some parents remain in denial. They refuse to face facts. And as long as parents are in denial, they cannot start their journey towards acceptance.

Some bring out their anger on their child through violence and rejection.

Some emotionally blackmail their child into marriage. I have

come across cases where a parent gets admitted to the hospital *"Ya saglya mule aai cha BP vadhali. Hospital madhe admit kelai. Tila vachan de ki tu lagna karshil..."* (Because of this issue, mom's BP has shot up. She is hospitalized. Promise her that you will marry...)
Some will inquire about 'Conversion Therapy' (Refer chapter: Sexual Attraction)

Eventually, many of them will reach the stage of acceptance. But they need assistance and support in this journey from denial to whole-hearted acceptance. This is no easy task and may take months or even years. Many parents eventually accept. But, this is possible only if the medical practitioner is sensitive and empathetic to the issue. At times, even after the reluctant acceptance, parents may, later on, unexpectedly regress. Sometimes attending marriage functions, inquiries/taunts by relatives triggers the regression. So the relationship with the medical practitioner may at times be a long-term one.

Since most parents find it difficult to confide in their neighbors or relatives, the medical practitioner becomes the counselor, confidant, and guide. The medical practitioner will have to be patient with their many queries and concerns, which may seem trivial but are of utmost importance to the parents. In addition to answering their queries, parents should also be referred to reading material and information videos (Refer Appendix E: Additional Reading).

The medical practitioner also needs to be mentally prepared for the worst-case scenario, where the parents, despite the support may simply abandon their child and break off all ties with the child. *"tu amcha saathi melas"* (You don't exist for us anymore). But even in such cases, the LGBTIQA youth should continue to consider the medical practitioner as a strong support.

Concern for their Child

Understandably, most parents who accept their child's sexuality/gender are worried about their child's future. They want the best for their child and assurance that their child will find everlasting happiness. This expectation is unrealistic. A gay

or transgender person will generally have more challenges than others. Hopefully, with changing laws, and a more accepting society, there will be more acceptance, and less discrimination. (I sincerely hope that gay marriage gets legal recognition at the earliest.) The LGBTIQA person may get a partner and a family, but it may not be the type of family the parents desire. And that is life; there is no certainty, and no false promises or assurances should be given.

Guilt

> **Parent:** *"Amcha kai chukla?"* (Where did we go wrong? in bringing up the child)

Many parents eventually accept their child's sexuality/gender but continue to harbor tremendous guilt. They hold themselves responsible for their child's sexuality/gender. They need to be told in no uncertain terms that parental upbringing has nothing to do with their child's sexuality or gender. This guilt may lead to the parent constantly pitying the child, making the child feel disempowered. Empathy for the child is very important, but parents should not mistake it for pity. These areas of guilt and pity need to be explored because some parents get depressed and start overcompensating by providing their child whatever he/she wants, even when the demands are irrational.

Anxiety of Gay Parents

Many a time, closeted gay parents have approached me and anxiously asked me-

> **Gay father:** *"Is homosexuality hereditary? Will my son be gay? I don't want my child to go through the trauma that I went through. I am unable to sleep at night thinking about this."*

There is no evidence that homosexuality is hereditary. Ideally, it should not matter what sexuality or gender the child has, as long as we accept and raise the child with love and support. But considering the conservative culture, this anxiety is understandable. Nevertheless, it needs to be addressed.

Heterosexual Marriage and Erectile Dysfunction

At times the gay son does not disclose his sexual orientation to his parents. After marriage, some gay men find out that they cannot have an erection/sustain an erection when trying to have intercourse with their wife. When the parents come to know through their daughter-in-law that 'there is some problem' they approach the family doctor. The son does not disclose his sexual orientation to the family doctor. The doctor assumes that the erectile dysfunction is related to an organic cause or anxiety/stress.

At times the person gets referred to a Urologist for a Penile Tumescence Test (PTT). The test results generally rule out organic cause.

At times the family doctor assumes that the erectile dysfunction is due to anxiety or stress.

Some doctors prescribe tablets of Sildenafil Citrate (and its newer variants) to the individual. Sildenafil Citrate is used to treat male erectile dysfunction (ED). It works by temporarily increasing blood flow to the penis to help a man get and sustain an erection. But it works only in the presence of sexual stimulation. In the above cases, the inability to get or maintain an erection stems from the absence of sexual attraction for the woman, so prescribing such tablets is pointless.

Many medical practitioners and parents do not consider the possibility that the man could have erectile dysfunction with a woman because he has no attraction to women and may have no erectile dysfunction when having intercourse with a man.

At times, parents of the wife have approached me, stating-

> *"Lagna houn char mahine zhale. Ekda pan ticha sanga tyanni kahi kela nahi. Honeymoon la jaun hi te tasech kahi na karta ale. Vicharla ki kahi pan uttara deto-companit khup kaam ahe, taan ahe, tumchi lek changli nahi. To samalingi asel ka? To samalingi ahe ka he tapasni karun kalel ka?"* (It has been four months since marriage. The husband has not had intercourse with her (their daughter) even once. They went for a honeymoon

but came back without sexual congress. Whenever we ask him, he gives vague answers- there is a lot of work in the Company, a lot of stress, your daughter is not a good wife. Could he be gay? Is there a test that can disclose his sexual orientation?)

There could be various possibilities of why the husband is not having intercourse with his wife. Being gay is one of the possibilities. But, it needs to be explained to the parents that there is NO test to know a person's sexual orientation. Only the person knows who he is sexually attracted to.

Stubborn Parents

I have come across parents who insist that their son/daughter has to be 'cured' whatever the cost. They do not care about the cost or consequences, or their child's suffering. They do not care whether the treatment works or not. If there is a possibility that it might work, they are willing to try it. The gay person generally is too timid to stand up for himself/herself and simply nods assent to whatever the parents say. In such cases, I provide the only answer that is possible:

Bindumadhav Khire: *"Being gay is not an abnormality or a disease. So there is no 'cure'. It is a normal variant of human sexuality. I can provide you with copies of the IPS and WPA Position Statements on the issue. Yes, I can understand that it could be difficult for you to accept your child's sexuality. Yes, I can understand your desire to be grandparents. I am aware that you are concerned about your 'khandan ki ijjat'. All these concerns are valid. You can take the assistance of a psychologist or counselor to work on these challenges. But, what you are asking for is not possible. You are forcing your child, who is disempowered to stand up for himself/herself, into conversion therapy which in addition to being unethical is also cruel, inhuman and completely useless. It will be unethical to waste your time and money in trying to fix something that is not broken.''*

MEDICAL PRACTITIONERS

Dr. Umesh Nagapurkar (Psychiatrist, Nashik): *"Acceptance of LGBT by medical professionals, including psychiatrists, needs to increase. There is a lot of work to be done in this area."*

Introduction

Like LGBTIQA persons and their parents, medical practitioners too may be carrying their own baggage. Since they too are part of this society, it is but natural the mores of the society will influence them too. So many medical practitioners are uneducated on these issues. Some are extremely prejudiced against gays and transgender people. These attitudes reflect in their outlook and behavior in their profession.

Lack of Training

With no training on LGBTIQA issues in medical colleges, most medical practitioners carry more or less the same prejudices and misconceptions as a layperson. An LGBTIQA inclusive medical curriculum could address some of these issues, but such curriculum is not in place as of this writing.

LGBTIQA+ Inclusive CBME (Competency Based Medical Education) Curriculum

Following the directions of the Madras High Court, an expert committee was set up by National Medical Commission (NMC) Undergraduate Medical Education Board comprising: Dr. Vijayendra Kumar (Chairperson), Dr. Prabha Chandra, Dr. Surekha Kishore, Dr. Indrajit Khandekar and Dr. Surabhi Sharma.[1]

The expert committee has provided many valuable suggestions to-

1. UG and PG Competency Based Curriculum in relation to LGBTIQA+ inclusion
2. Virginity test in Forensic Medicine curriculum

Discomfort
Some medical practitioners are very uncomfortable providing services to LGBTIQA persons, and their body language and mannerisms give them away. Within the first few minutes of disclosing their sexuality or gender, the individual realizes that they have approached the wrong medical practitioner.

Prejudice and Discrimination
At times, the medical practitioner has deep prejudices about gays and transgender people and is openly discriminatory.

> **Example:** The following was told to me outright by a Venereal Disease specialist (when I was trying to build a referral linkage database of Dermatologists and VD specialists who could treat STIs in MSM and transgender people), while his students dutifully stood around, taking in his every word.
>
> **Doctor:** *"I don't want you to come here again, and I don't want you to bring such* persons *(gay men, transgender people) having STIs here either."*
>
> You can well imagine what my experience would have been if I had visited him as a patient with an anal STI.

Insecurity
Some male medical practitioners fret while examining a male person who is openly gay, wondering whether the patient will make a pass at them. The thought terrifies them.
'If the gay man makes a pass at me, how should I react?'
'Why does he think I am 'available'?'
'Why does he think I am 'like that'?'
'Do I look like one? Dress like one? Talk like one?'

I guess this is the only time where a heterosexual male comes close to understanding what a woman goes through when a man makes a pass at her. If such a pass were to be made by a woman, it might be an ego booster for some male medical practitioners,

but god forbid if a man were to make it. The medical practitioner is too anxious and panicky to realize that all unwanted sexual attention by anyone is to be treated in the same way- patiently, firmly, without any anxiety, guilt, or panic.

At times, the medical practitioner may read/misread the gay male patient and assume that the patient believes the doctor to be gay (or has realized that the doctor is gay) and may panic.This could be due to insecurity about his sexuality or a homosexual inclination, which the doctor fears might surface with this patient (homosexual panic).

If the medical practitioner comes across many gay or transgender patients in a short span, a different kind of anxiety might set in. It may suddenly seem as if there is an alarming rise in LGBTIQA numbers. Some may suddenly feel insecure as if their security about their sexuality/gender lies in the brute majority and not of their own understanding and acceptance of self.

For them, the good news is that the straight community is more than 95%, the rest– biological sex, gender, and sexuality minority communities, in total, constitute less than 5% of the population. If the medical practitioner sees an increase in numbers, it's not because there are more LGBTIQA persons than before. It is because, with the law, medical science, and society slowly opening up and the LGBTIQA rights activists working for their rights, more and more are showing the courage of coming out of the closet. If more LGBTIQA persons are coming to a medical practitioner through affirmative LGBTIQA referrals, it should also be considered a compliment; it means they have been able to win the community's trust.

Professional and Personal Views

There may also be a conflict between modern scientific understanding and the medical practitioner's religious or conservative views on LGBTIQA issues. On the one hand,

medical practitioners are expected to provide scientific information and guidance on acceptance. On the other hand, some may not agree with what they are expected to tell the LGBTIQA person or parents. How is the medical practitioner to deal with these conflicting viewpoints? Will they be able to keep their prejudices aside and deal with the LGBTIQA person without any discrimination? What kind of stressors would such conflict create? How does the medical practitioner resolve them in a healthy manner?

Medical Practitioner as a Family Man

Meeting LGBTIQA persons and objectively assessing and counseling them is one thing; having an LGBTIQA person in your own family is another. When seeing LGBTIQA persons, every medical practitioner is bound to reflect on his/her own family.

What if my son is gay? What if my daughter is a transman?

What if my son is a transwoman? Would I allow him to crossdress?

Do my children trust me to confide in me on these issues? Would it be better that they keep it a secret, rather than put me in a position where I have to face this issue?

Should I start monitoring my children closely? Watch out for 'signs'?

How do I deal with their coming out? How will my spouse handle it? What would relatives and colleagues say? To what extent will it affect me? In what way?

These are unsettling questions because they pose challenges at a personal level.

Finally…

If the medical practitioner does not want to work on LGBTIQA issues, it will make a big difference to tell the person, *"I do not deal with these issues; I know ……. who does, and I can refer you to them"*, rather than misguiding them or discriminating against them.

References

[1] Ms. S. Sushma and Ms. U. Seema Agarval V/s Commissioner of Police, Greater Chennai Police, and Ors. WP 7284 of 2021. High Court of Madras.

2nd Status Report filed on behalf of the National Medical Commission -12th Respondent (February 2022).

PART II: SEXUAL ORIENTATION

SEXUAL ATTRACTION

Bindumadhav Khire: *"I, the author of this book, am a cisgendered gay man who takes a receptive role with a male partner. I am not a transgender, nor do I cross-dress."*

Introduction

On issues related to sexual attraction, the common scenarios seen by medical practitioners are:

- A person who clearly identifies himself/herself with a sexual orientation, accepts it, is comfortable with it, but is facing challenges from various fronts, e.g., coming out, un-acceptance by parents, harassment, discrimination, etc.
- A person who identifies himself/herself with a sexual orientation and is distressed by it.
- A person who is unsure/confused about his sexuality.
- A person who may have symptoms of STI/HIV infection

In all the above categories, except the last (a person with STI/HIV), the medical practitioner has to, during clinical assessment, understand where the individual fits into the three-dimensional spectrum of Biological Sex, Gender, and Sexuality. To have this understanding, it is important to keep in mind the fundamental differences between sexual orientation and gender identity.

Sexual Orientation and Gender Identity

Most LGBTIQA persons and medical practitioners are unaware that the dimensions of sexual orientation and gender identity are different and so they are unable to differentiate between the two. A few differences/similarities between the two are listed in Table 1. Medical Practitioners need to explore both of these dimensions before reaching a conclusion.

Sexual Orientation	Gender Identity
Difference	
This dimension deals with sexual attraction toward another person	This dimension deals with gender self-identification. A Person's gender self-identification could be male or female or both or none.
Similarities	
A person could have any sexual orientation- attraction to men or women or trans or some/all of them or none.	A transperson could have any sexual orientation- attraction to men or women or trans or some/all of them or none.
Depending on their desire, partner, mood, etc., they may take an insertive/receptive/ versatile role during intercourse.	Depending on their desire, partner, mood, etc., they may take an insertive/ receptive/versatile role during intercourse.
Gay, bisexual, pansexual, asexual sexual orientations are not disorders	Gender Dysphoria is not a disorder

Table 1: Sexual Orientation and Gender Identity- Differences & Similarities

Issues to be Explored

When a person approaches a medical practitioner on sexual attraction issues, various aspects of sexual attraction and gender need to be examined.

Sexual Attraction

- Who is the person sexually attracted to?
  The person could be attracted to men, women, transpersons, some/all of them. Some could be attracted to none (Asexual).
- If there is same-sex attraction, is it a passing phase?
  Some adolescents experience same-sex attraction. Some may experiment sexually with their same-sex friends, class-mates, hostel room-mates. For many, this is a passing phase. So, their same-sex attraction or same-sex experimentation during adolescence is not considered an indicator of their sexual orientation.
- Is it a case of same-sex attraction? or intense same-sex attachment for a person without sexual attraction?
  Example: *Kapil, a cisgendered man, is very emotionally attached to a woman but feels no sexual attraction for her. Kapil feels sexually attracted to men only. So Kapil is a gay man despite his intense emotional attachment to a woman.*
- Is the person's sexual attraction stable?
  Example: *Ever since John remembers, he has always been sexually attracted only to men. He didn't need a sexual experience with a man to realize he was gay. John always fantasized and masturbated, thinking of men.*

Note that, in understanding the sexual orientation of the individual, the sexual role fantasized/played by the person is irrelevant. In fantasy or real life, gays, bisexuals, pansexuals could take the insertive role (being Top) or take the receptive role (being Bottom) or take both the roles (being Versatile). For many, their sexual role is more or less fixed, and hence identify themselves as Bottom or Top or Versatile. For some, this role can change depending on the partner, mood, etc.

At times, some gay men who always desire to take the receptive role with another man have a misunderstanding that, since they desire a receptive sexual role, they must be transgender/transwoman. This misunderstanding has to be addressed. A man's desire to play a receptive sexual role is NOT

an indicator of being a transgender/transwoman.

Gender

- What is the person's gender?

Some persons are very clear about their gender identity and find no difficulty articulating it. But some are confused about who they really are. I have come across a few LGBTIQA community members who are confused about whether they are lesbian or transmen.

> **Example:** *Kavita, a 21-year-old woman, is sexually attracted only to women. With this information, some could prima facie conclude that Kavita is a lesbian. But by omitting to understand her gender, this conclusion is drawn from incomplete data. It is essential to know her gender too.*

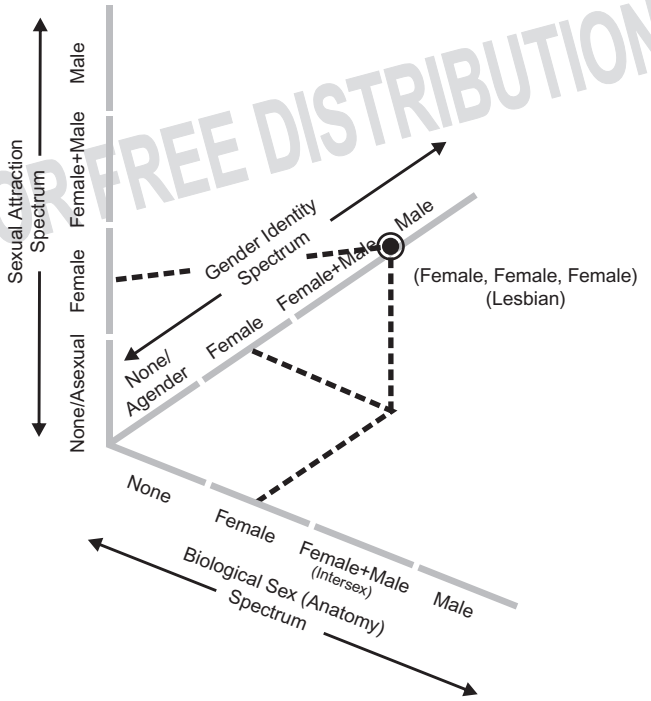


Figure 1: Kavita's point plot as a lesbian

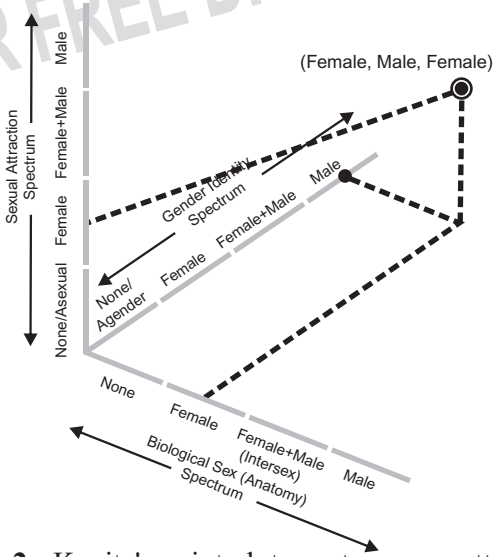
So, exploration is needed to know Kavita's gender.

Suppose Kavita dresses in male attire and presents in a masculine manner. Is that enough to draw a conclusion that she is a transman? No. Remember that butch lesbians are cisgendered and may wear male attire and present in a masculine manner. So appearance is not enough to draw a conclusion about Kavita's gender. So, some of the possibilities which arise are- Kavita is a butch lesbian or Kavita is a transman or Kavita is gender-nonconforming.

Note that for gender assessment, what sexual role Kavita fantasizes with another woman is immaterial.

If Kavita is a cisgendered lesbian, her Biological Sex, Gender and Sexuality point plot is as shown in figure 1.

If Kavita is not cisgendered, Kavita must be assessed for Gender Nonconformity and Gender Dysphoria. (Refer to chapter 'Gender Dysphoria' for details.) If Kavita's gender identity is male, then Kavita is a transman, and his Biological Sex, Gender, and Sexuality point-plot is as shown in figure 2.



· **Figure 2:** Kavita's point plot as a transman attracted to women

After exploring sexual orientation and gender identity, explain to the person where he/she/they fit in the three dimensional graph of Biological Sex, Gender, and Sexuality so that they get a clear understanding.

Marital Status of the Individual

There are many instances where, during clinical assessment, the individual mentions that he/she is married and has children. The medical practitioner automatically assumes that the person must be heterosexual and cisgendered. Due to the stigma associated with being gay, bisexual, or transgender, most gay, bisexual men and some transgender persons get married in a heterosexual marriage. So, marriage and parenthood are not indicators of a person's sexual orientation or gender identity.

Misconceptions

Many LGBTIQA persons and their parents have common misconceptions related to homosexuality. These need to be explored and addressed. A couple of examples are listed below.

- Is it natural?
  Gay male: *"Homosexuality is not seen in animals. So is it unnatural?"*
  The statement is incorrect. Homosexuality is seen in animals and birds and fishes.[1]

- Is it a western fad?
  Parent of a gay youth: *"Is it a western fad? We don't have such things in our culture."*
  This perception is incorrect. References to homosexual behaviour are seen in various ancient Indian texts e.g. *Manu Smruti, Kamasutra* etc. Some *Khajuraho* sculptures depict homosexual intercourse.

Child Abuse

During the clinical assessment, some gay men may narrate incidences of sexual abuse they faced at the hands of an older man when they were young.

> **Doctor:** *"Can you tell me something about your first sexual experience?"*
>
> **Feminine gay male Mohit:** "*Mai 10 saal ka tha tab mere chachane mere saath ulta-pulta kiya. Usne muzhe ye lat lag gai...muzhe ye lat chodni hai*" (My uncle sexually abused me when I was a boy of 10 years. He got me addicted to this…I want to get rid of this habit)

In the above example, Mohit has stated that it is his uncle who is responsible for his sexually desiring men, and he considers it a habit (something that can be suppressed or got rid of).

Many laypersons, medical practitioners, and gay male survivors of sexual abuse by men believe that sexual abuse of boys by men leads to the boys becoming gay. Statements, such as the one given above, by an LGBTIQA person also feed into the widespread belief that it is a 'habit' that needs to be got rid of.

On hearing such statements, the medical practitioner needs to keep the following in mind:

- Ensure that they are not influenced or swayed by words that feed into their own bias.
- Gender non-conforming boys are more likely to be sexually abused than gender conforming ones. So young boys who are feminine are more likely to be targets of sexual abuse.[2]
- Many gay men have never been sexually abused by men or women (neither have I).
- There are men who identify as heterosexual even if they were sexually abused by men as young boys.
- Being sexually attracted to men is not a habit. A gay man is naturally sexually attracted to men in the same way a heterosexual man is sexually attracted to women (in the heterosexual context, we don't use the word 'habit', do we?)

- At the proper time, the medical practitioner, without fail, has to explore the gay male's beliefs in detail and address them so that the individual gets an appropriate perspective and gains acceptance of his sexuality.

Conversion Therapy

Many gay men (and parents) approach medical practitioners for 'conversion therapy'. i.e treatment/therapy/counseling to change the sexual orientation of the gay man to heterosexuality. Innumerable gay persons have gone through the ordeal of 'conversion therapy' Persons of various kinds, needless to say, without any success.

> **Gay male:** *"The psychiatrist told my father that homosexuality is an abnormality and can be changed. He said that, it is a good sign that the patient is cooperating to change his sexual orientation. He then directed me to a counselor. The lady counselor gave the following suggestions-*
>
> 1. *Masturbate thinking about a man, and as you near orgasm, switch your fantasies to a woman. With practice, you should be able to masturbate by fantasizing about a woman only,*
> 2. *Join a gym, develop muscles and a masculine body,*
> 3. *Trim your nails as boys don't have long nails,*
> 4. *Consciously keep your walk masculine,*
> 5. *Your voice is feminine- speak as if you are speaking from deep down- from your navel so that your voice will sound manly.*
>
> *Needless to say, nothing worked, and I realized that they were jerking my chain when the psychiatrist complained to my father that I was no longer co-operating."*

All such treatments- counseling, therapy, medication, shock therapy, to convert gay persons to heterosexuals (straight) are unethical. Tragically such inhuman practices continue. At times this results in loss of life, with the LGBTIQA person dying by suicide[3].

Law and Conversion Therapy

The Mental Healthcare Act, 2017
Section 18(2) states that no person can be discriminated against in mental healthcare services based on biological sex, gender, and sexuality. **This clause makes conversion therapy discriminatory.**

Interim Directions of Madras High Court (year 2021): "Prohibit any attempts to medically "cure" or change the sexual orientation of LGBTIQA+ people to heterosexual or the gender identity of transgender people to cisgender. To take action against the concerned professional involving themselves in any form or method of conversion "therapy", including withdrawal of license to practice…." (Refer Appendix A: Directions of Madras High Court)

National Medical Commission (NMC) Expert Committee Recommendation
Following the Order of the Madras High Court, an expert committee was set up by National Medical Commission (NMC) Undergraduate Medical Education Board to address LGBTIQA+ related issues raised by petitioners. The expert committee recommended that attempts by medical practitioners to effect a 'cure' be treated as 'Unethical Conduct' and 'Professional Misconduct'.[4]

16(c) Any attempts / interventions (commonly referred to as conversion therapy) to "change" sexual orientation of a person to heterosexual shall constitute UNETHICAL CONDUCT on the part of the medical professionals under chapter 6 of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulation, 2002.

16(d) Any attempts / interventions (commonly referred to as conversion therapy) to "change" sexual orientation of a person to heterosexual shall constitute

PROFESSIONAL MISCONDUCT on the part of the medical professionals under chapter 7 of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulation, 2002.

A Word on Medications

In my long years as an activist, I have come across innumerable cases where gay persons/their parents have unintentionally or intentionally been misled about treatment.

> **Gay male:** *"I was very depressed. The psychiatrist gave me medications and asked me to come after 15 days. And over the next few months, I kept going to him, and he kept giving me medications. Although the medications made me drowsy, I diligently took them. I was desperate to get cured of my homosexuality. It didn't work, and I gave up going to the doctor. Much later, I realized that he had given me medications to address my depression and not cure me. He never mentioned that the medications were not for my cure, but for my depression."*

There is an implicit belief of gay persons/their parents that if they are seeking to 'cure' homosexuality, the medications being given are for bringing about the 'cure'. Giving medications without specifying what they are for, misleads gay persons/their parents into believing that the medications will bring about the 'cure'.

When giving medication, it is very important to send out the correct signal to the gay person about the objective of the medication-

- What is it that is being sought?
- By when will it start to take effect?
- What the medication will NOT do (convert the individual to heterosexuality)

If the medicine has sexual side-effects, e.g., erectile dysfunction, anorgasmia, or anesthetic ejaculation, do mention

them to the individual.

Acceptance and Marriage

Innumerable gay persons have asked me -

> *"I know I am gay. But I have to marry (a woman) because of .... reason. My concern is, will I be able to have intercourse with my wife?"*

Some gay men can have intercourse with women and beget children. After fathering a child, they feel relieved that they have proved their manhood. Some are unable to have intercourse with women, and this, more often than not, results in separation and divorce. (Why some gay men can have sexual intercourse with a woman and others cannot do so is not known.)

My writing the above paragraph may tempt medical practitioners to advise gay persons to go in for heterosexual marriage, but that is not my intention at all. The solution of marriage should be resisted because the individual is entirely focused on proving his manhood and nothing else. The medical practitioner knows better that marriage is more than just fornication for proving his manhood and reproduction.

But, coming back to the basic query, "Will I be able to sexually perform with a woman?" The simple answer is that unless the gay man tries to have intercourse with a woman, he will not know, and no one else can answer that for him. A few make efforts to seek a girlfriend to experiment. A few others approach a female sex worker. If they are able to successfully have and maintain an erection with a woman, they feel relieved that they will be able to do the 'job'. That they have to spend their entire life viewing their married life as a 'job' to be done, like a robot, is, methinks, the most painful punishment of all.

Bisexuality, Pansexuality

> **Male :** *"I am confused. I am sexually attracted to men as well as women."*

Many persons believe in a strictly binary world, where-

- they must be sexually attracted to either men or women. They feel confused if they are attracted to both, or are asexual.

- they have assumed that, right from adolescence, they must have absolute clarity about their sexual orientation. During adolescence, some boys and girls may experience a passing phase of same-sex-attraction and may feel confused, unsure about their sexual orientation. This phase and sexual experience (if any) during this phase will not dictate their sexual orientation.

Dr. Bhooshan Shukla: *"Quite a few young adults report confusion about their sexual orientation or gender identity.*
Medical practitioners are trained to diagnose quickly, but in such cases, patience is required, even if the parents are anxious to reach the diagnosis quickly. It could take a couple of years before the person can be certain about their sexual orientation (or gender identity). So, all that the medical practitioner may have to do is- a) assure the individual and parents that the sexual orientation (or gender identity), whatever it may eventually turn out to be, is a normal variant of sexuality (or gender) and b) discuss issues related to the safety of the individual-vulnerability to sexual abuse/harassment and safety measures, especially in cases where others are aware of the person's sexuality/gender or the young male is feminine in appearance/behavior or cross-dresses/has expressed intense desire to cross-dress."

Men Who Cross-Dress

We may come across men who sometimes cross-dress. They face no or very little conflict between their anatomy and gender, nor are they distressed about their gender assigned at birth. In such cases, a few possibilities are listed below:

- Like the dimensions of Biological Sex and Sexual Attraction, the dimension of Gender Identity, too, is a spectrum. So the

point-plot of their gender identity falls slightly towards female gender identity. So they could be gender nonconforming.

Example: *We may come across a person who has male anatomy, who experiences predominantly male gender identification, who is sexually attracted only to men, and who sometimes desire to cross-dress.*

- Some could be Transvestites (those who feel aroused by cross-dressing).
- Some could be Cross-Dressers (those who cross-dress for various reasons but are cisgendered)

Exploring Sexual Fantasies

Gay male: *"When I forcefully try to fantasize about a woman and try to masturbate, I either lose erection, or I reach a point (generally near climax) where I lose control over the female fantasy, and she gets replaced by a handsome man."*

Wherever the individual is unsure about his/her sexual orientation, exploration of his/her sexual fantasies may assist in understanding the sexual orientation.

Dr. Bhooshan Shukla *"Fantasy is difficult to assess as the assessing professional must go entirely by reported information. In real life, one's body can give a compulsive/programmed/instinctive sexual response even in an aversive or abusive sexual encounter. But in fantasy, one is free to assume a role for oneself and partner and experience sexual satisfaction without conflict or discomfort. Suppose the person can share their sexual fantasies or report a consistent pattern in their fantasies (in general as a reverie or for masturbation). In that case, it becomes helpful in determining sexual*

orientation as well as sexual role of the person."

At times, it helps to ask the person to keep a diary for a month or so of the fantasies they have when they try to masturbate and record the details of the fantasies. E.g. the person they fantasize about- male/female/transgender, age of the partner, sexual acts fancied, body parts of the partner that are a turn-on, etc. It is important to tell them not to force a particular gendered person into their fantasy but let the fantasy flow naturally. It gives them and the evaluator a clearer picture of whether the person is gay or somewhere on the bisexual scale- mostly gay or equally attracted to men and women or mostly straight.

Some of the themes for exploration of sexual fantasy-

- Anatomy of the partner, gender of the partner, partner clothed or nude, sexual acts fancied, sexual role played.
- Themes to be explored about pornographic images/films watched by the individual
  -Who does the person focus on? The male person or the female person in the film?
  -What does the person focus on? Body parts (e.g., buttocks, penis, testicles, chest, thighs, breasts, vulva, etc.) What body characteristics are a turn on- e.g., size of the penis, breasts, buttocks, etc.
  -Who is the person **sexually attracted to**? The man in the insertive role? The man in the receptive role? The woman in the dominant role? The woman in the submissive role?
  -Who does the person **identify** with? The man in the insertive role? The man in the receptive role? The woman in the dominant role? The woman in the submissive role?

Sexual fantasies need to be explored in detail, especially when the person desperately wants and 'tries to be straight'. He tries hard to fantasize / pushes himself to feel sexual desire and arousal when fantasizing about a female. He may delude himself and report that his sexual orientation is changing. Medical practitioners who have a bias against

homosexuality may be eager to accept this statement as a sign of success.

Asexuality

Many laypersons use the words arousal, sexual desire, and sexual attraction interchangeably. But, to understand asexuality, it is important to understand the differences between these terms.

Sexual arousal (sexual excitement) refers to the physiological changes in the body when the brain desires sexual intercourse/pleasure. E.g., a man will experience penile erection etc.

Sexual desire (libido/sex drive) is a conscious and motivated interest in a sexual act. External stimuli or fantasies trigger it.

Sexual attraction is sexual desire caused by a specific person/group of persons. Asexuality is the lack of sexual attraction towards any gendered person.

So in cases related to asexuality or lack of libido, it is important to know the differential diagnosis. If the person is asexual, increasing the libido through medications is of no use.

Let me explain this with an analogy: pressing the accelerator of your car to drive fast or slow towards a destination of your liking is like sexual desire (libido). But, pressing hard on the accelerator (giving medications to increase libido) when there is no destination to drive to (no sexual attraction towards persons of any gender) is pointless. In cases of asexuality, giving medications for increasing libido makes matters worse. So exploration and investigations may be needed for reaching a differential diagnosis.

If the person is asexual, explain that asexuality is not a disorder, so there is no question of a 'cure'. Counseling may be required to enable him/her to accept their asexuality.

Listed below are some scenarios which are NOT related to asexuality-

- Menopause/Andropause may cause a lessening of libido. This is not asexuality. Asexuality is not related to deficit or excess hormone levels.

  Example: *Amita experienced a significant loss of libido on reaching Menopause. She experienced increase in libido after starting ERT (Estrogen Replacement Therapy).*

- Male to Female transgender people/transwomen may experience a significant loss of libido after Orchiectomy as testosterone level goes down significantly. This is not asexuality.

  Example: *Tritiyapanthi Amruta experienced significant loss of libido after undergoing Bi-lateral Orchiectomy.*

- If the person feels no sexual attraction only towards his/her partner, it is not asexuality.

  Example: *Rajesh finds his wife Sulabha a complete turn-off but masturbates fantasizing about a female movie star.*

- At times, a person may feel no sexual attraction in certain surroundings but realizes that he/she feels sexual in different surroundings. This is not asexuality.

  Example: *Reema, who stays in a crowded room with her in-laws, finds her husband Alok a complete turn-off, but she feels sexual desire for him when she is out-station with him on vacation.*

- In rare cases, a person may feel that they are asexual, but realization unexpectedly dawns that they are sexual only in the presence of a certain fetish that they do not have general access to. This is not asexuality.

Example: *Raunak believes he is asexual. But one day he sees a woman wearing leather jacket and pants and suddenly feels sexual attraction for her.*

Pedophilia

Doctor: *"Pedophiles must be coming to you in large numbers. Can you refer them to us for.....?"*

This was asked of me by a doctor. Well knowing the doctor's attitude towards LGBTIQA, I was aware of the implicit assumption and accusation that gay men like me are pedophiles.

I need to underline that, just as adult heterosexual men are sexually and emotionally attracted to adult women, similarly gay men are sexually and emotionally attracted to adult men. Gay men are NOT sexually attracted to children. Pedophiles are sexually attracted to Prepubescent children, and this attraction is called Paedophilia.

Sexual Attraction Towards Persons of a Particular Age Group

The sexual attraction of one person towards persons in a particular age group is a separate dimension. Medical practitioners may encounter adult persons-

- who are sexually attracted to children less than five years old e.g. infants, toddlers (Infantophilia).
- who are sexually attracted to prepubescent children (Pedophilia).
- who are sexually attracted to pubescent youths (Hebephilia),
- who are sexually attracted to post-pubescent youths (Ephebophilia).
- who are sexually attracted to adults (Teleiophilia).
- who are sexually attracted to middle-aged adults (Mesophilia).
- who are sexually attracted to the elderly (Gerontophilia).

The first four have legal and moral implications. No legal or moral stand need to be pegged to any other categories.

Un-understood Sexualities

The acronym MSM (Men who have Sex with Men) was coined during the 1980s for high-risk male population groups vulnerable to HIV/AIDS. Most men who were having sex with men, did not know that HIV could be transmitted from an HIV infected male to another male through unprotected (without use of condoms) anal intercourse. Hence HIV infection spread rapidly within these high-risk male population groups. So the acronym MSM was an umbrella term that covered- gay men, bisexual men, *tritiyapanthis,* men who had sex with men because they lacked access to female partners, etc. The umbrella also covered other MSM categories which did not have specific terminologies. Medical practitioners may, at times, come across such cases. A few of these categories are briefly mentioned below.

- I have seen quite a few men who have sex, not just once but many times, with gay men who take the receptive role in intercourse. These men are well aware that they are having sex with a cisgendered gay male. Some take great pains to avoid seeing the genitalia of the receptive gay male partner. Generally, they do not go for foreplay, touching, fondling, kissing, etc. They always take the insertive role. But, these men are not homosexual. They are not bisexual either. They consider themselves heterosexual. They have sex with men purely for sexual release, without any sexual attraction for men.

  I am aware that some of them believe, that any man who is willing to have receptive sex with another man is either impotent or has a very small penis. The reasoning goes that, due to the above reasons, receptive gay men cannot get satisfaction in the insertive role, and so they take the receptive role. This belief is totally wrong.

  Perhaps they believe that a man willing to have receptive sex with another man is 'not a man'. And being a 'not-man', he is game for them. Whether or not the person has male genitals, whether or not he gets an erection. Whether he is dressed in

shirt & pants or a sari is irrelevant. At times, some even request the receptive male partner, *"Tula karaila mi tayar ahe, pan mala ek item de."* (I am willing to have intercourse with you (I will be the insertive partner), but provide me with a female partner in exchange.)

There is a possibility that some of these men could be closeted, deeply repressed gays or bisexuals. But I don't believe this explanation is true for most of them. Their unwillingness to discuss various aspects of their sexual desires and sexual acts has made it impossible for me to understand their sexuality.

- There are rare cases where the husband gets aroused to have sex with his wife only after playing the receptive role (the layman uses the coarse term *dhakka-start*) with another male. There are also rare cases where- the husband gets aroused to have sex with his wife only after seeing another man have intercourse with his wife. What is the husband's sexuality/sexual dynamics here? (Their unwillingness to open up about these issues has made it impossible to explore these dynamics.)

- I know some persons who have unconventional sexual attraction. Two examples are given below:

  Transman: *"I am not sexually attracted to men or women. I am sexually attracted only to male-to-female transgenders… and that too only those who have surgically removed their testes and penis."*

  ***Tritiyapanthi* sex worker (**who has not undergone Gender Affirmative Surgery): *"I have a male customer who, when I am wearing a sari, and not otherwise, loves to take a receptive role in performing oral sex on me. I feel uncomfortable, but since he pays for it…."*

The list goes on.

Out there, sexual and gender diversity is in millions. I have

mentioned a few only to underline the reoccurring theme that we understand very little about gender, sexuality, sexual desire, and sexual pleasure. Suffice to say that as long as the partners are adults, consenting, and the act is done in privacy, we should not have any moral stand on the issue or respect the person any less for the diversity.

Treatment of Sexually Transmitted Infections (STIs)

Due to shame and stigma associated with STIs, many persons who notice symptoms of STI generally tend to ignore the symptoms and try to carry on with the discomfort or pain. It is only as a last resort that they approach a Dermatologist or Venereal Disease (VD) specialist.

The location of certain STIs may be, at times, a clear indication that a person has had same-sex intercourse. A penile Gonorrhoea/Chlamydia infection may not give an idea whether the person has had unprotected intercourse with a woman or a man. But, a man who presents genital warts on his anus indicates that he has had unprotected, receptive intercourse with a male.

I have come across cases where the VD specialist repeatedly asks the person with anal warts- "*What do you think is the source of the problem?*". The person repeatedly lies about it, the charade ending with the specialist finally making derogatory remarks. Due to such humiliation, persons with STIs drop out and do not complete the treatment. This leads to warts spreading inside the rectum, making surgery imperative.

So, humiliating the person having an STI is to be avoided at all costs. Gently explain to the person the source of the STI, even if the person is in denial, and suggest that the best way to avoid STIs is to have the insertive partner wear a condom. In this way, the person can protect himself from getting (and, in turn, spreading) STIs like Genital Warts, Syphilis, Gonorrhoea, Herpes, etc.

> **Dr. Kanchan Pawar:** *"When it comes to history taking with patients who have STIs, it is of utmost importance to be non-judgemental, not only in speech but also in body*

language. Even a sneer, smirk or a glance of disdain makes the patient feel uncomfortable, ashamed and hesitate to open up about their history of intercourse. Based on their history, Dermatologists/VD specialists may also counsel patients about STI symptoms (IEC material is handy here) and the need to get themselves and their partners tested regularly every six months for HIV and Syphilis. Many patients, particularly the young ones, hook up through online dating apps and have unsafe sex with multiple partners. They only get tested for HIV, assuming it is the only infection they need to be concerned about. Sparing a few minutes to educate them about STIs and common symptoms of STIs will encourage them to take their sexual health responsibly."

References

[1] Biological Exuberance: Animal Homosexuality and Natural Diversity. Bruce Bagemihl. Stonewall Inn Editions.

[2] Does Sexual Orientation Precede Childhood Sexual Abuse? Childhood Gender Nonconformity as a Risk Factor and Instrumental Variable Analysis.Yin Xu, Yong Zheng. Sex Abuse. 2017 Dec;29(8):786-802.
https://doi.org/10.1177/1079063215618378.
Epub 2015 Nov 29.

[3] The Kerala student's suicide puts focus on dubious 'conversion therapy'. Hindustan Times, New Delhi. By HT correspondent. May 18, 2020.
https://www.hindustantimes.com/india-news/kerala-student-s-suicide-puts-focus-on-dubious-conversion-therapy/story-fmgMhK8nFVUuddV97xvDXN.html

[4] Ms S. Sushma and U. Seema Agarwal V/s The Commissioner of Police, Greater Chennai police and Ors. WP 7284 of 2021. High Court of Madras.

2nd Status Report filed on behalf of the National Medical Commission-12th Respondent (February 2022).

LEGAL STATUS OF GAYS

Same-Sex Intercourse (Gay Sex)
In 2018, the Hon'ble Supreme Court of India, in the landmark judgment of [Navtej Johar and Ors v/s Union of India][1], declared that Section 377 IPC was unconstitutional to the extent that it criminalized same-sex intercourse between two consenting adults. So, same-sex intercourse (gay sex) between two consenting adults is not an offence.

Gay Marriage
As of April 2022, gay marriage has no legal sanction in India. A few petitions, pleading legal recognition of gay marriage, are currently being heard in the Delhi High Court and Kerala High Court.

Artificial Insemination / IVF
The Assisted Reproductive Technology (Regulation) Act, 2021, provides the legal framework for assisted reproductive technology services like obtaining a pregnancy by handling the sperm or the oocyte outside the human body, cryo-freezing freezing gametes, embryos etc. Since laws keeps on changing, the LGBTIQA person desiring to use assisted reproductive technology, should consult an Advocate, who is proficient on fertility issues, on the legalities involved before undertaking any action in this regard.

Surrogacy
As of April 2022, the option of surrogacy is available only for heterosexual married couples, so single persons cannot resort to surrogacy to beget a child[2]. The prevalent legal position may change in the future; the readers are advised to validate the legal position at the relevant times.

Adoption
As of April 2022, there is no bar on giving children in adoption to single gay men, gay couples, or transpersons[3]. While there is no explicit bar to such adoptions, considering the conservative mindset of the adoption agencies and society, adopting of a child

by an LGBTIQA person who is out about their sexuality/gender is expected to be a challenge. The norms of the adoption agency shall be read and clarification must be sought, if any, from the agency at the time of approaching such an agency for adoption.

Sperm/Ova/Embryo Preservation

Some LGBTIQA persons may consider freezing sperm or ova for future use. This option may be especially relevant to transpersons who are planning Gender Affirming Hormone Treatment (GAHT)/surgical transition.

Cryo-preservation (sperm/ova/embryo preservation)
Dr. Sanat Pimpalkhare
(Gynaecologist and Obstetrician)

Cryo-preservation means the freezing and storing of gametes, zygotes, embryos, ovarian and testicular tissues.

Freezing Semen

The procedure, in short, for semen freezing, is as follows:

- After 4-5 days of abstinence, semen is collected and analyzed. If the analysis shows suitable semen parameters, freezing of the same can be done.
- Repeated samples can be used for more/additional freezing after short intervals and following the same abstinence days.
- The sample frozen can be used for insemination later.
- The cost is upwards of ₹1,500.00 per straw. The number of straws depends on the semen volume and count of sperms in the sample. (Straw is the container in which the sperms are frozen).
- The freezing cost is upwards of ₹20,000.00 per year.

Freezing Oocyte (Ova)

The procedure, in short for Oocyte freezing, is as follows:

- Various tests (including HIV test and tests for studying hormone levels- TSH, PRL, AMH) are done. (In these

times of Covid, Covid test too is done)
- Stimulation starts on day 2 of the Menstrual Cycle- after checking E2, LH, and Progesterone levels.
- The Ovary is stimulated by injections, as per appropriate protocol, for approximately ten days.
- At periodic intervals, hormone cross-checking is done.
- After the first trigger injection, Ovum Pickup (OPU) date and time are fixed after ten days.
- Under suitable anesthesia, with ultrasound guidance, OPU is done trans-vaginally.
- The Oocytes retrieved are subjected to lab procedures, and suitable grade Oocytes can be frozen or, following insemination with sperms- an embryo can be harvested.
- The whole procedure costs upwards of ₹1.5 lakhs.
- The freezing cost is upwards of ₹25,000.00 (freezing + maintenance for the first six months) and upwards of ₹1,000.00 per month after that.

Embryo Freezing
- The procedure for embryo freezing is as follows:
- After OPU, Oocytes are inseminated with sperms after processing of sperms.
- Fertilization is checked after 24 hrs.
- After follow-up checks on day 3 or 5, the embryos can be frozen after grading and analysis.
- Freezing cost is the same as that for Oocytes.

Legality

For all the above procedures-
- Aadhar card/PAN card details are essential.
- A marriage certificate is essential for married couples.
- A single parent can also avail of the above procedures (single LGBTIQA persons can opt for these procedures.)
- The gamete of a donor or embryo shall be stored for a period of not more than ten years.[4]
- Age limit: The banks shall- obtain semen from males

between twenty-one years of age and fifty-five years of age, both inclusive; (b) obtain oocytes from females between twenty-three years of age and thirty-five years of age.[5]

References

[1] Navtej Singh Johar & Ors V/s Union of India.
Writ Petition (Crl) No. 76 of 2016.
Judgment dated 06th September 2018.
Coram: CJI Dipak Misra, and justice A. M. Khanwilkar, Rohinton F. Nariman, J, Dr. D. Y. Chandrachud, J, Indu Malhotra. J.

[2] The Surrogacy (Regulation) Act, 2021. Section 4.

[3] Adoption Regulations, 4th January 2017. Ministry of Women and Child Development Notification. New Delhi).

[4] The Assisted Reproductive Technology (Regulation) Act, 2021. Section 28(2).

[5] The Assisted Reproductive Technology (Regulation) Act, 2021. Section 27(2).

PART III: GENDER IDENTITY

GENDER DYSPHORIA (GENDER INCONGRUENCE)

Male to female transgender: *"When mom is not around, I wear her sari. I am a woman, I don't know why I have a male body..."*

Introduction

On issues related to gender identity, the typical scenarios seen by medical practitioners are:

- gender-nonconforming persons
- persons who clearly identify themselves with a gender other than the one assigned at birth and are distressed by the gender assigned at birth
- persons who clearly identify themselves with a gender other than the one assigned at birth, but face challenges from various fronts, e.g., challenges in coming out, un-acceptance by parents, harassment, discrimination etc.
- persons who need referrals for clinical assessment for Gender Dysphoria (GD) or Gender Affirming Hormone Therapy(GAHT) or Gender Affirmative Surgery.
- persons who are unsure/confused about their gender.

When working with an individual on gender issues, the medical practitioner has to, during clinical assessment, understand where the individual fits in the three-dimensional spectrum of Biological Sex, Gender, and Sexuality.

Gender Non-Conformity and Gender Dysphoria

Figure 1 shows a simplified chart of 'Gender' so that it can be easily understood. Admittedly, it may not be 100% accurate.

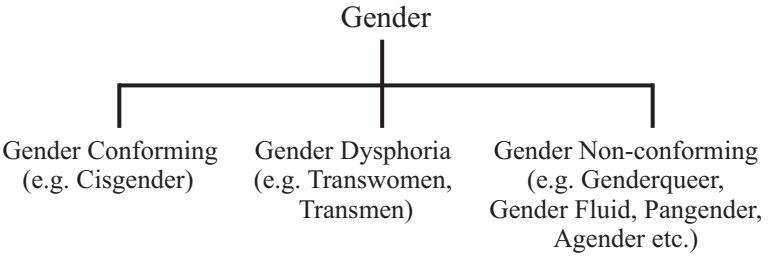


Figure 1: Gender

Gender Dysphoria (GD) is persistent incongruence felt by the person about their anatomy and the gender experienced by them.

Gender nonconformity refers to how a person's gender identification, expression, social role differs from the cultural standard practiced for persons of a particular gender.

Gender Dysphoria

DSM and ICD Codes for Gender Dysphoria

Manual	Diagnosis	Code
DSM-V	Gender Dysphoria in Adolescents & Adults	302.85
ICD-11	Gender incongruence of adolescence or adulthood	HA60
ICD-11	Gender incongruence of childhood	HA61
ICD-11	Gender incongruence unspecified	HA6Z

Terminology: Gender Dysphoria and Gender Incongruence

DSM-V which is followed in the USA uses the term 'Gender Dysphoria'. ICD (11th Revision) which is followed by India uses the term 'Gender incongruence'. In India many psychiatrists use the DSM terminology. So although the term 'Gender Dysphoria' is frequently seen in practice, from the legal perspective the term 'Gender incongruence' is the more accurate term.

Criteria for a Gender Dysphoria Diagnosis[1]

At least six months of-

- persistent incongruence felt by the person about their anatomy and the gender experienced by them
- distress about their gender assigned at birth
- severe impairment in social, educational, vocational functioning due to their gender assigned at birth
- desire to get rid of primary and secondary sexual characteristics
- desire to acquire sexual characteristics of the experienced gender
- desire to express themselves socially/culturally (e.g., dress code) according to their experienced gender
- desire to be addressed with the gender they experience
- desire to be accepted with the gender they experience

Clinical Assessment

Due to a lack of understanding/communication/maturity in minors, the GD assessment of minors and adults is done through different mechanisms.[2] GD diagnosis in minors is always tentative, as not all minors diagnosed with GD turn out to have GD in adulthood. There are also many cases that do not exhibit GD in childhood but are diagnosed with GD in adulthood.[3] Given below are some notes on adolescent and adult GD clinical assessment.

Setting Expectations for Adolescent and Adult Gender Dysphoria Clinical Assessment

> ***Tritiyapanthi* activist:** *"Who are the psychiatrists to give us (GD) certificate? I have the right to live the way I feel."*

The *tritiyapanthi* activist's anger was understandable but misplaced. The word 'certificate' unfortunately conjures psychiatrists as gatekeepers with the power to decide who is to be granted the GD certificate. So education is needed on the following-

- GD assessment is meant to assist the transperson and not obstruct them. If some psychiatrists use this tool to wield power over the transperson, they will be condemned in the strongest possible terms.
- GD assessment assists the psychiatrist in exploring the person's understanding of the issue, identifying mental health issues, and checking the person's capacity to adjust to the inevitable changes in lifestyle that will follow during and after the transition.
- So, GD assessment should be looked at as a safety tool rather than a hurdle race.
- GD assessment is not a 'confirmatory test' of one's gender. No test can confirm one's gender. Only that person knows the gender he/she/they identify with. Clinical assessment of GD only assists in understanding the extent of gender incongruence and its severity.

Clinical Assessment Timeline

The person should be informed in the first session that they will need a minimum of four sessions before a decision on the certificate can be taken. The sessions will generally be-

1. Clinical assessment
2. Psychometry Tests, GD assessment test
3. Interviews of family/siblings/neighbors/friends
4. Dissemination of findings

   There could be more sessions, depending on the findings of the tests.

GD ASSESSMENT AND CERTIFICATE

The Gender Dysphoria clinical assessment, testing has to be done by a team of psychiatrist and clinical psychologist. Based on the findings, the Gender Dysphoria certificate is issued by the psychiatrist.

Use of gender pronouns

Many unhappy transpersons' feedback is related to the gender in which medical practitioners address them.

Transman: *"When I told the doctor that I have a male gender identity and want to be addressed as a male, she promptly replied, 'I will use the gender as is currently reflected in your legal documents.' I felt that was insensitive."*

Tritiyapanthi: *"I was wearing a Punjabi dress, and yet the counsellor kept on repeatedly calling me using masculine gender because I had not changed my masculine name. Even after I told him that I wished to be addressed as female, he kept on smiling mischievously and continued to address me as male."*

It cannot be emphasized enough that the gender identity of a person is the core of their being. Imagine the reader being intentionally addressed in the wrong gender even after a correction has been suggested- men being addressed/referred to as 'she'/'her' or a female as 'he'/'him'. So why should we be so unyielding when addressing transpersons according to the gender they experience? Yes, indeed, many may not have had their gender reflected in their legal documents or have their birth name changed, but still, medical practitioners can respect this fundamental desire of the person.

Author Bindumadhav Khire: *"I have personally made the mistake of using the wrong gender many times with quite a few of my transperson clients. At times I make that mistake because I have known them long before I came to know of their gender identity; at times, I make that mistake because they have not changed their birth name; at times, I make a mistake because of their masculine or feminine voice. The reasons are many, but wherever possible, I accept the mistake, apologize, and try to make an honest effort to correct myself.*

In my sessions, whenever possible, I tell transpersons that they should also understand that there will be times when people will slip in this exercise. Especially if they have known the transperson long before they came out. Parents, siblings, friends, and colleagues may make this

mistake repeatedly. So, transpersons, should provide for a margin of latitude in this matter."

When a person comes with the issue of GD or is cross-dressed, ask the person- *"How would you like to be addressed- in terms of name and gender?"* Do not insist on legal identification or medical diagnosis of GD before using their preferred gender and name. As far as possible, avoid using the gender assigned at birth or dead-naming a person(using the name assigned at birth).

The person may desire to be addressed as a male (pronouns he/him) or female (pronouns she/her) or as non-binary (pronouns they/them).

In-Depth Interview

The psychiatrist conducts an in-depth interview with the person. In addition to the usual background information, the interview should also cover the span from childhood till date on feelings, distress, expression/mannerisms, fantasies, punishment/ rewards related to gender and sexual expression, incidents, and understanding/interpretation of incidents associated with GD. Evidence, e.g., photos/videos of cross-dressing/dancing, etc., should be examined. It is also important to understand the persons' first sexual experience, sexual understanding/maturity, and their sexual fantasies. Explore the idea of family they desire to have and their role in it.

Note on Articulation

Some transgender persons cannot articulate their experience, so special efforts have to be taken to help them express themselves. It should not be assumed that the person, although mature by age and intellect, can articulate their experience and feelings of gender identification. Some transgender people can tell who they are sexually attracted to but cannot say which gender they identify with. This is especially true when the person has not met anyone who is similar to them. They feel as if they are a 'stranger in a strange land', where others cannot comprehend their experience. As the dialogue progresses and the person realizes that the doctor does not seem to understand what they are trying to say, the patient gives up and accepts whatever diagnosis the

doctor formulates. Tragically, the person may be aware that the doctor's diagnosis is incorrect but does not protest, and worse, at times, the person may be unaware that they have been misdiagnosed. In the example given below, the transwoman was misdiagnosed as gay because the doctors had not explored her gender.

> **Transowman:** *"I come from a tribal village. I was a thin, very introverted youth. I knew I liked men, so a couple of doctors told me that I was gay. I assumed that as the doctors have stated I am gay, I must be gay. Later on, when I came to Pune and attended a session by Bindumadhav Khire in my college, I became aware of the LGBTIQA terminology. It was then that I realized that I am a transwoman who is attracted to men. Until then, I was unable to give myself a label and was unsure of articulating what I felt. The doctors I had met were unable to help me understand myself."*

The point-plot of Biological Sex, Gender, and Sexuality of the transwoman given in the above example is shown graphically in Figure 2.

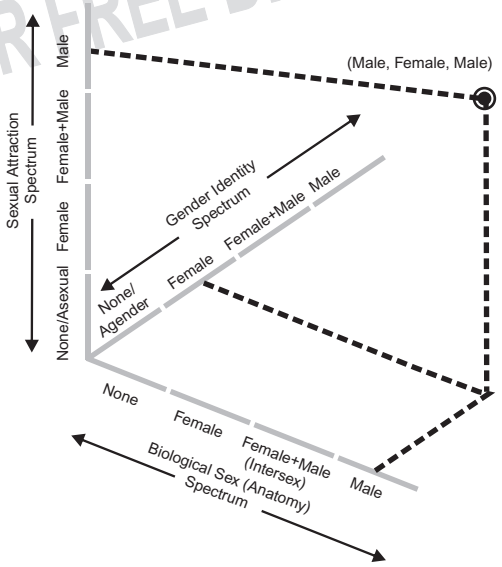


Figure 2: A transwoman sexually attracted to men

In addition to the in-depth interview, it helps if a parent/sibling and neighbor/childhood friend are also interviewed for their perception of the transperson. They can narrate incidents relating to GD behavior/expression, corroborate on incidents narrated by the transperson. Note that, for those transpersons who have been thrown out of their homes, or have migrated, or have lost all contact with their family/neighbors, these interviews may not be possible. In such circumstances, these interviews should not be insisted on.

Ruling Out Intersex Presentation

During the clinical assessment, adult female persons could present amenorrhea, atypical appearance or male persons could present with unusual genital presentation (e.g., non-palpable testes, Hypospadias, etc.). In such cases, the medical practitioner shall prescribe a physical examination and tests/imaging to rule out intersex presentation.

Psychometry Tests

The person is referred to a clinical psychologist trained in working with LGBTIQA persons for conducting various psychometry and GD assessment tests. The person should be informed of the tests to be done, the objective of each test, and the cost.

There is no standardization of tests for clinical assessment of GD. The clinical psychologist will generally select a few tests from the range of available tests, e.g., Rorschach, TAT (Thematic Apperception Test), Utrecht Gender Dysphoria Scale-Gender Spectrum (UGDS-GS), MCMI (Millon Clinical Multiaxial Inventory), MMPI (Minnesota Multiphasic Personality Inventory) to understand the personality traits, psychopathology of the person, etc. In addition to some of these tests, the person may need other tests, e.g., IQ assessment, etc., if indicated by clinical examination/assessment.

Issues to be Explored

Cross-Dressing

There is a belief amongst medical practitioners that transpersons always cross-dress, and the person's dress indicates their gender. Quite a few transgender people do not cross-dress, despite having a deep desire to do so, because of the stigma attached and societal pressures. A closeted male-to-female transgender person is likely to cross-dress only in privacy. Similarly, it is quite possible for a transman living in a village to wear a Punjabi dress instead of shirt & pants at his parents' insistence. Clothing worn by the person cannot be the sole or essential indicator of gender identity.

Sexual Role

The sexual role (insertive/receptive/versatile) desired/played by the person is not a criterion for diagnosing GD or ruling out GD.

> **Example:** *Sunita is a transwoman. She has not undergone transition. She is sexually attracted to men and plays the receptive as well as insertive role with her male partner. That does not mean that Sunita does not have Gender Dysphoria.*

Impact of Cultural Discrimination

There will be times when a girl/woman may wish that she was male. It is important to explore this wish- for a GD, this desire to be male should be unrelated to cultural surroundings. e.g., in a culture where being male is valued, there are girls who openly wish they were male, but this does not mean that their gender identity is male. It is important to distinguish between the feeling of incongruence between the gender assigned at birth and the gender experienced vis a vie the frustration of living in a culture that severely discriminates on the basis of gender.

Intense Attachment

At times the person is so emotionally attached to their best friend that they may desperately desire to take on a gender role of their best friend- to identify with the friend in every way possible. At times, they may desperately desire to take on a gender role

opposite of their best friend- to marry their best friend. Such strong emotional attachments, where there is no incongruence between the gender assigned at birth and the gender experienced, no accompanying distress with the primary and secondary sexual characteristics, does not warrant a tag of GD.

Gender Non-Conforming Persons

Many gender non-conforming persons believe in a strictly binary world, where they must be male or female by gender, never a combination of both or neither. But, the fact is, there are some persons whose experience of gender is non-binary. They may state that "I sometimes experience being male and sometimes experience being female". There will be times when they state that they desires to cross-dress, and there will be other times when they do not desire to do so. At times, the person does not express this outright, but clinical assessment and interviews may conclude that the gender identification is not consistent/stable. In such cases, the person needs to be assured that being gender non-conforming is ok and normal and not a disorder. Gender Nonconforming behaviour is not a basis for assigning the diagnoses of GD.

Example: *Some gender-fluid or genderqueer persons may state that they are confused. They are very clear about what they feel and experience- there is no confusion about that; the confusion for them arises when they try to fit themselves into one of the binary gender roles and are unable to do so; they feel that something is amiss.*

Check for Consistency and Ambiguity in Gender Experience
Dr. Bhooshan Shukla
(Child and Adolescent Psychiatrist)

During clinical assessment of GD, the two aspects- Consistency of gender experience and Unambiguousness of the gender experience, need to be explored thoroughly.

Consistency
All diagnostic criteria for GD point to not being comfortable with the gender assigned at birth and physical aspects of that gender– anatomy, voice, menstruation, etc. This feeling of being uncomfortable and distressed should be consistent for months (DSM V requires at least six months, in real life, persons with GD experience it consistently for years).

For some, this distress and discomfort starts in childhood (pre-puberty), for others, this discomfort and distress are experienced at puberty (onset of the development of secondary sexual features). Many adults report repeated attempts to fit in with the gender assigned at birth and experience worsening distress with each of these attempts to 'fit in'.

Ambiguity
Ambiguity can occur at two levels –
a. Ambiguity about gender identity itself. It is possible that a person may not "feel" a specific gender all the time. They may find a different gender role okay or even attractive for some period or in specific situations or with specific company/socialization.

b. Ambiguity in the expression of gender– one may feel like one gender inside but continue to dress/appear as another gender without any conflict or with minimal conflict.

Example: *Rajesh sometimes cross-dresses, and his gender identification is male. No discomfort or distress is associated with the male gender assigned to him at birth, nor is he distressed about his primary or secondary sexual characteristics.*

So Rajesh does not have GD. Other people may see Rajesh's cross-dressing as ambiguous, but for him, there is no ambiguity– he is comfortable with unisex or opposite-sex appearance.

A frequently-made mistake is that medical practitioners always expect a binary gender (male or female), binary sexual orientation (sexual attraction to men or women), and binary sexual role (insertive or receptive) in persons with GD. They need to keep an open mind.

At times, a lack of consistency may be noticed; at times, the ambiguity of gender may raise its head repeatedly. This should be accepted as part of the assessment process, especially when working with young persons.

Mental Health Issues and Gender Dysphoria

Various studies have observed that transgender and gay people have higher than expected psychiatric disorders as compared to the general population[4], but these rates drop in an enabling environment[5].

So there are instances where the person who has come for GD assessment could have mental health issues. In such cases, the psychiatrist will generally suggest treatment on this issue before assessment of GD.

> **Dr. Arvind Panchanadikar (Psychiatrist):** *A 20 something young biological male had a precise GD diagnosis but, due to some other issues happening in her life(at that time), had developed a brief psychotic episode. Psychotic symptoms clouded the persons's ability to decide for herself, and she used to think that transitioning would stop the hallucinatory tormentors from troubling her. She was successfully treated by the psychiatrist and once fit was given GD certificate by the team."*

After facing rejection from society on all fronts, being denied the GD certificate can be extremely demoralizing. Hence, it is important to give hope to the person, be sensitive, and explain why the assessment is postponed or the certificate is being withheld.

Why Bother with Gender Dysphoria Certification?
Dr. Arvind Panchanadikar (Psychiatrist)

The term Gender Dysphoria (GD) is relatively vague, and there are no concrete diagnostic criteria for the same. Various diagnostic systems and organizations have tried to come to a consensus, but no consensus has been reached so far. As a result of this ambiguity, there is a possibility that either it can be misdiagnosed or other psychiatric conditions can masquerade as GD.

Conditions such as schizophrenia, delusional disorder, bipolar illness, dissociative disorder, and personality disorders can present GD as a part of their symptomatology. Also, it should be noted that any condition can be present as a co-morbid diagnosis with an existing GD. This makes it very important to diagnose a 'true' GD.

Feeling that a person does not identify with their gender can be a psychotic symptom in some cases in schizophrenia or delusional disorder. It can be seen as a persecutory delusion or through delusions of guilt. 'not being man enough/a woman enough' feeling is not enough to diagnose a GD. This feeling can result from psychosis, mood disorder, depression, or a part of a personality disorder. So some dysphoria around one's gender due to these conditions can be easily seen as GD with disastrous consequences. Taking a casual approach will push these individuals into a life of misery.

Any suspicion that a condition other than a GD is present should make a clinician thorough in his workup. A GD diagnosis is withheld until the clinician is convinced that the co-morbidities do not impact the diagnosis.

Suppose it is felt that the diagnosis of GD is unclear due to other disorders being present. In that case, every attempt is made to treat or control the primary disorder (NOT GD) with

the help of all the modalities a clinician has. GD diagnosis is deferred until the point when other conditions are not impacting the GD diagnosis. A fresh GD assessment is carried out once things settle down.

Another important reason to rule out any differential diagnosis is that it will directly impact a person's ability to decide and care for themselves.

Body Image and Gender Dysphoria

Many persons are particular about their body image- looks, proportion, appeal etc. But in rare cases, this presents as a mental health issue resulting in severe distress. The medical practitioner should not confuse such mental health issues with Gender Dysphoria. Two examples are given below:

1. In Body Dysmorphic Disorder the person believes that some part of their body is defective and so it should be fixed. They can't stop thinking about it. They repeatedly check themselves in the mirror and constantly seek reassurance. This perceived flaw and repetitive behavior can cause considerable distress.

Example: *Pravin's penis is average in size but he believes that it is very small. He is ashamed of it. He believes he is not man enough. As a consequence he refuses to seek physical intimacy. All this causes him considerable distress and he is obsessed with this thought. He has become severely depressed.*

Pravin's obsession with the appearance / size of an organ / part of his anatomy has nothing to do with his gender identity or sexual orientation. His focus of distress is a perceived flaw, not gender. It is important to note that **those with body dysmorphia have a distorted view of how they look. Those who have gender dysphoria have no such distortion**.

2. In the eating disorder Anorexia Nervosa the person shows intense fear of gaining weight. They view themselves as overweight even when they are dangerously underweight and

go to extreme lengths to loose weight.

Example: *Chitra suffers from Anorexia Nervosa. She presents as a thin, anaemic person with very small breasts. Although she is very underweight, she constantly worries that she is overweight. She worries that there is too much fat on her body- breasts, hips, buttocks, stomach and starves herself to get rid of the fat.*

Chitra's obsession with reducing the fat on her body i.e. desiring that her breasts become flat, her hips lose their fat deposition etc. has nothing to do with her gender identity or sexual orientation. Her focus of distress is weight not gender.

Findings

The psychiatrist discusses the findings of clinical assessment, tests, and interviews with the person. If no conflicting mental health issues are identified, and the clinical assessment is affirmative of GD, the psychiatrist grants a GD Certificate. A sample format for the GD Certificate is given in Appendix B.

The transperson needs to show the reports of the tests done to another psychiatrist and obtain another GD Certificate. After obtaining two GD Certificates, Gender Affirming Harmone Therapy (GAHT) can be started. (This is not a hard and fast rule. At times even one GD certificate may be considered sufficient to start GAHT.)

It is possible that after obtaining the GD Certificates the person may, later on, face mental health issues. If the psychiatrist and clinical psychologist have been professionally sensitive in providing care, the person will unhesitatingly approach them should the need arise.

References

[1] Kaplan and Sadock's Synopsis of Psychiatry. 11th Edition. Wolters. Kluwer. Chapter 18. Gender Dysphoria.

[2] Book 'Basics of Sex, Gender, and Sexuality' (Authors Dr. Bhooshan Shukla and Bindumadhav Khire. Published by Dr.

Bhooshan Shukla. 2021)
Chapter "RAVI" provides a short and simplified example of using play and picture methodology to elicit the mental framework of the child for GD assessment.
[3] Diagnosis of Gender dysphoria
(I) Kaplan and Sadock's Synopsis of Psychiatry. Eleventh Edition. Wolters. Kluwer. Chapter 18. Gender Dysphoria. *Course and Prognosis. Children diagnosed with Gender dysphoria do not necessarily grow up to identify as transgender adults. Several studies have demonstrated that more than half of those diagnosed with gender identity disorder, based on the DSM-IV, later identify with their birth-assigned gender once they reach adulthood.*
(ii) Possibility of change is diagnosis of Gender dysphoria. Chantal M. Wiepjes, Nienke M. Nota, Christel J. M. de Blok, Maartje Klaver, Annelou L.C. de Vries, S. Annelijn Wensing-Kruger, Renate T. de Jongh, Mark-Bram Bouman, Thomas D. Steensma, Peggy Cohen-Kettenis, Louis J.G. Gooren, Baudewijntje P.C. Kreukels, Martin den Heijer. The Amsterdam Cohort of Gender Dysphoria Study (1972–2015): Trends in Prevalence, Treatment, and Regrets. The Journal of Sexual Medicine, Volume 15, Issue 4, 2018, Pages 582-590.
[4] World Psychiatric Association (WPA) Position Statement on Gender Identity and Same-Sex Orientation, Attraction, and Behaviours. March 2016. Papers referenced: Levounis et al 2012, Kalra et al 2015.
[5] World Psychiatric Association (WPA) Position Statement on Gender Identity and Same-Sex Orientation, Attraction, and Behaviours. March 2016. Papers references: Gonzhales 2014, Hatzenbuehler et al 2009, 2012, Padula et al 2015.

THE NEED FOR TRANSITION

Counselor: *"Kashala karaichi asli jhanjat? Tyacha kai upyog?"* (Why get into this mess of gender affirmation hormone treatment/surgery? What's the use?)

Introduction

I know many healthcare providers who have voiced the above point of view privately. What they mean is:

a) In the case of a transwoman: What is the point of going in for Gender Affirmative Surgery (GAS) when she won't be able to have a baby anyways? (as she wont have a uterus) Note the emphasis on reproductive ability.
b) In the case of a transman: What is the point of going in for Gender Affirmative Surgery when he cannot have peno-vaginal intercourse with a woman? (as many transmen do not go for a penile prosthesis) Note the emphasis on the role of the penis.

Their mindset is rooted in the primary function of a male impregnating the female and the female giving birth to a baby. Any treatment/surgery that does not assist in fulfilment of these roles is not worth undertaking. It is a stark reminder of how little we understand sexuality, gender, and sexual/gender expression.

I try to explain, to them, in the following way:
Observe or recall how you, in every direct or indirect, conscious and sub-conscious manner, express/suppress your sexuality and gender traits.

We view our body image, sexuality, gender identity, and gender/sexual expression from different perspectives. I highlight three important areas:

1. We, as we see ourselves in the mirror
2. We, as our partner, sees us and responds to us
3. We, as the world, sees us and responds to us

It is human nature to express those traits, expressions that come to us naturally. We desire to accentuate those traits and

expressions which reflect our anatomy, gender, and sexuality. So it is but natural that transpersons will desire to bring unity in their anatomy and gender, as their anatomy is an essential accessory of their gender, just as it is for all of us.

When a pre-transition transman stands naked in front of the mirror, he sees a female body, one he does not desire, a body that makes him dislike himself.

1. When he goes in for male GAHT he experiences facial hair growth, his menses cease. When he undergoes Mastectomy, he sees a man in the mirror, which is a true reflection of his gender. When he undergoes Bi-lateral-Salpingo-Oophorectomy, he is rid of his ovaries and uterus. He feels more comfortable, more confident, more natural, more complete because he has less 'female burden' to carry.

   When he has Scrotoplasty, he has a scrotum like a man. When he has Metoidioplasty (surgically converting a clitoris to a penis) or Phalloplasty (surgical construction of a penis from skin), he has a penis, and he can urinate standing up like a man. It is possible that he may not be completely satisfied, as he won't be able to perform the insertive role with a penis with his partner (unless he has a penile prosthesis), but the issue is that the correct anatomical reflection of his gender is crucial, even if it does not lead to penile arousal and fulfilment of the insertive role. He is more of a man than he ever was before.

2. In his partner's eyes, he is now a man. Before the surgery, he was a man by gender. Now he is also a man by anatomy. So the partner's response will be towards a person who, by gender and anatomy, is a man, and that correct response makes the transman more complete.

3. As the transman stands up to urinate, he feels a universal bonding with all other men with a similar instinct, an act that enables him to be accepted as equal to other men. The 'taken for granted as a man' by others is a test that every transman desires to face and pass with flying colors, just as every

cisgendered man and every woman strongly, adamantly, from the very core of their being desires that the rest of the world does not misgender them.

Similarly, when a pre-transition transwoman stands naked in front of the mirror, she sees a male body, one she does not desire, one she intensely dislikes.

1. When she goes in for female GAHT / undergoes breast implant surgery, she sees a woman in the mirror, which is a true reflection of her gender.

   When she has Bi-lateral Orchiectomy and Penectomy, she feels more natural, more confident, more complete as she has less 'male burden' to carry. She is happy to be rid of the penis and testes that had constantly reminded her that she was anatomically a male. It is possible that she may not be completely satisfied, as she wont be able to carry her partner's baby due to the absence of a uterus. But for her, the correct anatomical reflection of her gender is crucial. She is closer to being a woman than ever before; the absence of a uterus is simply science lagging behind the needs of the human.

2. In her partner's eyes, she is now a woman. Before the surgery, she was a woman by gender; now, she is also a woman by anatomy. So the partner's response will be towards a person who, by gender and anatomy, is a woman, and that correct response makes the transwoman more complete.

3. As the transwoman puts on a sari, she feels a universal bonding with all other women, an expression of her gender that enables her to be accepted as equal to other women. The 'taken for granted as a woman' by others is a test that every transwoman desires to face and pass with flying colors.

And so this is the quest to live your gender, a strong, consistent, focused need. It is there in all of us, but since all the others take this need and its fulfilment for granted, we are unable to understand transpersons. It is our empathy which is sadly lacking.

This urge is so strong that transpersons are willing to go to great lengths emotionally, physically, and financially to have GAHT/surgery for this rebirth. They are willing to make a lot of sacrifices to undergo this transition and even forego the support of their families. This takes immense courage. The least we can do is respect that desire and support them.

Do Transpersons Regret Surgical Transition?

There is an extremely low prevalence of regret in transpersons after GAS.[1]

In my experience of more than two decades, I have come across only one case where the person regretted her surgical transition. The *tritiyapanthi* had undergone a surgical procedure without proper counseling on the long-term consequences. Her parents stayed in a village far from Pune and did not know she was a *tritiyapanthi.* She panicked when she had to move back to her village for personal reasons. She wanted to know whether the surgery could be undone. Her regret was not about either her gender identity or the surgery. She wanted to go back as her former self as her family and neighbors would not have understood her.

References

[1] Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence. Bustos, Valeria P. MD; Bustos, Samyd S. MD; Mascaro, Andres MD; Del Corral, Gabriel MD, FACS; Forte, Antonio J. MD, PhD, MS; Ciudad, Pedro MD, PhD; Kim, Esther A. MD; Langstein, Howard N. MD; Manrique, Oscar J. MD, FACS.
Plastic and Reconstructive Surgery-Global Open. March 2021 - Volume 9 - Issue 3 - p e3477
doi: 10.1097/GOX.0000000000003477

PLANNING FOR TRANSITION

Transgender: *"I wish I had someone who had counseled me on the transition process. It would have mentally prepared me better. What are the costs, the options, and the challenges involved?... When I was given the consent form for starting hormones, it was in English and difficult to understand. All the medical terms were unknown to me. I wish the consent form was in Marathi."*

Introduction

It is optional for transpersons to decide whether to undergo hormonal or surgical transition, both, or neither after obtaining a GD certificate. Some transpersons do not go in for transition, either hormonal or surgical. Some go in for hormonal transition only, while others go in for hormonal and, later on, surgical transition.

Those who desire to transition are generally very eager to start the process. But their eagerness does not imply their understanding and readiness for the transition. Medical Practitioners should not presume that if a transperson has been diagnosed with GD and is cross-dressing, they are fully aware of the transition process. I.e., the choices involved, the financial commitment needed, issues related to allied services (e.g., laser treatment for facial and body hair removal), and necessary support structures. All of these have to be discussed, and the transperson should be given enough time to understand these issues, think over them, and come back with more queries.

Sadly, there is no concept of 'Transition Counseling', in Indian context, and, many a time, counseling is provided in bits and pieces by psychiatrists, endocrinologists, and plastic surgeons.

Transition Counseling is extremely important, as it presents to the person an accurate, objective, and a realistic perspective of the transition process.

Some of the issues to be covered in transition counselling are-

- Understanding the person's resolve, background (family, social, economic, medical, professional, etc.), knowledge/views about the transition processes, transition plan, support systems.
- Referrals to medical practitioners who provide transition-related services, referrals to transitioned persons for learning and support
- Groundwork
- In-transition/post-transition support

Medical practitioners and psychologists desiring to work with LGBTIQA can also refer to 'Guidelines for Psychological Practice With Transgender and Gender Nonconforming People'.[1]

Resolve

The most important aspect of transition is the resolve of the transperson. The person needs to be mentally fully prepared to face the challenges of life post-transition. Suppose the person has all other preparations for transition in place, e.g., finance, support systems, etc. but is unsure of their ability to handle the inevitable challenges they will face post-transition. In that case, the person should not be hasty in starting their transition.

Background

The person's background gives us a good idea of the challenges they may face during and after the transition.

> **Example 1:** *At times, the person assumes support structures are in place without speaking to the supporting family members/friends/groups about the transition or the patient's expectations.*

> **Example 2:** *At times, it is seen that the person has not planned financially for the transition. I know a few transpersons who started GAHT and gave it up after six months as they could not afford it.*

> **Example 3:** *Some medical conditions may contra-*

indicate GAHT/surgery.

Example 4: *How would the transition affect the person's profession/occupation? Would discussing their issue with Human Resources (HR) and Head Of Department (HOD) of the concerned department help matters? Perhaps having a sensitization session with the department staff? Are there other options that can be explored?*

I know transpersons who have left their jobs, transitioned, changed their name & gender on legal documents, and then sought new employment as a transitioned person. They were too uncomfortable to take a break, transition, and join the same Company again.

But what if the person is a government employee?How would the department handle it? Would it make sense to meet a sensitive senior officer in private to discuss this beforehand? What are the rules (if any) of the State/local government in such matters? Would the transperson be willing to approach the relevant forums, including the High Court for justice, if discrimination occurs? Would the person (and the family) be mentally strong to withstand the media spotlight in such a scenario?

Knowledge and Views

Some transpersons are well informed about the process. They have searched extensively on social media, heard experiences from transitioned persons, read articles, and watched videos. But many have knowledge only in bits and pieces, which leads them to have unrealistic expectations regarding timelines and outcomes. An inquiry should also be made about whether the transperson has thought about the kind of family they would like to have and the impact of transition on planning for such a family. Knowing the person's knowledge and views gives us an opportunity to list down areas for counseling.

Transition Plan

Understanding the person's transition plan (if any) is important as it becomes a baseline for preparing a detailed plan, taking into account the person's views and concerns.

Support Systems

> **Transman:** *"I want to transition quickly, preferably within a month. I stay with my parents, but I don't want them to know about this until it is done."*

Quite a few transpersons are in the closet and desire to do the transition without coming out to anyone. In some cases, they live with their parents but are not out to them. I can understand that they are afraid of the opposition from their parents. But, it is essential to understand that transition is a long process and is very emotionally taxing. A lot of mental health support is required from family/friends, and transpersons who have transitioned. Keeping the entire transition process a secret from everyone is very difficult and also unwise.

Referrals

The transition process needs a team of medical practitioners working together- Psychiatrist, Endocrinologist, Plastic surgeon etc. In addition, referrals may also have to be made to Urologists, Gynaecologists, Fertility experts, Dermatologists, etc. Advice from an Advocate experienced in these issues may also be needed. Medical practitioners and NGOs can assist the transperson in providing referral linkages for building such a team.

Transitioned Persons

Wherever possible, transpersons exploring transition should try to meet others who are transitioning or have transitioned. Medical practitioners and NGOs should provide contacts of transitioned persons to the transperson after obtaining consent from the transitioned persons. This assists the transitioning person in building a correct mindset and realistic expectations about the transition.

Groundwork

On the technical front, a lot of groundwork needs to be done on planning the transition. Various factors have to be worked on, such as finalizing the schedule, deciding on the transition team, financial planning, finalizing support systems, etc. Each transperson will have different goals and means to get there, and the plan will have to be tailored accordingly. The planning will have to take into account the current circumstances and projected circumstances.

While technicalities are important, the correct mental attitude of the person towards transition is crucial in this long journey. For some, this journey could take 3-4 years; for others, more. So proper planning, patience, and resilience are paramount for success.

The person needs to understand that unforeseen contingencies could derail their plans after embarking on the transition journey. There is a possibility that the transperson desperate for the transition could easily slip into depression. So, keeping hope alive and assuring the person of support, to whatever extent possible, is an integral part of this counselling.

In-transition/post-transition support

The person may face various challenges during transition and adjustment challenges post-transition. So, the person will need to have access to a counseling platform to share their experiences, ventilate, and seek support in adjusting to the transitioned lifestyle.

Common Medical Issues

Many medical issues related to transitioning are associated with the type of transition- male-to-female transition or female-to-male transition. But some medical issues are common to all and should be covered in counseling each transitioning person. Some of these issues are listed below.

Smoking and Drugs

It is vital to obtain all relevant information regarding smoking,

alcohol, recreational drug use, medications, herbs, etc., from the transitioning person. The psychiatrist, endocrinologist, plastic surgeon need to understand the risks of starting the transition process under these conditions.

> **Example:** *The risk of blood clot formation, cardiovascular disease may significantly increase in heavy smokers who go for feminizing GAHT.*

Over the Counter Hormone Medications

> ***Tritiyapanthi:*** *"Sir, I have been taking hormones from a chemist. This is the tablet name (Shows me the tablet strip). Is this the correct medication? He said I should take this daily to increase my breast size."*

The above scenario is widespread. I have time and again warned transgender people not to go for hormone medication without an expert's supervision. I admit I have not been very successful. Buying over-the-counter hormones bypassing the endocrinologist is far less expensive, and hence many transgender people take this approach. So, medical practitioners who work on transition issues need to educate transitioning persons on the dangers of over-the-counter hormone medications. A couple of examples are given below.

- Estrogen and testosterone are metabolized in the liver and excreted through the kidneys. So periodic monitoring of liver and renal function is essential.

- Different hormones have different side effects, some leading to serious health issues. In rare cases, estrogen hormone can lead to deep vein thrombosis (blood clot formation in veins). Some feminizing medications used in transition can lead to a rise in triglycerides, blood pressure, cardiovascular disease, stroke, type-2 diabetes, increase in potassium (hyperkalemia), and increased risk of breast cancer.

- Testosterone hormone injections may cause polycythemia (too many red blood cells). Some masculinizing medications

used in transition can lead to the development of an abnormal level of cholesterol and other lipids (dyslipidemia), high blood pressure (hypertension), type-2 diabetes, deep vein thrombosis, and sleep apnea.

So, periodic blood count, liver/renal function tests, hormone tests are necessary to monitor toxicity and ensure that hormone levels are within the appropriate range.

Generic V/s Branded Hormones

For some, hormone treatment is a costly exercise; they may find it challenging to sustain hormone treatment for long. So they keep on looking for cheaper drugs. But they need to keep in mind the difference between generic drugs and branded drugs before taking a call.

Dr. Varsha Jagtap (Endocrinologist): *"Generic drugs are cheaper but are not dependable. Some Companies function for a few months and are not heard from again. So, although costly, I always suggest the administration of branded hormones rather than generic ones. While on hormones, let me add another important point- transpersons should be told not to compare their hormone doses with others. The hormone doses are decided based on various factors like age, weight, tolerance, effect, etc. Initially, the doses are small, and then they are gradually increased, depending on various parameters. So, each person requires different doses depending on their requirement/tolerance. Comparing doses with each other can lead to confusion, loss of faith, and gnawing anxiety as to whether their therapy is correct and proper."*

Hormone Dose/Frequency

Some endocrinologists prescribe at least two years of GAHT before Gender Affirmative Surgery (GAS). Others prescribe a minimum of one year of GAHT before GAS. This duration may also vary due to various person-specific factors.

During the hormonal transition, the transitioning person should

be explained the importance of sticking to the hormone dose and frequency prescribed by the endocrinologist. The person should not make the mistake of believing that if they take the hormone in excess, the transition will occur faster. Taking hormone doses in excess of the prescribed quantity could harm the body and/or be counterproductive.

Example: *The body has the ability to convert excess testosterone to estrogen, which may, in turn, increase the risk of breast cancer and/or reduce the desired effect of testosterone.*

Puberty Blockers

If the person having Gender Dysphoria has not yet reached adolescence, the endocrinologist may prescribe Puberty Blocker medications to lessen the trauma of having secondary sexual characteristics. This shall be done only after consultation and informed consent of the parents.

Need of Hormones Before Surgery

Quite a few transpersons ask-

"Why do I need to go for GAHT if I want to go for surgical transition anyway?"

They need to be told that GAHT and GAS are not either-or options.

Dr. Varsha Jagtap (Endocrinologist): *"Gender Affirming Hormone Therapy (GAHT) assists the gradual adaptation of the person to the changing body contours. For example, their fat deposition will change, hair growth will be affected.*

Transitioning persons must be told that hormones need to be taken even after surgery. So the tolerance of hormones should be tested as early as possible before a transperson goes in for surgery. Based on their effect on the body, dosages may have to be changed. At times, for the sake of

health, GAHT may have to be stopped for good. It takes about a year of monitoring and fine-tuning to understand and stabilize the dynamics of the hormones in a transperson's body. So it is generally advised that the transperson take GAHT for at least a year before going in for surgery."

Biometric Tests

Before starting GAHT, the endocrinologist will advise the transitioning person to do specific tests. The results are analyzed to ensure that the person is healthy to take hormones. The test results are later on compared with subsequent tests to monitor toxicity.

In addition to periodic tests, other periodic medical checkups may also be advised. E.g., screening for cervical cancer, mammogram, etc.

Fertility

Many transpersons are so focused on transition that they either do not think about or forget to ask questions related to the kind of family they desire to have. Do they desire a child? If so, when? How?- by Artificial Insemination? by IVF? by Surrogacy? by Adoption? (Assuming the appropriate option is legally available to them.) Or do they want to postpone the decision of having a baby by the preservation of sperm/ova? This critical issue should be discussed before the transition. (Refer chapter 'Sexual Attraction' for short notes on ART, surrogacy, adoption, and sperm/ova/embryo preservation).

Informed Consent to Start Gender Affirming Hormone Therapy (GAHT)

The following criteria need to be fulfilled to start GAHT:

- GD certificates from two psychiatrists. (Exceptions may be made, and GAHT can be started based on a single GD certificate from a psychiatrist.)
- The transitioning person should be an adult. If the person is a minor, then written informed consent of parents/guardians is essential.

- The person should be of sound mental health, understand the process, consequences and give informed written consent.
- The person should read the consent form provided by the endocrinologist, understand it, seek clarifications, and sign it. The consent form (generally in English) mentions permanent and non-permanent side-effects, fertility issues, health risks, information about the need for following the doctor's instructions on dosage, periodic checkups, etc.

Dr. Varsha Jagtap (Endocrinologist): *"I would like if the transperson coming to me takes time to read the consent form thoroughly and discuss all the relevant points. For example, many don't ask any questions about fertility."*

References

[1] Guidelines for Psychological Practice With Transgender and Gender Nonconforming People. American Psychologial Association. December 2015.
https://www.apa.org/practice/guidelines/transgender.pdf

GENDER AFFIRMING HORMONE THERAPY (GAHT) FOR TRANSGENDERS/TRANSWOMEN

Tritiyapanthi: *"After my Bi-lateral Orchiectomy, a year or so later, I noticed that my libido had gone down."*

Before starting GAHT, the endocrinologist needs to discuss the following issues with the transitioning person (in addition to those discussed in the chapter 'Planning for Transition').

Libido

After Bi-lateral Orchiectomy (removal of testes), testosterone production drops significantly (although a small amount of testosterone does continue to get secreted through the adrenal glands). This results in loss of libido. But, this problem can be addressed with the correct adjustment of doses.

Fertility

If the transgender/transwoman has not started transition, she may consider freezing her sperm or becoming a parent, with a consenting adult female partner, through Assisted Reproductive Technology (ART). An Advocate's expertise is essential to understand whether the transgender/transwoman has legal access to the desired procedure, and to handle all the legalities involved.

It should be underlined that the exercise if it is to be done at all, should be done before the start of GAHT as GAHT may adversely affect the production of sperm. It should also be mentioned that healthy sperm production depends on a few factors- history of alcohol/drug use/smoking, medications, etc. So it makes sense to test the quantity/quality of sperm before opting for any of the fertility exercises.

Hormones

In GAHT, estrogen tablets are prescribed for transgender people/transwomen. Initially, a small dose is given and based on various factors, the dosage is gradually increased. Some endocrinologists prescribe testosterone blockers for the first few months. Some don't.

In addition to the hormone, allied medications like Calcium tablets, etc., may also be prescribed.

Cost

The cost per month of estrogen tablets may range upwards of ₹500.00. If testosterone blocker injections are prescribed, there is a steep rise in cost as the injection cost can be upwards of ₹7000.00 per month. Once the endocrinologist provides the prescription, a medical practitioner can give the injection as per the prescription.

> **Transwoman:** *"It is so much of a hassle to ask the doctor to give the injection. Doctors don't know anything about hormone treatment. Every time, I have to explain to the doctor who I am, what is transition, what is hormone therapy, and what is the injection for. It is so frustrating."*

The quarterly blood/urine tests will cost upwards of ₹4,000.00. The tests must be conducted every three months for the first year and then every six months or annually.

Timeline

Generally, in 8-12 months, the transgender person/transwoman starts noticing the growth of breasts. Other changes that will be gradually seen over a year or two are:

- decrease in libido
- decrease in spontaneous erections
- testicular atrophy
- redistribution of body fat
- reduced muscular mass
- skin becomes soft and less oily
- male pattern hair loss decreases

Side-effects

Persons on GAHT may experience irritation, mood swings, bloating, swelling in parts of the body, breast tenderness, feeling sick, headaches, leg cramps, indigestion, nipple discharge.

Experience Sharing
Transwoman Vijaya

The first thing that happened was I became moody and had mood swings for the first couple of months. My breasts took a long time, around 7-8 months, to start developing. I used to feel that the medications were not working as I was not told that this was the time required for them to develop. My breasts also became very sensitive, and I would feel pain in the breasts. When I travel in a crowded bus, and someone pushes against my breasts, I feel the pain.

Experience Sharing
Transwoman Damini

I am undergoing estrogen therapy. It is important to not to terminate the treatment halfway. I noticed side effects like mood swings and red patches on the skin on starting the therapy. I know some people who have suffered from constipation, other gastric problems, and sleep issues.

I have undergone Bilateral-Orchiectomy and Mammoplasty. Additionally, I am undergoing permanent hair removal laser treatment. I am looking forward to going in for a Vaginoplasty.

Since I started GAHT, my confidence level has gone up. I feel less stressed and more comfortable as I am now in a body closer to the female anatomy.

GENDER AFFIRMATIVE SURGERY FOR TRANSGENDERS/TRANSWOMEN

Dr. Ashish Davalbhakt(Cosmetic Surgeon)**:** *"The size and type of the breast implant to be used depends on a lot of factors- the person's constitution, cost, etc. The surgeon discusses these with the person and suggests an option best suited to the person."*

Introduction

After being on GAHT for a couple of years, some transgenders/transwomen decide to go for Gender Affirmative Surgery (GAS). These surgeries can be classified into two parts-

1. **Core surgeries:** These can be further divided into two parts- Top surgery and Bottom surgery.Some go only for Top surgery. Some go for Top and Bottom surgery.

2. **Ancillary procedures/surgeries:** Transgenders/transwomen many also opt for ancillary feminizing procedures / surgeries to get a more feminine look.

Core Surgeries

Top Surgery (Breast implant surgery)

Breast implants are mainly of two types, silicone, and gummy bear (cohesive) implants. Gummy bear implants are more expensive. The plastic surgeon will discuss the type and size of the implant best suited for the person. Top surgery involves incisions below the breasts to insert the implants. The incisions are then closed.

Post Surgery Recovery

For a week or so, there may be inflammation of the breasts. Infection is possible if proper post-operative care is not taken as directed by the surgeon. Some may experience less nipple sensitivity. For a couple of weeks after surgery, the surgeon will advice wearing a support bra. They will also advise the person about side effects to watch out for and how to take care of the

breasts, post-surgery.

Exercising, running, lifting weights, and other intense exercises should be avoided post-surgery for 3 to 6 months. The surgeon will guide the transperson on these issues.

Cost
Breast implant surgery costs upwards of ₹80,000.00.

Bottom Surgery
As compared to Top surgery, fewer transgender people/transwomen go for Bottom surgery. After Top surgery, some wait a year, some more to do Bottom surgery. It is expensive, complicated, and requires more recovery time. Additionally, very few plastic surgeons in India have the expertise in performing Bottom surgeries.

Although the phrase used is 'Bottom Surgery', in practice it is a series of surgeries- Bi-lateral Orchiectomy (removal of testes), Penectomy (removal of the penis), Vaginoplasty (creation of a vagina), Labioplasty (creation of labia). The plastic surgeon will discuss with the transperson whether Bi-lateral-Orchiectomy, Penectomy, and Vaginoplasty are to be done in a single surgery or in a series of surgeries spread over months/years.

Note that, not all transgenders/transwomen will go for all Bottom surgeries.

> **Example 1**: *Tritiyapanthi Rani (name changed) has only gone for a Bi-lateral Orchiectomy and Penectomy.*
>
> **Example 2:** *Transwoman Padmaja (name changed) has undergone Bi-lateral Orchiectomy, Penectomy, and Vaginoplasty.*

As there is no uterus, the transgender/transwoman cannot become pregnant. Those who go for Bi-lateral-Orchiectomy and Penectomy but do not go for a Vaginoplasty will be unable to have peno-vaginal intercourse. This surgery is relatively less expensive.

***Tritiyapanthi* :** *"I had my testes and penis removed but I did not go for Vaginoplasty. As my seminal vesicles are still there, semen will continue to generate."*

Vaginoplasty

There are different types of Vaginoplasty. Three of the well known are:

- Penile Inversion (the skin of the penis is used to create the vagina)
- McIndoe (a skin graft is used to create the vagina)
- Sigmoid-Colon (a part of the colon is used to create the vagina)

Each type has its advantages/disadvantages.

Example 1: *Sigmoid-Colon Vaginoplasty will provide the vagina with moistness.*

Example 2: *In the McIndoe procedure, the vagina will be dry, and the skin graft could leave scarring in the area from where the skin has been taken.*

Post-Surgery Recovery

The surgeries are complex, and the plastic surgeon will inform the transperson of the possible complications. Some of the complications that could result are- infection, fluid accumulation at the site (Seroma), blood clot formation at the site (Hematoma), narrowing of the urethra (Urethral stricture), etc.

Post-surgery, the surgeon will guide the transgender/ transwoman on vaginal hygiene. Depending on the Vaginoplasty procedure, the surgeon will also guide the person on the frequency of use of the dilators, to ensure that the vagina remains open.

Exercising, running, lifting weights, and other intense exercises should be avoided post-surgery for 3 to 6 months. The surgeon will guide the transperson on these issues.

The transperson should be informed that, disregarding the surgeon's advice, carelessness during the post-operative recovery, whether it be Top surgery or Bottom surgery, can lead to serious complications and adversely affect the outcome of the surgery.

Cost

For transgenders/transwomen who go in only for Bi-lateral Orchiectomy and Penectomy, the cost is upwards of ₹1,00,000.00 (One lakh Rupees.).

For those who want to go for Bi-lateral-Orchiectomy, Penectomy, and Vaginoplasty, the cost is upwards of ₹4,00,000.00 (Four lakh Rupees).

Experience Sharing
Transwoman Preesha

For Top surgery, I used silicone implants. The surgery was satisfactory, with very few scars. I noticed no side effects, and nipple sensitivity is satisfactory.

I took hormones for two years before undergoing Vaginoplasty, as advised by my endocrinologist and Gender Affirmative Surgery surgeon. Bi-lateral Orchiectomy, Penectomy, and Vaginoplasty were done in one go.

I underwent Sigmoid Colon Vaginoplasty. It took me around three weeks to recover. The scars have healed very nicely.

I was instructed to use Betadine scrub to clean the area and intimate wash products like V-Wash and soap. I used dilators every day or alternate day initially and later(after three months) twice a week.

The vagina was very sensitive initially; the sensitivity decreased after a month. I can achieve orgasm. No seminal fluid comes out, I think the vesicles have been removed.

Post-surgery I continue to take hormones.

On the mental health aspect, the effect has been positive. I always wanted to have a Vaginoplasty. It gives me mental peace. Transwomen who seek Bottom transition should know that it will bring a lot of mental peace, GD disappears. However, to achieve the best results, consult a good gender affirmative transition endocrinologist and surgeon and follow their advice stringently. My endocrinologist and surgeon were very good.

Experience Sharing
Transwoman Nikki

I took GAHT for one year before I went in for silicone implants. The total cost was around ₹1.10 lakhs. There are very light scars, but I am not very happy with the surgery. My breasts are hard and don't feel completely natural, although nipple sensitivity is present. There were no side effects, but since I was allergic to some antibiotics, the doctor changed the antibiotics, and I was fine.

I had Bi-lateral Orchiectomy a year after my breast implant surgery.

I saved money for Vaginoplasty and got it done about a year after Bi-lateral Orchiectomy. So I was on GAHT for three years before I went in for Vaginoplasty. GAHT brought specific changes in my body that alleviated my gender dysphoria.

I underwent Sigmoid Colon Vaginoplasty. It took me a month and a half to recover. I could have recovered earlier, but there was an infection. Now, the scars have healed completely.

Initially, after the surgery, I used antiseptic scrubs. Now, after full recovery, I use normal intimate hygiene products like vaginal liquid wash and sometimes PH balancing

liquids. Initially, for 5-6 months, I had to use dilators daily. Now, I don't have to use it every day.

My doctor had told me that there is a risk of UTIs if I don't maintain hygiene.

Post-surgery, I continue to take hormones.

After surgery, my vagina was very sensitive, now it's normal. I can achieve orgasm quite well, and there is no semen discharge as seminal vesicles have been removed.

The surgery has had a very good effect on my mental health. I feel good. I am in the right body. Physically too, it feels good. The surgery is costly, but it makes you a complete woman, so I would say to all my trans-sisters that if you can, you should undergo Vaginoplasty, there are risks, but you have to take risks.

In the end, I have a request to make- Gender Affirmative transition surgeons should charge reasonably. They should consider the fact that many transwomen can't afford to pay lakhs of rupees. As far as endocrinologists are concerned, they should be trans-friendly. I had to change four endocrinologists before I found a trans-friendly endocrinologist.

Cost-wise, Bi-lateral-Orchiectomy cost me around ₹30,000.00 and the cost of Vaginoplasty was around ₹3.5 lakhs.

Ancillary Procedures

Laser Treatment for Hair Removal

As long as testes are present, they will continue to secret testosterone, and the person will have facial hair. Purely from the cost perspective, it makes sense to start laser treatment for hair only after Bi-lateral Orchiectomy.

Feminization Procedures / Surgeries

Male-to-female GAHT does not change the bone structure. So some transpersons may undergo various facial feminization procedures/surgeries to remodel the face to appear more feminine.

> **Example:** *Tracheal shave surgery to reduce the Adam's apple, forehead contouring, eye, and lid modification, lip lift, and augmentation, Rhinoplasty (reshaping of the nose), Mandibular angle reduction (to give a more feminine curvature to the jawline), etc.*

WARNING

In the old days, transgender people approached quacks who traditionally performed Bi-lateral Orchiectomy and Penectomy. This practice is mercifully on the wane now. I know a few transgender people who continue to face complications because of surgeries done by quacks. So, it is important to inform transgender people/transwomen not to go for surgical transition at the hands of quacks.

GENDER AFFIRMING HORMONE THERAPY (GAHT) FOR TRANSMEN

> **Transman Trinay:** *"After starting GAHT, the first thing that happened was I started experiencing wild mood swings. I was irritated all the time, but since mom knew I was taking hormones, she was understanding."*

Before starting GAHT, the endocrinologist needs to discuss the following issues with the transitioning person (in addition to those discussed in the chapter 'Planning for Transition').

Libido

On starting GAHT, transmen are likely to experience increased libido. The size of the clitoris will also increase, and it will become more sensitive to stimulation.

Fertility

If the transman has not started transition, he may consider freezing his ova for future use or becoming a parent, with a consenting adult male partner, through the use of Assisted Reproductive Technology (ART). An Advocate's expertise is essential to understand whether the transman has legal access to the desired procedure, and to handle all the legalities involved.

It should be underlined that the exercise if it is to be done at all, should be done before the start of GAHT, as GAHT will adversely affect ova quality. It should also be noted that harvesting healthy ova depends on a few factors- history of alcohol/drug use, smoking, age of the person, etc.

Hormone

Testosterone is not readily absorbed through the stomach lining, so injections are preferred. Estrogen blockers are not prescribed because estrogen is good for the heart and prevents Osteoporosis.

The injection site is generally the buttock. After giving the injection, the doctor typically asks the transman to wait for 15 minutes to ensure that there is no adverse reaction.

Cost

The cost per month of GAHT for a transman is upwards of ₹600.00.

The quarterly blood/urine tests cost upwards of ₹4,000. The tests must be conducted every three months for the first year and then every six months or annually.

Timeline

Generally, in 3-6 months, the transman will start noticing the following changes

- cessation of menses
- deepening of voice
- growth of facial and body hair
- body fat redistribution
- increase in muscle mass and strength
- enlargement of clitoris
- increase in libido
- shrinking of the vagina (Vaginal atrophy)

Side-effects

Transmen may experience mood swings, pain or swelling at the injection site, numbness or tingly feeling, weight gain, headache, pimples (acne), male-pattern baldness.

Experience Sharing
Transman Trinay

My initial experience with psychiatrists has been very bad. The first psychiatrist I visited told me that I was abnormal. My parents immediately believed him and stated that I was a fool for desiring to live like a man.

Later on, I went to another psychiatrist who stated that I was abnormal and would cure me provided I undergo some medicine course- five sessions each costing ₹10,000.00. I stopped going to the psychiatrist.

It was years later that, through a Facebook friend Omkar Joshi, I met Bindumadhav Khire. He spoke to me, gave me all the information, and sent me off for GD assessment to an LGBT-friendly and knowledgeable psychiatrist. And that is where my nightmare ended. I soon got two GD certificates and then started GAHT.

After starting GAHT, the first thing I noticed was my wild mood swings. I also started feeling horny. Later on, I noticed an increase in my clitoris size. It had also become more sensitive, and my frequency of masturbation increased.

In about three months, my menses ceased.
It took around 2-3 months for my voice to become deep.
In 3-4 months, I started noticing facial hair.
Gradually I sensed an increase in strength and loss of body fat.

Mental health-wise, after getting my GD certificates and starting GAHT, I started feeling better, more at peace with myself.

GENDER AFFIRMATIVE SURGERY FOR TRANSMEN

> **Dr. Ashish Davalbhakt (Cosmetic surgeon):** *"Will there be scarring after Mastectomy? If the breasts are large and the breasts are sagging, the skin has to be reduced too, and hence there may be external scars, and the nipples have to be relocated upwards as free nipple grafts."*

Introduction

After being on GAHT for a couple of years, some (not all) transmen decide to go for Gender Affirmative Surgery (GAS).

Core Surgeries

Core surgeries can be divided into two parts- Top Surgery and Bottom Surgery. Many only opt for Top surgery. Very few opt for Top as well as Bottom surgery.

Top Surgery (Mastectomy)

In Mastectomy, the breasts are removed, and the nipples are retained. If the breast size is small, the surgeon may be able to spare the skin and relocation of nipples. The procedure results in minimal scarring and will generally preserve nipple sensation.

If the breasts are large, the skin is reduced, resulting in external scars. The nipples have to be relocated upwards as free nipple grafts.

Note: There is no point in removing the nipples during Mastectomy and then going in for another surgery for reconstruction of nipples.

Post Surgery Recovery

After surgery, the chest will swell due to inflammation for a week or so. The plastic surgeon advises the transman about side effects to watch out for, when to start wearing a constraining jacket and for how long, aftercare etc.

Possible Complications
There is a possibility of death of one or both nipple grafts. The surgeon will educate the person on various possible complications.

Cost
Mastectomy costs upwards of ₹1,00,000.00 (One lakh Rupees).

Bottom Surgery
Bottom surgery is a series of surgeries- Bi-lateral Salpingo-Oophorectomy (removal of fallopian tubes and ovaries), Hysterectomy (removal of the uterus), Vaginectomy (removal of the vagina), Scrotoplasty (creation of scrotum), Metoidioplasty(restructuring the clitoris into a penis) / Phalloplasty (creating a penis from a skin graft from another part of the body), Glansplasty (creating a penis-glans).

Very few opt for Bottom surgery as it is complicated, expensive, and requires more recovery time. Additionally, very few plastic surgeons in India have expertise in these surgeries.

Example 1: *Transman Pratham (name changed) has gone for a Hysterectomy only.*

Example 2: *Transman Sid (name changed) has gone for a Bi-lateral Salpingo-Oophorectomy and Hysterectomy, but not for any other transition surgery, e.g.,Scrotoplasty, Metoidioplasty, etc.*

Scrotoplasty
In Scrotoplasty, a new scrotum is created from existing tissue. Later on, silicone testicular implants can be inserted into the scrotum. As the testicles are artificial, there will be no sperm generation.

Penis
There are two options for creating a penis- Metoidioplasty and Phalloplasty.

Metoidioplasty
In Metoidioplasty, the urethra is elongated, and the clitoris is restructured into a penis. The length of this new penis may be around 3-5 cm. Eventually, the transman can stand up and urinate through the new penis.

Phalloplasty
A Phalloplasty involves a variety of procedures- the creation of the penis using skin from the body, lengthening the urethra, creating the tip (glans) of the penis. There are various types of Phalloplasty. They mainly differ in the part of the body the skin is removed form and how it is removed and relocated.

> **Examples:** *Radial forearm free flap (RFFF) procedure uses the skin from the forearm.*
> The *Anterolateral Thigh (ALT) procedure uses skin from the thigh.*
> *Musculocutaneous latissimus dorsi flap procedure uses skin from the back.*

The length of this new penis may be around 3-6 cm.The size of the penis depends on the size of the skin flap available to create the penis. Eventually, the transman can stand up and urinate through the penis. The penis is unable to achieve an erection.

Later on, some transmen who have undergone Phalloplasty, go for a penile prosthesis to enable them to achieve an erection of the penis. Using this prosthesis, the transman is able to have intercourse in the insertive role. As no sperm is generated, the transman cannot father a child. The complication rates in having a penile prosthesis tend to be high.

Post-Surgery Recovery
The surgeries are complex, and the plastic surgeon will inform the transman of the possible complications.

Exercising, running, lifting weights, and other intense exercises should be avoided post-surgery for 3 to 6 months. The surgeon will guide the transman on these issues.

The transman should be informed that disregarding the surgeon's advice, carelessness during the post-operative recovery, whether it be Top surgery or Bottom surgery, can lead to severe complications and adversely affect the outcome of the surgery.

Note on Experience Sharing

Despite sending out requests for experience sharing by transmen who have had Bottom surgery, I received no responses.

LEGAL STATUS OF TRANSPERSONS

The Legality of Surgical Transition

Case: Swati Baruah was a transwoman who came to Mumbai from Gauhati (Assam). She wanted to go for Gender Affirmative Surgery to become a woman. Her father was opposed to this surgery. Swati approached the Mumbai High Court.

In the Order, the Hon'ble Court mentioned that *"1. The learned counsel appearing on behalf of Union of India and the State of Maharashtra state that neither the Union of India nor the State of Maharashtra has any objection to the petitioner undergoing the surgery he wishes to undergo. They state that as far as they are aware, there is no law that prohibits the same."*[1] So, there is no legal bar for any adult transperson voluntarily willing to undergo gender affirmative transition.

Marriage Between Transwoman and a Male/Marriage Between a Transman and a Woman

Case: Shri Arunkumar and Ms. Sreeja married as per Hindu rites and customs. Their Memorandum for Registration of marriage before Joint Registrar II (Tuticorin & District) was refused on the ground that the term 'Bride' in the Hindu Marriage Act, 1955 refers to a woman on her wedding day. Ms. Sreeja was not a woman but a transwoman.

In appeal, the decision of the Joint Registrar II (Tuticorin & District) was upheld. Thereupon, the Petitioners filed a Writ Petition under Article 226 in the Madurai bench of the Madras High Court, challenging the refusal to register their marriage.

On 22nd April 2019, the Hon'ble Judge, Mr. Justice G. R. Swaminathan, relied on the landmark case of [NALSA V/s Union of India], which states that every person has the right to self-identification of gender as male or female or transgender/third-gender.[2] Sreeja has chosen to express her gender identity as that of a woman. This falls within the domain of her autonomy and her right to privacy and dignity.

The expression 'bride' occurring in Section 5 of The Hindu Marriage Act, 1955, will include within its meaning not only a

woman but also a transwoman, an intersex person/transgender person who identifies herself as a woman. The Hon'ble Court directed the Joint Register II (Tuticorin and District) to register the said marriage.[3]

Although this is not a Supreme Court judgment, it does have persuasive value.

Marriage Between *Tritiyapanthi* and a Male/Marriage Between *Tritiyapanthi* and a Woman

The Special Marriage Act, 1954 (which is secular) and personal marriage laws like The Hindu Marriage Act, 1955 mention the words 'bridegroom' which is traditionally interpreted as male on the wedding day and 'bride' which is traditionally interpreted as female on the wedding day. There is no mention of transgender/*tritiyapanthi* in these laws. So prima facie, my interpretation, based on current laws (as of April 2022), is that marriage between a person who identifies neither as a man nor as a woman (i.e. identifies as a transgender/*tritiyapanthi*) and a male or female may not be considered valid by the Courts.

References

[1] Bidhan Baruah @ Swati Baruah V/s Supti Ranjan Barua & Ors. WP (Lodg) No. 1092 of 2012.
High Court of Judicature at Bombay Ordinary Original Civil Jurisdiction. Order dated 07th May 2012.
Coram: S. J. Vazifdar, J & A. R. Joshi, J.

[2] National Legal Services Authority (NALSA) V/s Union of India. WP (Civil) 400 of 2012 with WP (Civil) 604 of 2013.
Judgment dated 15th April 2014.
Coram: K. S. Radhakrishnan,J and A. K. Sikri, J.

[3] Arunkumar, Sreeja V/s The Inspector General of Registration and Ors.
WP (MD) No. 4125 of 2019 and WP (MD) No. 3220 of 2019.
Madurai Bench of the Madras High Court.
Order dated 22nd April 2019.
Coram: G. R. Swaminathan, J.

GENDER AND NAME CHANGE PROCEDURE

Introduction

After the landmark judgment of the Hon'ble Supreme Court in the case of [NALSA v/s Union of India] in the year 2014, The Transgender Persons (Protection of Rights) Act, of 2019 and the Rules framed therein give every transgender, transwoman, transman and intersex person the right to identify as male or female or transgender.

A transperson can obtain a transgender / male / female gender ID card and Certificate with the birth name or a new self-chosen name by applying to the District Magistrate in whose jurisdiction the person is currently residing. The Certificate issued can be used to change the name and gender on all documents like Aadhar Card, Pan Card, Voter ID, Ration Card, Driving License, School Leaving Certificate, Property documents, Passport, etc.

Transgender ID Card and Certificate

No medical examination, medical certificate of Gender Dysphoria, GAHT, or Gender Affirmative Surgery is required for applying for a transgender ID card and Certificate.

Male-to-Female or Female-to-Male Gender ID card and Certificate

If a transperson desires to change gender from male-to-female or from female-to-male, the transperson must first apply for an ID card and Certificate of transgender. On receiving it, the transperson has to reapply for a revised certificate from transgender to female or transgender to male.

For obtaining the revised certificate (from transgender to female or transgender to male)-

- a medical Certificate of Gender Dysphoria and
- a Certificate from the endocrinologist that the transperson is undergoing GAHT or, a certificate from the plastic surgeon that the transperson has undergone Top or Bottom surgery are required.

Note: Medical prescription of hormone treatment is not sufficient evidence. A proper Certificate of hormone treatment from the endocrinologist is required.

Steps for applying for Transgender ID Card and Certificate

- As of April 2022, the application has to be made through the online portal: **http://transgender.dosje.gov.in/** Applications cannot be filed offline. The User Manual is available on the website.
- A mobile and an email id are required for initial registration.
- After logging in, the applicant has to select the option 'Transgender Certificate and Identity Card'. The following information is asked for: the full name given at birth, the new self-chosen name, if any, the option of which name (birth name or the new name) is to be printed on the ID card and Certificate, current address, permanent address, father's full name, educational qualifications, and annual income.
- The applicant is required to upload a scanned copy of the Aadhar Card (both sides). Uploading other documents like Pan card, Voter ID, etc., is optional.
- The applicant is required to upload scanned copies of the applicant's passport size photo, applicant's signature in blue ink, notarized Affidavit (all pages) executed on ₹100.00 non-judicial stamp paper. The format of the Affidavit is given in Appendix D.
- The application registration number, etc., is sent by email on submitting the form online. The applicant can track the application status on the portal.
- In rare cases a district may have additional requirements.
  Example: *In Pune district an Affidavit in Marathi (whose content is different from the English affidavit) has to be executed on a ₹100.00 non-judicial stamp paper. This Affidavit is not to be uploaded on the website. The original copies of the English and Marathi Affidavit, along with a Xerox of the Aadhar card, have to be submitted to the Social Justice Commissionerate office (Pune).*

- As per the Act, the applicant is expected to get the ID card and Certificate within 30 days of filing the application. The scanned copy of the ID card and Certificate can be downloaded from the website. The hardcopies of the same can be collected from the Social Justice Commissionerate.

Steps For Changing Gender From Male To Female Or Female To Male

- On getting a Transgender ID card and Certificate, the applicant should use the second option 'Revised Certificate of Identity Under Section-7 & Identity Card' to reapply for a change of gender- from transgender to female or transgender to male.
- When entering various details, the applicant is asked whether they have any transgender ID card or Certificate. The applicant has to answer in the affirmative. The applicant is required to upload the scanned copy of transgender Certificate that they have received. The applicant is also asked to provide details of GAHT / Gender Affirmative Surgery, name of the medical practitioner, address of the clinic/hospital etc. (Sample format of GAHT/Gender Affirmative Surgery Certificate is provided in Appendix C.)
- In rare cases a district may have additional requirements.
  Example: *In Pune district, a Xerox copy of the GD Certificate and GAHT/Gender Affirmative Surgery Certificate from the medical practitioner/clinic/hospital must be submitted to the Social Justice Commissionerate office (Pune).*
- As per the Act, the applicant is expected to get the revised ID Card and Certificate within 30 days of filling the application.

PART IV: INTERSEX

LAWS RELATED TO INTERSEX

Intersex person: *"I went to the doctor you had referred me to. He examined me and stated that I am a unique case. Will I come with him to a medical conference, where he can present my case to the participants? I don't want to go to him again."*

Introduction

In the quest for science, some medical practitioners are eager, curious, and excited about finding rare cases of intersex. Some surgeons, too, are keen to perform 'rare case' surgeries on such infants and adults, write papers about the case, and present them at conferences. They tend to forget that, in the case of adult intersex persons, they are dealing with a traumatized human being. A person who, in all probability, is ashamed of their anatomy has taken pains to hide it from all and has little to no support from society. And in the case of infants, they are making life-altering decisions based on the probability of gender of the baby, which is based on various investigations.

Various topics related to intersex- basics, causes, guidelines for bringing up an intersex child, the issues faced by intersex persons in an ignorant and hostile environment, experience sharing of an intersex person, etc., are presented in the book- Basics of Sex, Gender, and Sexuality[1]. So, here, I will highlight only the legal aspects.

Ban on Intersex Surgeries

Some parents and medical practitioners discuss and decide the gender of the intersex infant and perform surgery on the infant to remove organs that are not in sync with the gender they have chosen. They believe that the sooner such surgery is done, the better the chance of the infant integrating with the binary world. Such approach is not advisable for the following reasons-

- No one knows the gender of the infant, and there is a chance that a wrong and irreversible decision may be taken.
- Such surgery at a young age may result in adverse consequences that may manifest only after the infant reaches

puberty. E.g. pain during arousal/intercourse (Dyspareunia).

Ban on Intersex surgeries

Case: In 2020, in the case of Arunkumar, Sreeja vs. The Inspector General of Registration and Ors., the Hon'ble Madras High Court passed a judgment banning Sex Affirmative Surgeries on intersex babies.[2] The Court stated that, in these cases, parental consent would not be considered valid.

Gender Identification and Certificate

The Transgender Persons (Protection of Rights) Act, 2019 provides the framework for every intersex person to legally identify as male or female or transgender. Once they become aware of their gender, on reaching adulthood, they can change their existing name and gender assigned at birth. Refer to chapter 'Gender and Name Change Procedure' for details.

The Key is Gender, not Anatomy

Case: The 'Tamil Nadu Uniformed Services Recruitment Board, Chennai', conducted a selection process for direct recruitment to the post of Grade II Police Constable [Women] for the year 2009-2010. Nangai applied for the job and got selected. The Superintendent of Police, Karur District, issued an order of appointment. While undergoing training, she was asked to undergo a medical examination. The medical authorities diagnosed her with Partial Androgen Insensitivity Syndrome (she was intersex). Nangai was terminated from service on various grounds, including- *"Failure to disclose that the applicant is transgender and appearing under Women Quota concealing this fact."* Nangai approached the Madras High Court for relief.

The Hon'ble Court framed two core questions:

(1) Whether the petitioner is a 'female' and whether she is eligible for appointment as a 'Woman Police Constable'?

(2) Whether the termination of the Petitioner from service on the ground that she is a transgender person sustainable?

On 17th April 2014, Hon'ble Mr. Justice S. Nagamuthu passed the Order stating that- (paraphrased) [NALSA v/s Union of India] grants the right to every person to self-identify as male or female or transgender. The Petitioner identifies herself as female (whatever be her anatomical presentation). *"Therefore, the Petitioner should be treated as a female for all purposes, such as employment, property rights, etc…I hold that she is a female in the legal parlance, and thus, she is eligible for appointment as a Woman Police Constable… The respondents are directed to issue consequential order within a period of six weeks from today permitting the Petitioner to join duty as Grade II Police Constable [Woman] with continuity of service."*[3]

References

[1] Basics of Sex, Gender, and Sexuality. Authors Dr. Bhooshan Shukla, Bindumadhav Khire. Published by Dr. Bhooshan Shukla, 2021.

[2] Arunkumar, Sreeja V/s The Inspector General of Registration and Ors. WP(MD) No.4125 of 2019 and WMP(MD) No.3220 of 2019. Madurai Bench of the Madras High Court.
Order dated 22nd April 2019.
Coram: The Hon'ble Justice Mr. G. R. Swaminathan, J.

[3] Nangai V/s The Superintendent of Police, Karur District, Karur and Ors. WP No. 587/2014 and M.P. Nos. 1 and Nos. 2 of 2014. High Court of Judicature at Madras.
Order dated 17th April 2014.
Coram: The Hon'ble Justice Mr. S. Nagamuthu.

PART V: USE OF TERMS

TERMS, UNDERSTANDING AND INTERPRETATION

Transwoman: *"I come from a rural area. I did not know these LGBTIQA terms at all."*

Introduction

While the interaction between the medical practitioner and the LGBTIQA person is not an explicit legal contract, one of its principles needs to be underlined- both the parties have to agree to the '**same term in the same sense**'. It will not be an overstatement to state that getting the terminology and basic understanding between the medical practitioner and the LGBTIQA person on the same page is crucial.

Basic Terms

The medical practitioner may be new to terms used in the vernacular, and the LGBTIQA person may be new to the terms used in English. Many LGBTIQA persons from rural areas do not understand the English words "intersex", "transman", "transwoman", "genderqueer", etc. At times the person may not even know the vernacular term. Below are a few common vernacular and slang words used in Marathi/Hindi in the context of LGBTIQA.

Homosexual/Gay: Some persons use the terms *samalingi,* Homo, *gud*. In rare cases, they may use the behavioral term MSM (Men who have Sex with Men). The Marathi words *Gandu, Bulya, Pavli Gul* sometimes used to address a gay person are derogatory terms, and their use is to be strictly avoided and discouraged.

Bisexuals: Some persons use the term *'Bi'*. e.g., *"Mi Bi ahe."/ "Mai Bi hu"* ("I am Bi"). Very few know the Marathi/Hindi term *Ubhaylingi* for bisexuality. They may state, *"Mala donhi pan avadtat."/"Muzhe dono acche lagte hai"* (I like (am attracted to) both.)

Transgender: Many male-to-female transgender persons and those persons who do not identify either as male or female gender (especially those from a non-English speaking background) use the terms- *tritiyapanthi, kinnar, hijra.*

When a person uses the term *hijra*, e.g., *"Mi hijada ahe"* (I am a *hijra*), it can have the following interpretations:

1. The word *hijra* has traditional/cultural significance and it could mean that the above statement is made by a *tritiyapanthi* who has become a member of the *hijra* community.

2. At times, the word *hijra* is interchangeably used with the word *tritiyapanthi*. In the above example, it is possible that the person is a *tritiyapanthi* but is not a member of the *hijra* community.

So, it will be convenient for medical practitioners to use the words transgender or *tritiyapanthi*.

The word *chakka*, a derogatory term, is at times used to address gays and transgender people. Such use is to be strictly avoided and discouraged.

Intersex: Some medical practitioners and medical textbooks use the terms 'hermaphrodite'/'pseudo hermaphrodite' or 'Disorders of Sexual Differentiation' (DSD). But, it is no longer considered appropriate to use these terms. The correct term to be used is intersex. Many medical practitioners and intersex persons do not know the Marathi/Hindi term for intersex: *Dwilingi.*

Sexual Role: Some men use the word *panti* (Top) to denote the insertive role they play. Some men and transgender people use the word *koti* (Bottom) to denote the receptive role they play. Some use the Marathi word '*kota-panti*' to indicate a person who takes a Versatile role.

Difference in Understanding

An LGBTIQA person may use a term, but their understanding of it could be different from the scientific understanding of the term.

Example 1: *"Mi hijada ahe".* (I am a *hijra*)

Without due exploration, a medical practitioner may assume that the person is a male-to-female transgender.

Doctor : *"Why do you think you are a hijra?"*
Person : *"I am different from others."*
Doctor : *"In what way?"*
Person: *"Down there, I am both a man and a woman.*"
Doctor : *"Can you elaborate?"*
Person: *"I have a penis and a vaginal opening."*

In this example, it has turned out that, in the scientific sense, the person is intersex.

Terms with Multiple Meanings

A person may use a term with multiple meanings and hence is liable to be misinterpreted.

Example 1: *"I told my parents that I am a koti."*

koti is a Marathi/Hindi term that is generally used by an LGBTIQA person to indicate a transgender person or, a gay man who takes the receptive role in intercourse with another male.

So, in this case, what does the person mean when he uses the term *koti* ?

Example 2: *"I am a tomboy, and my parents are giving me a difficult time for this."*

In the general sense, the term Tomboy means a girl who dresses and behaves like a boy. In the above example, is the term used in the general sense? Or is it meant to imply that the person is

gender-nonconforming? Or is the person male by gender (transman)? The answer can only be found through exploration. But be aware that a direct question to the person in the following manner is likely to confuse the person, as many of them will be unable to understand the term 'gender identity' or are unable to express themselves clearly.

> **Doctor:** *"Do you mean Tomboy in the general sense or Tomboy in a gender-identity sense?"*

Incorrect Use of Terms

At times, the person may use a term related to sexuality to express their gender; at times, the person may use a term related to gender identity to express their sexuality. At times, the person may use confusing terms to address self.

> **Example:** *"I told my parents that I am a tritiyapanthi and they were shocked. They asked me- since when I have known? I told them that I have known since the ninth standard that I am gay."*

Many LGBTIQA persons, especially those from rural areas, do not know the exact terms. They tend to use terms in a general sense. In this case, what does the person mean?

- is she a transgender person using the word gay because she believes that the words *tritiyapanthi* and gay mean the same thing?
- is he a cisgendered, gay person using the word *tritiyapanthi* because he believes that if a male is sexually attracted to men, then he is a *tritiyapanthi*?

In all the above cases, the LGBTIQA person, parents/relatives depend on the medical practitioner to provide a correct understanding of the issue and present it to them in a manner/terms they understand.

Transgender, Transwoman, and *Tritiyapanthi*

While a person may use the words transgender, transwoman, *tritiyapanthi* interchangeably, it is important to understand the medical, cultural, legal context related to these words.

Umbrella Use of the Term Transgender

The use of the word transgender is dependent on the context. It is sometimes used in a general sense, as an umbrella term, to denote any person whose gender is not congruent with their anatomy. This includes- *tritiyapanthis*, transwomen, transmen. At times it is specifically used to refer to *tritiyapanthis*.

Transwomen and *Tritiyapanthis*

From the medical point of view, transwomen and *tritiyapanthis* have Gender Dysphoria.

Tritiyapanthis generally self-identify as having neither male or female gender. In contrast, transwomen self-identify themselves as having a female gender identity.

The difference between transwomen and *tritiyapanthis* is related to the cultural, legal, and political contexts.

Culturally, Indians have known *tritiyapanthis* for centuries under various names, e.g., *hijra, kinnar*, etc. Some *tritiyapanthis* become *chelas* (Prote'ge') of a *hijra guru* and thus become part of the *hijra* community. They earn their living by asking for alms, dancing at weddings, or sex work.

In comparison, although transwomen have been around for a long time, their recognition as transwomen is a relatively new construct (They have been traditionally clubbed with *tritiyapanthis*). Transwomen generally do not become part of the *hijra* community. Many aspire to be mainstreamed as women. Quite a few transwomen are empowered and work

at various jobs.

From the legal perspective, every person has the right to gender self-identification as male or female or transgender.

From the social perspective, the Central and State governments view transgenders as a disempowered community and make various provisions for empowering them. For example, in Maharashtra- transgenders whose annual income is Below Poverty Line (BPL) are eligible for the *Sanjay Gandhi Niradhar Anudan Yojana.*

PART VI: CLINIC

BASIC TIPS FOR A LGBTIQA INCLUSIVE CLINIC

Bindumadhav Khire: *"Bharati hospital (Dhankawdi, Pune) became the first hospital in Pune to start an LGBTIQA inclusive clinic. We signed an MOU with them for referring LGBTIQA persons to them. Then KEM hospital (Pune) started work on studying its systems to make them LGBTIQA inclusive. I am thankful to both of them for these initiatives."*

Introduction

Although the percentage of LGBTIQA persons coming to a clinic/hospital is small, it is a big boost for the community to have LGBTIQA inclusive medical practitioners in their city/town where they can go without fear of discrimination.

Some medical practitioners are worried that having LGBTIQA persons (especially transgender people/transwomen) will drive away their other patients. Many want to take steps to become LGBTIQA inclusive but do not know how to go about it without it becoming a big issue. So given below are some tips to guide them on making their clinic/hospital LGBTIQA inclusive.

Posters

Since the LGBTIQA person will approach the medical practitioner at a private clinic or hospital OPD, an LGBTIQA affirmative poster, in the waiting room, in English and vernacular would go a long way.

Registration Form

Many clinic/hospital registration forms list only two genders- male and female. A third option, 'transgender' can be added to the registration form.

Examination

For the safety of female patients, clinics/hospitals generally have a policy that when a female patient is being examined or is

undergoing a diagnostic procedure (e.g., Sonography, X-Ray, etc.), 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 all the patients and the staff.

Analysis of Investigations

When blood, urine, and other relevant investigations are done, a note about the gender identity and GAHT/GAS status must be provided. If the lab technician/medical practitioner is unaware that the transperson is undergoing GAHT or has had GAS(e.g., Orchiectomy or Oophorectomy), the comparison of the results with the baseline would be incorrect, and conclusions drawn would be wrong.

Toilets

Have a 'Gender Neutral' toilet or a separate toilet for transpersons. It should have an appropriate label on the door.

Policy on Sexual Harassment

The clinic/hospital's staff and patient relationship is a fiduciary relationship. In any unequal relationship, there is a chance of abuse. Hence, it is paramount that a sex, sexuality, and gender-neutral policy against sexual harassment, which applies to staff, consultants, interns, patients, and visitors, should be in place. The scope of ICC (Internal Complaints Committee) should be widened accordingly.

Prevention of Sexual Harassment at Workplace

Although currently the The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013 covers only women, the staff training on this Act should also cover sexual harassment of and by LGBTIQA persons. A clear signal should go out that sexual harassment of any staff member, patient, visitor will be strictly dealt with irrespective of the biological sex, gender, sexual orientation of the victim or perpetrator.

Information Education Communication (IEC) Material

If the clinic/hospital has a website or runs a YouTube channel, information/photos/videos conveying LGBTIQA inclusive information can be created and uploaded. The clinic/hospital can keep IEC material in the form of pamphlets for distribution to LGBTIQA persons. This is especially relevant in specialty clinics that are more likely to see LGBTIQA persons. E.g., psychiatrists, endocrinologists, cosmetic/plastic surgeons, gynecologists, dermatologists, ICTCs etc.

Linkages

If the LGBTIQA person needs to be referred to another LGBTIQA inclusive medical practitioner, it helps to have relevant referral linkages in place.

APPENDIX A: DIRECTIONS OF MADRAS HIGH COURT

On 07.06.2021, in the case of Ms. S. Sushma and Ms. U Seema Agarval V/s Commissioner of Police, Greater Chennai Police and Ors.[1] the Hon'ble Justice Mr. Justice N. Anand Venkatesh gave a set of interim guidelines/directions for the care and protection of LGBTIQA persons. Points A to G include directions on non-harassment of LGBTIQA+ persons by police, setting up a shelter home for LGBTIQA+ persons, providing skill development facilities, etc. Parts of point H which are relevant for medical practitioners are listed below.

H. For the sake of creating awareness, this Court is suggesting the following sensitization programs be conducted by the concerned Ministry of the Union/State Government(s). This list is only indicative and not exhaustive.

Table is given on next page.

References

[1] Ms. S. Sushma and Ms. U. Seema Agarval V/s Commissioner of Police, Greater Chennai Police and Ors.
W.P.No.7284 of 2021. High Court of Madras.
Order dated 7th June 2021.
Coram: N Anand Venkatesh, J.

Sr. No.	Stakeholder	Sensitization Programme	Concerned Department/ Government
4	Physical and Mental Health Professionals	Assistance to LGBTQIA+ community and their environment, by offering Physical and Mental health support to those who are facing stigma and discrimination from society. Mental health camps and awareness programs to understand gender, sexuality, sexual orientation and promote acceptance of diversity. **Prohibit any attempts to medically "cure" or change the sexual orientation of LGBTIQA+ people to heterosexual or the gender identity of transgender people to cisgender. To take action against the concerned professional involving themselves in any form or method of conversion "therapy", including withdrawal of license to practice.** *(Emphasis by the author of this book) (abridged)*	National Medical Commission, Indian Psychiatric Society, Rehabilitation Council of India.

5	Education Institutions	Effective change in curricula of Schools and Universities to educate students on understanding the LGBTQIA+ Community. *(abridged)* Amendment of necessary policies and resources to include students belonging tothe LGBTQIA+ community in all spheres of Schools and Universities. E.g. 1. Ensure availability of gender-neutral restrooms for the gender-nonconforming student. 2. Change of name and gender on academic records for transgender persons. 3. Inclusion of 'transgender' in addition to M and F gender columns in application forms for admission, competitive entrance exams, etc. Appointment of counselors who are LGBTQIA+inclusive. *(abridged)*	National Medical Commission, Ministry of Education, Government of India, School Education Department, Government of Tamil Nadu, Department of Higher Education, Government of Tamil Nadu, UGC, AICTE, National and State Councils for Education Research and Training (NCERT, SCERT)

APPENDIX B: Sample Format- Gender Dysphoria Certificate

[LETTER HEAD]

Date: _____ Ref. No._____

Gender Dysphoria (Gender Incongruence) Certificate

This is to certify that I have examined
(birth name) _____,
preferred name _____,
preferred pronouns [he/him]/[she/her]/[they/their],
age____ years (date of birth: _____). The above mentioned person has also been assessed by psychological testing.

Psychological testing shows no evidence of any major psychopathology.

The person has been diagnosed with Gender Incongruence (Gender Dysphoria) as per ICD 11th Revision.

The person identifies self as- [Male/Female/Transgender].

The person has expressed a desire for gender affirmation treatment and plans to undergo hormone/surgical transition.

This certificate has been issued at the request of the person. The person can understand and make informed decisions about gender affirmative transition, including gender affirmation hormone treatment and gender affirmation surgery.

[Psychiatrist's Name, Credentials, Reg. No, Stamp, Signature]

APPENDIX C: Sample Format- GAHT/Surgery Certificate

[LETTER HEAD]

Date: _____ Ref. No._____

Transition Procedure Certificate

This is to certify that
(birth name)_____,
preferred name _____,
preferred pronouns [he/him]/[she/her]/[they/their],
age _____ years (date of birth: _____) has been diagnosed with Gender Incongruence (Gender Dysphoria).

The person identifies self as- [Male/Female/Transgender].

The person has expressed a desire for gender affirmation treatment and desires to undergo hormone/surgical transition. The person can understand and make informed decisions about gender affirmative transition, including gender affirmation hormone treatment and gender affirmation surgery.

The person is undergoing Gender Affirmation Hormone Treatment since (date)_____ at (clinic/hospital name and address) _____
under (doctor name) _____

The person has undergone (surgical procedure name) _____ on (date)_____ at (clinic/hospital name and address)_____
under (surgeon name)_____

[Endocrinologist/Surgeon's Name, Credentials, Reg. No, Stamp, Signature]

APPENDIX D: Affidavit for Transgender ID and Certificate Application

AFFIDAVIT

I, (full name)_____, son/daughter of (parent's full name) _____, age____ completed years, residing at- (address) _____, Taluka _____, District _____, City _____, Pin code _____, State _____ do hereby solemnly affirm and declare as under:

1. I am currently residing at the above address.

2. I perceive myself as a transgender person whose gender does not match with the gender assigned at birth.

3. I declare myself as transgender.

4. I am executing this Affidavit to be submitted to the District Magistrate for the issue of a certificate of identity as a transgender person under Section 6 of the Transgender Persons (Protection of Rights) Act, 2019 under Rule Transgender Persons (Protection of Rights) Rules, 2020.

Deponent
(Signature of the Applicant)

Verification

I, (full name) _____, hereby state that whatever is stated herein above serial Nos. 1 to 4 are true to the best of my knowledge.

Deponent
(Signature of the Applicant)

Identified by Me
Advocate
Public
Tehsil
Date

Before Me
Notary

APPENDIX E: ADDITIONAL READING

Books in English

- Beautiful People; an English translation of the Marathi book *Manachiye Gunti*. Bindumadhav Khire. Samapathik Trust, Pune. 2016
- Hospital Inclusion Manual for LGBTIQA. Version 1.0. Bindumadhav Khire. Published by Samapathik Trust and Bindu Queer Rights Foundation. 2019.
- No Man's Land. A Memoir of a Gay Activist. Bindumadhav Khire. Published by Bindumadhav Khire. 2020.
- Legal Tips for Social Workers working on LGBTIQA Issues. Version 1.0. Bindumadhav Khire. Published by Bindu Queer Rights Foundation. 2021.
- Basics of Sex, Gender, and Sexuality. Dr. Bhooshan Shukla, Bindumadhav Khire. Published by Dr. Bhooshan Shukla. 2021.
- Manual of Mental Health Care of Transgendered Persons in India. For Practising Psychiatrists. First Edition. Naveen Manohar Pai, Shalini S Naik, C. Naveen Kumar, Suresh Bada Math. National Institute of Mental Health and NeuroSciences. Bengaluru. 2021.

Books in Marathi (authored by Bindumadhav Khire)

- *Partner.* Self-published, Pune. 2004. (Fiction novella)
- *Indradhanu: Samalaingikateche vividh ranga* (Rainbow: Different colors of Homosexuality). Samapathik Trust, Pune. 2008.
- *Manavi Laingikata- ek prathamik olakh* (Introduction to Human Sexuality). SamapathikTrust, Pune. 2011.
- *Intersex- ek prathamik olakh* (Introduction to Intersex). Samapathik Trust, Pune. 2015.

Books in Marathi (edited by Bindumadhav Khire)

- *Antaranga* (Anthology of true stories of gays and lesbians.) Samapathik Trust, Pune. 2013.

- *Saptaranga* (Anthology of true stories of Transgenders and Tritiyapanthis.) Samapathik Trust, Pune. 2013.
- *Manachiye Gunti* (Anthology of true stories of parents of gays and lesbians.) Samapathik Trust, Pune. 2013.

Online Resources

- http://www.wpath.org (Standards of Care Manual. Ver.7)
- http://www.mayoclinic.org
- https://fenwayhealth.org/the-fenway-institute/

Online Videos

English

Out and Proud, but Why? (TEDx (PICT College, Pune))
https://www.youtube.com/watch?v=TDLqA4_FZpU

Satyameva Jayate S3 - 'BINDUMADHAV AND HIS MOM'
https://www.youtube.com/watch?v=cf4DEs5xGws

TEDx LGBT Kyu? (St.MEERA's College, Pune)
https://www.youtube.com/watch?v=61pAhuqCNzo

Project BOLO (By HST and Solaris Pictures)
https://www.youtube.com/watch?v=3VEqSZY88Ec

Marathi

Yaala Jeevan Aise Naav (ZEE Marathi TV)
Part 1: https://www.youtube.com/watch?v=ICijm8VpsTE
Part 2: https://www.youtube.com/watch?v=3jp7h2jfSa4

Great Bhet (Channel: Maharashtra 1)
https://www.youtube.com/watch?v=A-DOSzO3NtU

APPENDIX F: ABOUT THE AUTHOR

Bindumadhav Khire

Contact: bindumadhav.khire@gmail.com
Whatsapp: 9763640480

Bindumadhav Khire, born in 1968 in Pune, is a gay activist working in Pune (India) since 2000 on LGBTIQA rights. He has done his B.E. in Computer Science and has a degree in Law (LLB). Bindumadhav retired from his IT career at the age of 35 and founded Samapathik Trust (2002) in Pune. In 2019 he founded Bindu Queer Rights Foundation.

He has authored numerous books on LGBTIQA, organized Pune Annual LGBTIQA Pride March for eight years, has run a helpline on sex, sexuality education, HIV/AIDS, is director of Advait Pune Queer International Film Festival, has been director of HIV/AIDS Targeted Intervention Projects (funded by Pathfinder International and Maharashtra State AIDS Control Society) and has conducted numerous sessions on LGBTIQA health and rights for counseling students, medical students/practitioners, police personnel, students of journalism and mass communication, and corporates. He has authored and edited a dozen books in Marathi/English on LGBTIQA issues.

ABOUT BINDU QUEER RIGHTS FOUNDATION

Contact: bqrf2019@gmail.com
Website: http://www.binduqueerrights.org

Bindu Queer Rights Foundation, a Section 8 Company (CIN: U85300PN2019NPL182601), based in Pune, was founded by Directors Bindumadhav Khire and Tinesh Chopade in 2019. It works for health and rights issues of LGBTIQA+ community in India. As of May 2022, donations to the Company are eligible for 80G (Income Tax) relief.

WORKING TOGETHER

Bridging the Gap Between Medical Practitioners and LGBTIQA

is intended to assist mental health professionals in providing informed, appropriate, high-quality care to LGBTIQA communities.

Bindumadhav Khire presents his two decades of experiences of working and advocating for LGBTQIA persons concisely, with examples, case studies, and guiding practices that are easy to understand and adapt, in providing professional mental health services.

Bindumadhav Khire
(LGBTIQA Activist)

Published by:
BINDUMADHAV KHIRE

ISBN 978-93-5620-586-4

Price: ₹ 250/-