

2017

A
Good Practice Guide to
Gender-Affirmative Care



Initiative by
Sappho for Equality
Kolkata, INDIA



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ACRONYMS AND ABBREVIATIONS

DSM – Diagnostic and Statistical Manual of Mental Disorders

FtoM / FtM – Female to Male

GAT – Gender Affirmative Therapy

GTRS – Gender-Transition Related Services

HBV – Hepatitis B Virus

HCP – Health Care Professional

HIV – Human Immunodeficiency Virus

ICD – International Classification of Diseases

MHP – Mental Health Professional

MtoF / MtF – Male to Female

SRS – Sex Reassignment Surgery

SRT – Sex Reassignment Therapy

WPATH – The World Professional Association for Transgender Health

PREFACE

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

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

Following the NALSA judgement in April 2014¹ by the Supreme Court of India recognising the right of every citizen to self-determine gender, more and more individuals were observed seeking SRT in private hospitals. Individuals have expressed the need for varied degrees of transition – breast reduction, breast augmentation, laser removal of body hair, breast reduction with chest reconstruction without hormone therapy, only hysterectomy, penectomy, etc.

However, a number of factors are creating major hurdles in the meeting of these pertinent health needs. There is no established state health service facility in place for gender transition of transsexual persons in West Bengal. At the time of preparing the final version of this document there were reports of two state hospitals in the city of Kolkata to start providing SRT facilities.

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

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

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

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

The Making of the Guide

In preparation to the good practice guide, *Sappho for Equality* held a number of consultations with FtoM transgender persons on one hand and with medical and legal professionals on the other hand. Three meetings with FtoM transgender persons were held: August 2015, January 2016 and October 2016.² Each meeting had around 25 to 30 participants on an average including *Sappho for Equality* members who came together to discuss various issues and concerns at various points relating to their lives as transmen. With regard to health of transmen and SRT,

²Since Sappho for Equality works with FtoM transpersons only, the consultations held brought forth mostly the needs and concerns of female to male transpersons. However when the good practice guide was being compiled experts took care to include protocols for both transwomen and transmen based on their specific needs and concerns.

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

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

involved in the transition process. Medical and legal experts participating in the meeting suggested the following:

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

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

Medical and Legal Experts who Contributed in Preparing the Guideline

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

Psychiatrists

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

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

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

Endocrinologists

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

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

Plastic Surgeon

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

ENT Surgeon

Dr. Soumitra Ghosh: Soumitra Ghosh, MBBS, DLO (Gold Medallist), DNB, is Associate Professor, Department of ENT and Head Neck Surgery, Vivekananda Institute of Medical Sciences, Kolkata. He is also Associate Editor, International Journal of Phonosurgery and Laryngology. He is specialist in Microear Surgery and Endoscopic Sinus Surgery with special interest in Laryngology (Voice Surgery).

Voice Therapist

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

Legal Expert

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

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

Psychiatrists

Dr. Abir Mukherjee

Dr. Ayanangshu Nayak

Dr. Debashis Chatterjee

Dr. Indrajit SenGupta

Dr. Neelanjana Paul

Dr. Rima Mukherji

Dr. Sabyasachi Mitra

Dr. Sarmishtha Chakrabarti

Dr. Satyajit Ash

Dr. Suchandra Brahma

Psychotherapists

Dr. Anuttama Banerjee

Prof.(Dr.) Jayanti Basu

Dr. Jhuma Basak

Ms. Parmeet Soni

Dr. Sreemoyee Tarafder Chattopadhyay

Dr. Ushri Banerjee

Plastic Surgeons

Dr. Akhilesh Agarwal

Dr. V.S. Rathore

Gynaecologists

Dr. Chaitali Datta Ray

Dr. Pallab Gangopadhyay

Dr. Paromita Srimani

Dr. Samarendra Mondal

Dr. Sanjay Kumar Biswas

Dr. Susmita Chattopadhyay

Endocrinologist

Dr. Rana Bhattacharjee

ENT Surgeons

Dr. Amitabha Roychoudhury

Dr. Chirojit Dutta

Physicians

Dr. Arup Dhali

Dr. Partha Chakraborti

Legal Experts/Lawyers

Ms. Bijaya Chanda

Mr. Debashis Banerjee

Ms. Sananda Ganguly

Mr. Tapas Mukherjee

Student Volunteers from the NUJS Queer-Friendly Law Network

Akshita Jha

Drishti Das

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Priyambada Datta

Raktima Roy

Ringicha Chakma

Shreya Mishra

Shreyashi Ray

Vishakha Gupta

Vyjayanthi Raghu

Yamini Kumar

Members of *Sappho for Equality* Contributing in Various Capacities

Anush

Apu

Deep

Dev

Epsita Halder

Minakshi Sanyal

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Paromita Banerjee

Provat

Ree

Rukmini
Sayan Bhattacharya
Shreosi Ray
Srabasti Majumdar
Dr. Subhagata Ghosh
Sutanuka Bhattacharya
Swarup

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Purpose and Scope of this Guideline

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

In this guideline we have used the term ‘gender affirmative care’ to denote the wide range of services sought by a transgender person who wishes to change the gender assigned at birth to the gender desired as more appropriately expressing the individual’s personality. For transgender people transition/Gender Affirmation Process refers to the process of coming to recognize, accept, and express one’s desired gender identity. This is also the time when a self-identified transgender person makes the important conscious decision to take social, legal, and/or medical steps such as an appearance makeover, change name and/or sex designation legally, and use medical interventions. This process is often called gender affirmation, because it allows people to affirm their gender identity by making outward changes. Gender affirmation/transition can

greatly improve a transgender person's mental health and general well-being.³ Gender affirmative care/service would encompass all forms of medical and surgical interventions including psychological assessment, psychotherapy, occupational therapy, vocational counseling, pre and post-operative nursing care, as well as social and legal interventions.

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

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

This guideline is applicable for assessing and treating transgender people who have attained the legal age of 18 years. It does not cover therapeutic interventions for gender transition of gender non-conforming minor children and adolescent. There are number of reasons for the same such as, lack of expertise in intervention around puberty, lack of support system to cater to the gender-transition related needs of children and adolescents, lack of access to relevant endocrinal agents etc. However, this guide can be utilized to provide emotional and social support for affirmation of desired gender expression of the gender non-conforming children.

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

³Affirmative Care for Transgender and Gender Non-Conforming People: Best Practices for Front-line Health Care Staff, NATIONAL LGBT HEALTH EDUCATION CENTER A PROGRAM OF THE FENWAY INSTITUTE http://www.lgbthealtheducation.org/wp-content/uploads/13-017_TransBestPracticesforFrontlineStaff_v6_02-19-13_FINAL.pdf

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

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

INTRODUCTION

Health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and legal reforms that promote tolerance and equity for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma. The National Planning Commission, India in its Twelfth Five Year Plan has accepted the need to meet the health and social protection needs of lesbian, gay, bisexual and transgendered (LGBT) community who has been neglected for a long time.⁴

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

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

⁴ http://www.in.undp.org/content/dam/india/docs/HIV_and_development/the-case-of-tamil-nadu-transgender-welfare-board--insights-for-d.pdf

interventions are not optional but extremely necessary for the person to be able to achieve a satisfactory gender identity. However, the extent of desired body transformation/medical-surgical intervention may vary from person to person and may not conform to the “normal” sex-gender binary.

Gender Dysphoria in DSM 5

According to the DSM 5, transgender identity is termed as Gender Dysphoria and not a disorder. There are two major universally standardized classificatory systems of mental disorders, Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD). Definitions of the ICD-10 (World Health Organization, 1993) are under review. The DSM-5, published by American Psychiatric Association (APA) in 2013 has a newer and more inclusive understanding of Gender Identity. The category, ‘Gender Identity Disorder’ in DSM-IV-TR has been replaced by ‘Gender Dysphoria’ in DSM-5. Gender Dysphoria is defined as a condition with marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months duration, that is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning (See **Annexure 1**). In this guideline we follow the criteria for Gender Dysphoria as per DSM-5.

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

Definition of Transgender and Transsexual

The term transgender is used more widely to refer to all individuals whose lived and expressed gender does not match with the gender assigned to them at birth. Transsexual is an older term

used to indicate people whose expressed gender identity is different from their socially assigned gender and seek transition from female to male and male to female. The term is not preferred too much nowadays. Trans* (spelt with an asterisk) is an umbrella term referring to all non-cisgender identities including transsexual, transvestite, genderqueer, genderfluid, genderless, nongendered, third gender and many others.

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

NALSA and Allied Legislations

In recent times the NALSA judgement has served as an instrument for recommending certain legal policies for transgender people. The judgement affirms that even in the absence of any statutory regime in this country, transgender persons have the right to identify as woman, man or transgender with or without going through Sex Re-assignment Surgery (SRS). In other words, surgery, hormones or other interventions are not required for legal recognition of one’s change in gender identity. The verdict further orders the Central and the State Governments to look into and take steps proactively in matters of health, education and employment of the transgender people. Any form of discrimination in any of the above will be open to challenge and redress. With legal status accorded, transgender people have full moral citizenship. However, it is to be noted that the judgement is fraught with inconsistencies. The judgement oscillates between gender self-determination (understanding gender identity as determined by oneself) and biological essentialism (seeing ‘biological’ or physical characteristics as the basis for gender identification). The court also held that the Yogyakarta Principles⁵ are not inconsistent with the rights under the constitution or the domestic laws and hence should be recognised and followed. Extract from principle 3 of the Yogyakarta principle includes the words “No one shall be forced to undergo medical procedures, including sex reassignment surgery, sterilisation or hormonal

⁵ The Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity: http://www.yogyakartaprinciples.org/principles_en.htm

therapy, as a requirement for legal recognition of their gender identity” However, it is also important to note that in the absence of harmonisation of other laws – such as Section 377 of the Indian Penal Code, 1860 – with the judgement, mere formal recognition of the right to self-determine one’s gender identity creates vagueness in the country’s legal position with respect to transgender persons and results in deficiencies in the rights of transgender people in various facets of their lives.

There are also many operational difficulties due to infrastructural, informational and other factors. In this perspective, it is submitted that there is an acute need for having a comprehensive legislation on SRS in India that can duly address many of these concerns. A comprehensive legal policy that ensures a transgender person's safe and easy access to gender transition in any part of the country can guarantee respect, equality and dignity to this community. At the same time medical professionals engaged in providing such services also need certain protective measures and legal provisions to be able to effectively dispense their expertise.

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

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

level Screening Committee that will certify transgender persons which is completely against the NALSA judgement's provision of self-determination of gender.

The Transgender Persons (Protection of Rights) Bill 2016 was placed in the Lok Sabha in the last Monsoon Session and its clauses have shifted heavily from the NALSA judgement and the previous two bills. The bill defined transgender persons as 'neither wholly female nor wholly male; or a combination of female or male; or neither female nor male; and whose sense of gender does not match with the gender assigned to that person at the time of birth, and included trans-men and trans-women, persons with intersex variations and gender-queers'. Moreover, the bill also maintains that transgender persons have to undergo a certification process and an identity card is required to validate their transgender identity. Such a clause curbs transgender persons' right to self-determination of gender that has been ensured by the NALSA judgement.

Legal Status of Transpersons' Sexuality

Section 377 of the Indian Penal Code (IPC) states, "Whosoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with imprisonment for life or with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine."

According to this law there is ambiguity regarding the illegality of sexual activity of transgender persons. If a transgender person without undergoing SRS has sexual intercourse with a person who would be of the opposite gender in terms of biological sex but is of the same gender identity as of the said transgender person, would that be a criminal act under Section 377? On the other hand, if a transgender person has sex with a cisgender person, both being of the same biological sex but of different genders, would that constitute a criminal offence according to the IPC. Would the gender identity or the biological attributes be given priority in determining whether the nature of the sexual activity falls under Section 377?

CHAPTER 1

INDIAN LAW, TRANSGENDER IDENTITY AND GENDER TRANSITION

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

Challenges Faced *vis a vis* Gender Transition

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

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

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

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

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

A study conducted in 2013⁶ to assess the situation of gender transition related health services for MtoF transgender people reported the following issues:

- Lack of free sex reassignment surgery (SRS) in public hospitals and the prohibitive cost of SRS in private hospitals seem to be the key reasons behind why some *hijras* and other MtoF trans people go to unqualified medical practitioners for surgery – resulting in post-operative

⁶*Transforming Identity: Access to Gender Transition Services for Male-to-Female Transgender People in India: A Study conducted by India HIV/AIDS Alliance, New Delhi in 2013 [mentioned in Ministry of Social Justice and Empowerment, ‘Access to Healthcare: General Health Services (Physical/Mental) and Gender Transition Services (including Sex Reassignment Surgery)’], Report of the Expert Committee on the Issues relating to Transgender Persons(Chapter 10), 2014; available at <<http://socialjustice.nic.in/pdf/chapter10.pdf>>].*

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

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

However, very little academic or grey literature is available on access to gender transition services for female to male (FtoM) transgender people in India. Information from a study conducted among 50 identified FtoM people in Mumbai (LABIA, 2013)⁷ and interactions with FtoM people who are part of support groups or activist collectives indicate the following issues:

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

⁷*Breaking the Binary: Understanding Concerns and Realities Of Queer Persons Assigned Gender Female at Birth Across a Spectrum of Lived Gender Identities: A study conducted by LABIA – A Queer Feminist LBT Collective in 2013 [mentioned in Ministry of Social Justice and Empowerment, ‘Access to Healthcare: General Health Services (Physical/Mental) and Gender Transition Services (including Sex Reassignment Surgery)’], Report of the Expert Committee on the Issues relating to Transgender Persons (Chapter 10), 2014; available at <<http://socialjustice.nic.in/pdf/chapter10.pdf>>].*

transgender people such as binders, packers, urinating devices, and penile prosthesis (with air pumps to facilitate erection). Limited knowledge about male hormone therapy (for FtoM transgender people) among HCPs means many FtoM transgender people are led to self-administer male hormones.

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

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

Issues Pertaining to Legal Status of People Seeking SRS

- The judgement grants legal status to Sex Reassignment Surgery.
- A person who has undergone SRS can definitely avail all rights due to that gender. However, the judgement leaves it unclear whether a transperson can avail all legal rights before undergoing SRS.
- In the absence of a uniform process of changing one's gender identity in documents in all states, documents of an SRS seems to be the most definite document warranting gender identity change. Transgender persons who undergo gender-reassignment and who do not, face discrimination and harassment due to bureaucratic hurdles when attempting to change their name and gender in legal documents, and confusions leading to further anxieties.
- In West Bengal, in most cases, the Official Gazette still seeks documentation of SRS to publish the change of gender from 'female to male', and does not accept a pre-operation affidavit – despite the directive on the right to gender self-determination without requiring SRS.

- In some cases surgeons insist on family consent before SRS to avoid future litigations.
- Affidavits are needed for a change in name and gender by paying the appropriate court or notary fee and getting these signed by a magistrate.
- A person can, at any point during the course of SRS (and even without it as well), go to a lawyer in case they want to change their name and gender in their official documents. The process involves the following steps. However there is no clarity about the process and requirements differ from place to place, case to case, and is often dictated by individual bureaucratic specificities.
 - (i) Getting an affidavit notarised at the court: Such affidavit should mention the change in gender identity (male to female, female to male, or male/female to transgender).
 - (ii) An official gazette notification must be done to notify the change.
 - (iii) Two newspaper advertisements need to be published that include age, date of birth, place of residence, previous official name, and current gender and name.
 - (iv) Filing an application before employer: This application must request for relevant changes in the employee identity card and attach copies of the gender-change affidavit, newspaper advertisements and/or gazette notification.
 - (v) Pursuant to this, applications can be filed before relevant authorities for changes to Voter's ID Card, PAN Card, Bank documents including Debit/Credit Card, Driving License, Passport, Ration Card, etc. These applications must include copies of the affidavit, advertisements and the fresh employee identity card.
 - (vi) Renewal of passport is not yet possible without SRS certificate, contrary to provisions given in the NALSA judgement.

CHAPTER 2

THERAPEUTIC APPROACHES TO GENDER AFFIRMATION

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

1. The World Professional Association for Transgender Health’s (WPATH) standards of care for health of transsexual, transgender and gender non-conforming people (WPATH SOC 7th Version, 2011).⁸
2. Good practice guidelines for the assessment and treatment of adults with Gender Dysphoria by Royal College of Psychiatrists, UK (2013).⁹
3. Interim National Guidelines – Good practices for sex reassignment surgeries (SRS) for male-to-female transgender people in India, 2011.

Age for Gender Affirmative Therapy

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

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

Therapeutic Approaches

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

⁸Coleman E, Bockting W, Botzer M, *et al.* 2011. “Standards of care for the health of transsexual, transgender and gender non-conforming people”, version 7.*Int. J. Transgend*;13(4), 165–232.

⁹<http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr181.aspx>

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

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

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

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

Consent and Decision-Making

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

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

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

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

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

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

scope for individual becoming victim to unethical practices. However, the HCP should not give in to the unreasonable demands of the individual and clinical judgement should prevail.

Throughout all stages of treatment, the clinician has a responsibility to inform clients of the treatment options, benefits, potential unwanted side-effects and health risks of the treatment, in terms that can be readily understood. The advantages and disadvantages of not undertaking treatment should also be discussed. Client information documentation should be provided in a timely manner. It is in line with best practice that consent forms for treatment are signed and dated by client and clinician.

Addressing the Transgender Individual

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

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

Referral

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

lacunae in the existing mental health service delivery system of our country, the experts also opined that, of the two referring MHPs, at least one should be a qualified psychiatrist.

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

At every stage of consultation it is the responsibility of the treating medical professional to document in details all processes/treatments/therapies undertaken in their respective prescriptions or medical records. Since GAT is a multidisciplinary approach, this helps in appropriate communication between the treating disciplines. In many cases due to the lack of any dedicated gender clinic the individual is compelled often to travel from one place to another in order to seek GAT related services. Thus, this record-keeping becomes necessary to help the person get appropriate and safe medical care.

Respect Privacy and Confidentiality

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

Consent for Research

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

Options for Psychological and Medical Management of Gender Dysphoria

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

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

Options for Social Support and Changes in Gender Expression

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

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

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

Training of Health Professionals and Research

The HCPs need to engage in continuing education and training in the assessment and treatment of Gender Dysphoria. This may include attending relevant professional meetings, workshops, or

seminars; obtaining supervision from health professionals with relevant experience; or participating in research related to gender non-conformity and Gender Dysphoria.

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

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

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

CHAPTER 3

MENTAL HEALTH SERVICES FOR GENDER AFFIRMATION

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

Competency of Mental Health Professionals Working with Adults who Present with Gender Dysphoria

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

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

- WPATH SOC keeps the minimum qualification from a broader field of mental health practice, i.e. Master's degree or its equivalent in a clinical behavioral science field that is granted by an institution accredited by the appropriate national or regional accrediting board. Considering the existing condition of clinical training and practice in the field of mental health in this region, the group of experts for this guideline suggested that the mental health professionals be preferably qualified in the field of Psychiatry or Clinical Psychology. They suggested – A Post-Graduate Degree/Diploma in Psychiatry (DPM/MD) or at least Master's degree in Psychology with clinical training, i.e. MA/M.Sc./M.Phil/PhD in Psychology. The MHP should have documented credentials from the relevant licensing board; national medical licensing board (Medical Council of India) for Psychiatry or equivalent authority in Psychology.

- Competence in using the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the International Classification of Diseases (ICD) for diagnostic purposes.
- Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from Gender Dysphoria.
- Knowledgeable about gender non-conforming identities and expressions, and the assessment and treatment of Gender Dysphoria.
- Continuing education in the assessment and treatment of Gender Dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender non-conformity and Gender Dysphoria.

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

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

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

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

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

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

Tasks Related to Assessment and Referral

1. Assess Gender Dysphoria

The evaluation includes, at least the following,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Referral for Feminizing/Masculinizing Hormone Therapy

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

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

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

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

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

If Applicable, Assess Eligibility, Prepare, and Refer for Surgery

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

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

Referral for Surgery

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

- Two referrals from qualified MHPs who have independently assessed the individual are needed for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries) as WPATH SOC(7th version) recommends.
- WPATH SOC (7th version) recommends that one referral from a qualified MHP is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty),

but as mentioned earlier, medical experts of this region, suggest two referrals from two qualified MHPs for breast/chest surgery as well. One of the two MHPs should be a qualified Psychiatrist as suggested by the medical experts.

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

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

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

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

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

Tasks Related to Psychotherapy

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

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

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

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

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

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

Therapy may consist of individual, couple, family, or group psychotherapy, the latter being particularly important to foster peer support. Family therapy may include work with spouses or partners, as well as with children and other members of a client's extended or broader support system. Peer support can reduce social isolation and distress. Peers can play an important role in providing support and encouraging the use of helpful organisations and resources. Because many

people may be more comfortable talking to those who have been through similar experiences, they are more likely to trust their help and accept their advice. When faced with a client who is unable to access services, referral to available peer support resources (offline and online) is recommended.

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

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

Transsexual, transgender, and gender non-conforming people may face challenges in their professional, educational, and other types of settings as they actualize their gender identity and expression. Mental health professionals can play an important role by educating people in these settings regarding gender non-conformity and by advocating on behalf of their clients.

Finally, harm-reduction approaches might be indicated to assist clients with making healthy decisions to improve their lives.

CHAPTER 4

GENDER AFFIRMATIVE HORMONE THERAPY

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

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

The age at which to begin treatment with cross sex hormones is codetermined in collaboration with both the person pursuing SRT and the mental health professional (MHP). In a retrospective and cross-sectional study conducted at an endocrine referral center in Kolkata between 2010 and 2015, it has been found the mean age of presentation of Gender Dysphoria is late (25.77 ± 6.25 years) and many of them may have some co-morbid conditions.¹⁰ Hence, hormone therapy must be individualized based on a client's goals, the risk/benefit ratio, the presence of other medical conditions, and consideration of social and economic issues.

The goals of hormonal therapy are:

1. To reduce endogenous hormone levels and, thereby, the secondary sex characteristics of the individual's biological sex.
2. To replace with cross-sex hormone by using the principles of hormone replacement treatment of hypo-gonadal patients.¹¹ The physical changes induced by this hormone therapy are usually accompanied by an improvement in mental well-being.

¹⁰Sanyal D, Majumder A. (2016). "Presentation of Gender Dysphoria: A perspective from Eastern India". *Indian J Endocr Metab*; 20:129-33.

¹¹Wylie C. Hembree, Peggy Cohen-Kettenis, *et al.*(2009). "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline". *J Clin Endocrinol Metab* 94: 3132–3154

Referral for Hormone Therapy

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

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

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

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

Informed Consent

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

Competency of Hormone-Prescribing Physicians

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

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

Responsibilities of Hormone-Prescribing Physicians

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

Physical Effects of Hormone Therapy

Feminizing/masculinizing hormone therapy will induce physical changes that are more congruent with the person's gender identity. Most physical changes, whether feminizing or masculinizing, occur over the course of two years and the changes may be highly variable. The following physical changes are expected to occur:

In FtoM Individuals:

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

In MtoF Individuals:

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

Risks of Hormone Therapy

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

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

A. Likely Increased Risk

Feminizing Hormones

Venous thrombo-embolic diseases

Gallstones

Elevated liver enzymes

Weight gain

Hypertriglyceridemia

Cardiovascular disease (in presence of additional risk factors)

Masculinizing Hormones

Polycythemia

Weight gain

Acne

Androgenic alopecia

Sleep apnea

Cardiovascular disease (in presence of additional risk factors)

B. Possibly Increased Risk

Feminizing Hormones

Hypertension

Hyperprolactinemia

Prolactinoma

Type 2 diabetes (in presence of additional risk factors)

Masculinizing Hormones

Elevated liver enzymes

Hyperlipidemia

Hypertension (in presence of additional risk factors)

Type 2 diabetes (in presence of additional risk factors)

C. Inconclusive or no increased risk

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

Feminizing Hormones

Breast cancer

Masculinizing Hormones

Loss of bone density

Breast cancer

Cervical cancer

Ovarian cancer

Uterine cancer

Clinical Situations for Hormone Therapy

1. Initiating Hormonal Feminization/Masculinization:

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

2. Hormone therapy after castration or mastectomy:

A significant number of subject presents with unplanned, ill-timed prior castration (MtoF) or prior mastectomy (FtoM) by non-qualified persons.¹⁰ Consideration of hormone therapy must be based on the client's goals and the risk/benefit ratio of individual subject.

3. Hormone maintenance prior to gonad removal:

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

4. Hormone therapy following gonad removal:

Hormone replacement with estrogen or testosterone is usually continued lifelong after an oophorectomy or orchiectomy, unless medical contraindications arise and adjusted for age

and co-morbid health concerns. In MtoF individuals, estrogen therapy may be discontinued after 50 yrs of age.

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

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

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

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

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

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

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

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

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

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

Hormone Regimens

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

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

Regimens for Feminizing Hormone Therapy (MtoF)

FIRST LINE THERAPY

Androgen-Reducing Medications (Anti-Androgens)

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

- Cyproterone acetate (50–100 mg per day), is a progestational compound with anti-androgenic properties and cost-effective but potentially hepatotoxic.
- GnRH agonists (triptorelin depot 3.75mg monthly or 11.25mg 3monthly) block the gonadal hormones very effectively. These medications are expensive and available as injectables.
- Spironolactone (100–200 mg per day), an antihypertensive agent, directly inhibits testosterone secretion and androgen binding to the androgen receptor and cost-effective. Blood pressure and electrolytes need to be monitored because of the potential for hyperkalemia.

- 5-alpha reductase inhibitors (finasteride 5mg per day or dutasteride 0.5mg per day) block the conversion of testosterone to the more active agent, 5-alpha-dihydrotestosterone. Beneficial effects are observed on scalp hair loss, body hair growth, sebaceous glands, and skin consistency.

SECOND LINE THERAPY

Estrogen

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

THIRD LINE THERAPY

Progestins

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

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

Regimens for Masculinizing Hormone Therapy (FtoM)

FIRST LINE THERAPY

Testosterone

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

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

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

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

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

SECOND LINE THERAPY

GnRH Agonists

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

THIRD LINE THERAPY

Progestins

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

Long-term Care of Transsexual Individuals

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

Monitoring of cross-hormone therapy on MtoF transsexual persons

1. Measure serum testosterone and estradiol every 3 months
 - a) Serum testosterone levels should be <55 ng/dl.
 - b) Serum estradiol should not exceed the peak physiologic range for young healthy females, with ideal levels, < 200 pg/ml.
 - c) Doses of estrogen should be adjusted according to the serum levels of estradiol.
2. Routine cancer screening (breasts, colon, prostate).
3. Consider bone mineral density (BMD) testing at baseline if risk factors for osteoporotic fracture are present (e.g., previous fracture, family history, glucocorticoid use, prolonged hypogonadism). In individuals at low risk, screening for osteoporosis should be conducted at age 60 or in those who are not compliant with hormone therapy.

Monitoring of Cross-hormone Therapy on FtoM Transsexual Persons

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

5. If cervical tissue is present, an annual pap smear examination.
6. If mastectomy is not performed, then consider mammograms as recommended.

Reproductive Health

Some transgender people may want to have children. Because feminizing/masculinizing hormone therapy limits fertility, it is desirable for persons to make decisions concerning fertility before starting hormone therapy or undergoing surgery to remove/alter their reproductive organs. Health care professionals should discuss reproductive options with clients prior to initiation of these medical treatments for Gender Dysphoria.

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

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

CHAPTER 5

GENDER AFFIRMATIVE SURGERY

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

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

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

A review of more than 80 qualitatively different case studies over 30 years demonstrated that the treatment is effective (Pfäfflin & Junge, 1998)¹². A study using the post-genital-surgery end-point showed only 3.8% regret rate (Landén *et al*, 1998)¹³. The study revealed that regrets were more likely where there was a lack of family support. Lawrence (2003)¹⁴ found that the most significant factor for regret was a poor surgical outcome.

¹² Pfäfflin F, Junge A (1998). "Sex reassignment. Thirty years of international follow-up studies after sex reassignment surgery: a comprehensive review, 1961–1991". *International Journal of Transgenderism*, available at <http://web.archive.org/web/20070503090247/http://www.symposion.com/ijt/pfaefflin/1000.htm>.

¹³ Landén M, Wålinder J, Hambert G, *et al* (1998). "Factors predictive of regret in sex reassignment". *Acta Psychiatrica Scandinavica*, 97, 284–9.

¹⁴ Lawrence AA (2003). "Factors associated with satisfaction or regret following male-to-female sex reassignment surgery". *Archives of Sexual Behavior*, 32, 299–315.

Factors that help to support successful outcomes are a consistent gender identity and psychological stability before and after surgery, adequate psychological preparation and transition at an early age (De Cuypere *et al*, 2006)¹⁵, including properly informed consent about benefits, risks and outcomes. A survey in the UK showed a high level of satisfaction (98%) following genital surgery (Schonfield, 2008)¹⁶. Two studies on outcomes in women and men showed that they function well on a physical, emotional, psychological and social level (Weyers *et al*, 2009; Wierckx *et al*, 2011)^{17,18}.

Overview of Surgical Procedures for the Treatment of Gender Dysphoria

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

Surgeries for Male to Female (MtoF) Transgender Persons

A. MtoF Chest Surgery

Augmentation Mammoplasty (implants/lipofilling)

B. MtoF Genital Surgeries

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

C. MtoF Non-Genital, Non-Breast Surgeries

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

D. Revision Surgeries

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

¹⁶Schonfield S (2008).*Survey of Patient Satisfaction with Transgender Services*. Audit, Information and Analysis Unit.

¹⁷Weyers S, Elaut E, De Sutter P, *et al* (2009).“Long-term assessment of the physical, mental, and sexual health among transsexual women”. *Journal of Sexual Medicine*, 6, 752–60.

¹⁸Wierckx K, Van Caenegem E, Elaut E, *et al* (2011). “Quality of life and sexual health after sex reassignment surgery in transsexual men”. *Journal of Sexual Medicine*, 8, 3379–88.

- Clitoroplasty: adjusting the size, shape, location or hooding of the neo-clitoris.
- Vulvoplasty or Labiaplasty: adjusting the size or shape of the labia minora or majora.
- Commisuroplasty: narrowing the superior aspect of the labia majora (the anterior commissure)
- Deepening the neo-vagina: occasionally the neo-vagina will not be long enough or will contract in size. This is usually the result of inadequate dilating.

Surgeries for Female to Male (FtoM) Transgender Persons

A. FtoM Breast/Chest Surgery

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

B. FtoM Genital Surgeries

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

C. FtoM Non-Genital, Non-Breast Surgeries

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

D. FtoM Revision Surgeries

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

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

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

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

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

Referral from MHP for Surgery

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

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

Competence of Surgeons Performing Genital Surgery

Surgeons who perform surgical treatments for Gender Dysphoria should be licensed urologists, gynaecologists, plastic surgeons, or general surgeons. Surgeons should have specialized

competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. It is desirable for surgeons to be willing to have their surgical skills reviewed by their peers. Surgeons should update themselves by regularly attending professional meetings where new techniques are presented.

Ideally, surgeons should have skill for more than one surgical technique for genital reconstruction so that they, in consultation with clients, can choose the ideal technique for each individual. Alternatively, if a surgeon is skilled in a single technique and this procedure is either not suitable for or desired by a client, the surgeon should inform the client about other procedures and offer referral to another appropriately skilled surgeon.

Roles and Responsibilities of Surgeons Performing SRS

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

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

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

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

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

Clients must be warned that in case of genital reconstructive surgeries there can be several separate stages of surgery and frequent technical difficulties, which may require additional operations. For example, Phalloplasty, using a pedicled or a free vascularized flap, is a lengthy, multi-stage procedure with significant morbidity that includes frequent urinary complications and unavoidable donor site scarring. Complications of phalloplasty may include frequent urinary tract stenoses and fistulas, and occasionally necrosis of the neophallus. In Metoidioplasty the objective of standing micturition cannot always be ensured (Monstrey *et al.*, 2009)¹⁹ and also penetration for sex is usually not possible due to small phallus size.

Surgical complications of MtoF genital reconstructive surgery may include complete or partial necrosis of the vagina and labia, fistulas from the bladder or bowel into the vagina, stenosis of the urethra, and vaginas that are either too short or too small for coitus. While the surgical techniques for creating a neovagina are functionally and aesthetically excellent, anorgasmia following the procedure can occur (Klein & Gorzalka, 2009; Lawrence, 2006)^{20,21}.

¹⁹Monstrey, S., Hoebeker, P., Selvaggi, G., *et al* (2009). "Penile reconstruction: Is the radial forearm flap really the standard technique"? *Plastic and Reconstructive Surgery*, 124(2), 510–518.

²⁰Klein, C., & Gorzalka, B. B. (2009). "Sexual functioning in transsexuals following hormone therapy and genital surgery: A review (CME)". *The Journal of Sexual Medicine*, 6(11), 2922–2939. doi:10.1111/j.1743-6109.2009.01370.x

²¹Lawrence, A. A. (2006). "Patient-reported complications and functional outcomes of male-to-female sex reassignment surgery". *Archives of Sexual Behavior*, 35(6), 717–727. doi:10.1007/s10508-006-9104-9

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

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

Pre-Surgical Screening and Precautions

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

- be physically fit for surgery
- be psychologically prepared for surgery
- have realistic goals and expectations of the surgery
- must have a good understanding of the surgical intervention to be performed, its cost, required length of hospitalization, likely complications.
- should be informed of, and understand, any alternative procedures, and risks and complications of the interventions
- have given their informed consent for the procedures

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

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

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

For genital surgical sex reassignment, person has to undergo a urological examination for the purpose of identifying and perhaps treating abnormalities of the genitourinary tract since genital surgical sex reassignment includes the invasion of and the alteration of the

genitourinary tract (urological examination is not required for persons not undergoing genital reassignment)

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

Living in Desired Gender Role Prior to Genital Surgery

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

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

The social aspects of changing one's gender role are usually challenging – often more so than the physical aspects. Changing gender role can have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role. Support from a qualified mental health professional and from peers can be invaluable in ensuring a successful gender role adaptation (Bockting, 2008)²².

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

²²Bockting, W. O. (2008). "Psychotherapy and the real-life experience: From gender dichotomy to gender diversity". *Sexologies*, 17(4), 211– 224. doi:10.1016/j.sexol.2008.08.001

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

Certificates Related to SRS

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

Postoperative Care and Follow-Up

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

Long-term postoperative care and follow-up after surgical treatments for Gender Dysphoria are associated with good surgical and psychosocial outcomes (Monstrey *et al.*, 2009)¹⁹. Positive outcomes have been reported in areas of cosmetic appearance, sexual functioning, self-esteem, body image, socioeconomic adjustment, family life, relationships, psychological status and satisfaction.

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

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

CHAPTER 6

GENDER AFFIRMATIVE VOICE TRANSFORMATION

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

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

A. Speech and Language Therapy

Referral

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

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

Assessment and readiness for therapy

Therapeutic intervention should be undertaken considering the physical limitations of the client's vocal anatomy enabling change without causing vocal abuse/damage (Dacakis, 2002; Adler *et al*, 2006)^{23, 24}. Intervention should commence taking into account the person's ability to participate in therapy (Söderpalm *et al*, 2004)²⁵. It should be consistent with current

²³ Dacakis G (2002). "The role of voice therapy in male-to-female transsexuals". *Current Opinion in Otolaryngology and Head and Neck Surgery*, 10, 173–7.

²⁴ Adler RK, Hirsh S, Mordaunt M (2006). *Voice and Communication Therapy for the Transgender and Transsexual Client: A Comprehensive Guide*. Plural Publishing.

²⁵ Söderpalm E, Larsson A, Almquist S (2004). "Evaluation of a consecutive group of transsexual individuals referred for vocal intervention in the west of Sweden." *Logopedics Phoniatrics Vocology*, 29, 18–30.

research/agreed expert opinion. Any pre-existing voice difficulty should be treated before voice modification (Taylor-Goh, 2005)²⁶.

Poor prediction factors for such laryngological intervention can be

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

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

Therapeutic Intervention (General)

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

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

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

Therapy may be offered on an individual basis or in groups (Chaloner, 2000)²⁷, with use of biofeedback to support therapy. Different communication styles and situations should be addressed. Activities like playing back audio recording of the voice, pitch matching of the

²⁶Taylor-Goh S (ed.) (2005).*RCSLT Clinical Guidelines*.Speechmark Publishing.

²⁷Chaloner J (2000).“The voice of the transsexual.”*Voice Disorders and their Management* (3rd edn) (eds M Freeman, M Fawcus): pp. 245–67. Wiley-Blackwell.

produced voice with the model voice on the acoustic analysis software motivates the client. Therapists should regularly evaluate progress in line with clinical practice guidelines.

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

Therapy with Women (male to female)

The introduction of female hormones will have no effect on the male voice. Therefore, other factors known to mark the difference between male and female voices have to be enhanced to give the individual a more 'feminine' voice. Key communication areas where males and females differ (Oates & Dacakis, 1997; Gelfer & Tice, 2013)^{28,29}, for example voice quality, pitch, intonation, prosody, rate, articulation, resonance, language and non-verbal communication are to be focused.

Therapy with Men (female to male)

The introduction of male hormones in women will lower the pitch of the voice, although the degree and rate of change is variable (Van Borsel *et al*, 2000)³⁰. Therapy may be offered at this time to help stabilise the voice and laryngeal support musculature that will have been physically altered by the male hormones. However, it is not simply lowering the pitch that will make the voice appear more masculine. Other aspects of the voice/communication need to be addressed during assessment and therapy.

B. Surgical Intervention

Male to Female

Pitch-changing surgery may be offered but this should only occur after speech and language therapy intervention and should be decided jointly by the laryngologist, psychiatrist, speech

²⁸Oates J, Dacakis G (1997). "Voice change in transsexuals". *Venereology*, 10, 178–87.

²⁹Gelfer MP, Tice RM (2013). "Perceptual and acoustic outcomes of voice therapy for male-to-female transgender individuals immediately after therapy and 15 months later". *Journal of Voice*, 27, 335–47.

³⁰Van Borsel J, De Cuyper G, Rubens R, *et al* (2000). "Voice problems in female-to-male transsexuals". *International Journal of Language and Communication Disorders*, 35, 427–42.

and language therapist and the client (Matai *et al*, 2003; Parker,2008)^{31,32}. There are various surgical procedures like cricothyroid approximation, anterior commissure webbing and shortening of vocal folds with or without LASER. This may precede or follow other types of gender-change surgery and should be followed by further voice-therapy review to optimise surgical results (Antoni, 2007)³³. Objective results are variable at present (Wagner *et al*, 2003)³⁴, although personal satisfaction rates are high (Kanagalingam *et al*, 2005)³⁵. Thyroid chondroplasty may also be offered to reduce the prominence of the thyroid cartilage for cosmetic appearance (Sandhu, 2007)³⁶.

Female to Male

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

Support Mechanisms and Continuing Professional Development

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

Discharge

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

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

³¹Matai V, Cheesman AD, Clarke PM (2003). "Cricothyroid approximation and thyroid chondroplasty: a patient survey". *Otolaryngology – Head and Neck Surgery*, 128, 841–7.

³²Parker AJ (2008). "Aspects of transgender laryngeal surgery". *Sexologies*, 17, 277–82.

³³Antoni C (2007). "The role of the speech and language therapist". *Transsexual and Other Disorders of Gender Identity: A Practical Guide to Management* (ed. J Barrett): pp. 139–54. Radcliffe Publishing.

³⁴Wagner I, Fugain C, Monneron-Girard L, *et al* (2003). "Pitch raising surgery in fourteen male-to-female transsexuals". *Laryngoscope*, 113, 1157–65.

³⁵Kanagalingam J, Wood GR, Cheesman AD (2005). "Cricothyroid approximation and subluxation in 21 male-to-female transsexuals". *Laryngoscope*, 115, 611–8.

³⁶Sandhu G (2007). "Feminisation of the larynx and voice". *Transsexual and Other Disorders of Gender Identity: A Practical Guide to Management* (ed. J Barrett): pp. 191–8. Radcliffe Publishing.

Annexure 1

Diagnostic criteria: DSM-5

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

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

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

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

Specify if:

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

Specify if:

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

Annexure 2

Criteria for Feminizing/Masculinizing Hormone Therapy

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

Annexure 3

Criteria for Breast/Chest Surgery

Mastectomy and Creation of a Male Chest in FtoM Persons:

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

Hormone therapy is not a prerequisite.

Breast Augmentation (Implants/Lipofilling) in MtoF Persons:

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

Although not an explicit criterion, it is recommended that MtoF persons undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

Annexure 4

Criteria for Genital Surgery

Hysterectomy and Salpingo-Oophorectomy in FtoM Persons and Orchiectomy in MtoF Persons:

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

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

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

Metoidioplasty or Phalloplasty in FtoM Persons and Vaginoplasty in MtoF Persons:

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

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

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

Annexure 5

SAMPLE OF A REFERRAL LETTER FOR HORMONE THERAPY BY MHP

1 April, 2016

RE: Medical referral

Apurbo (Apurva) Sinha

DOB: 14 November, 1990

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

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

5. Statement that informed consent has been obtained from the client: The criteria for CSHT for adults, the risks associated with cross-sex hormone therapy, as well as effects and expected time course of CSHT, as published by WPATH Standards of Care (7th ed.) has been reviewed with the client.
6. Statement that the referring health professional is available for coordination of care: The referring health professional will remain available to Apurbo for clinical care.

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

Sincerely,

.....

Signature

(Name of the MHP, designation, contact details)