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iHEAR
Initiative For Health Equity, Advocacy and Research

UNDP

Trans-Affirmative Medical Education in India

Need for Reform and Core Competencies

TransCare
Med-Ed

KASTURBA MEDICAL COLLEGE
MANIPAL
(A constituent unit of MAHE, Manipal)

AT THE FOREFRONT
UChicago Medicine
Bucksbaum Institute for Clinical Excellence

THE UNIVERSITY OF CHICAGO

TABLE OF CONTENTS

Abbreviations used

AETCOM	Attitude, Ethics & Communication
AHPE	Academy of Health Professions Educators
ATHI	Association for Transgender Health in India
CBME	Competency Based Medical Education
COVID-19	Coronavirus disease
CTP	Conversion Therapy Practices
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECT	Electroconvulsive therapy
ESSENCE	Enabling Translation Of Science To Service To Enhance Depression Care
ETI	Empower | Transform | Inspire
GAT	Gender Affirmative Therapies
FOGSI	The Federation of Obstetric and Gynecological Societies of India (FOGSI)
HIV	Human Immunodeficiency Virus
IAP	Indian Academy of Pediatrics
IAPSM	Indian Association of Preventive and Social Medicine
iHEAR	initiative for Health Equity, Advocacy and Research
IMA	Indian Medical Association
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, etc.
MoE	Ministry of Education
MoHFW	Ministry of Health and Family Welfare
MoSJE	Ministry of Social Justice and Empowerment
NACO	National AIDS Control Organization
NALSA	National Legal Services Authority
Nazariya QFRG	Nazariya Queer Feminist Resource Group
NGO	Non-Governmental Organisation
NHRC	National Human Rights Commission of India
NISD	National Institute of Social Defence
NIMHANS	National Institute of Mental Health and Neurosciences
NMC	National Medical Council
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PRIME	Programme for Improving Mental Health Care
SAATHII	Solidarity and Action Against the HIV Infection in India
SOGIESC	Sexual Orientation, Gender Identity, gender Expression, and Sex Characteristics
STI	Sexually Transmitted Infections
TGNB	Transgender and Non-binary
UChicago	University of Chicago
UCMS	University College of Medical Sciences
UN	United Nations
UNDP	United Nations Development Programme
USAID	United States Agency for International Development

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Executive Summary

Despite a history of acceptance of genders beyond the binary of male and female, transgender and gender non binary (TGNB) persons have found themselves routinely excluded from general healthcare services. One of the reasons for this has been the exclusion of trans identities and health concerns from health professional education in India including the MBBS. Most of the teaching focusses on the gender binary of male and female and excludes transgender and intersex experiences. Moreover,the curriculum itself as mandated by the National Medical Commission, until recently, explicitly classified the transgender experience as an abnormality and mental health problem.

Over the last decade numerous developments have occurred that have started to rectify this problematic aspect of health professional education in India. This includes the Supreme Court judgment under the NALSA vs Union of India in 2014 which for the first time recognised the existence of transgender persons as a third gender and gave the right to self-determine ones gender. In 2019, the Government of India passed the historic Transgender Persons (Protection of Rights) Act which was the first Central legislation to recognise the Transgender Identity. The Transgender Act mandates the reform of medical education to make it transgender inclusive. In response to this and with impetus provided by numerous verdicts from Hob'ble High Courts such as Sushma and Ors vs Commissioner of Police, the National Medical Commission has started to rectify the problematic competency based medical education curriculum by amending the competencies in Forensic Medicine and Psychiatry.

Nevertheless it is necessary for a systematic and overall reform in not just the medical curriculum but also of other health professional curricula. It is not enough to merely remove problematic content but also necessary to add foundational content that would train a health provider in providing transgender-affirmative care regardless of the health problem or the speciality.

Towards this, the TransCare MedEd project was planned to understand the challenges faced by TGNB persons in accessing general healthcare in order to reform the undergraduate health professional education. Towards this a series of consultative workshops and a national conference was conducted between August 2021 and May 2022. Participants included transgender community members, health professionals and students who identify as TGNB, health professionals who have experience providing care to TGNB persons, medical educators and other key governmental and non governmental stakeholders.

Based on this, a set of foundational competencies were developed which were refined through feedback. Competencies are defined as the knowledge attitudes or skills that a health professional should be able to use, express or perform in real life clinical settings. The competencies were organised according to the five-fold framework provided by the National Medical Commission. Based on the discussions a suggestive set of methods are also provided.

The core competencies provide a foundational starting point in equipping aspiring health professionals in providing trans-affirmative care. These competencies could be further refined, incorporated in regular health professional education and implemented in teaching health professional students.

To develop on this further there is need for advocacy, research and capacity building towards making healthcare in India trans-affirmative. The reform needs to be not only in medical education but also in nursing, dental and allied health professional education. There is also need to make health professional educational and work spaces trans-affirmative in order to have more trans-identifiying health professionals in the workforce who are currently underrepresented. All this require the combined effort of all key stakeholders.

INTRODUCTION
&
NEED FOR REFORM

Need for Reform

There has been historical invisibilization and lack of inclusion in healthcare systems, data and discourses. Transgender and gender non-binary individuals (TGNB) face hostility, unfair treatment and discrimination in healthcare services and providers such as physicians, gynecologists, endocrinologists, counselors, psychologists, psychiatrists, etc. Further, TGNB individuals have unique physical and mental healthcare needs. Compared to heterosexual and cisgender individuals, TGNB individuals are more likely to encounter poor healthcare experiences and outcomes. The intersectionality theory and minority stress theory suggest that other marginalized identities within the TGNB population experience even greater disadvantages.[1]

Surveys conducted with transgender population in different regions and expert committee reports have found that transgender persons faced high levels of mistreatment and discrimination in healthcare institutions and some did not seek health care due to fear of mistreatment and unaffordability of services. For example the **Kerala Transgender Survey 2014-15** found that 51% of the 3619 respondents had faced discrimination in health care institutions and the **2014 Report of the Expert Committee on the Issues Relating to Transgender Persons** has noted that health care providers in India have internalized stigma and heteronormativity which makes the health settings not an affirmative and inclusive space for transgender persons. The COVID-19 pandemic and subsequent lockdown exacerbated TGNB persons' general health, mental health and access to health care including vaccination.[2]

1.1 Increased Risk of Diseases

TGNB persons have increased health risks, both physically and psychologically. Studies and surveys show increased disparity between the health of TGNB and cis-heterosexual individuals. Several studies have documented higher prevalence of adverse health outcomes such as sexually transmits infections (STIs), mental health distress, and substance abuse in transgender population while many other health areas remain understudied. The 2015 US Transgender Survey reported that the prevalence of HIV infection among transgender persons was five times (1.4%) the HIV infection prevalence in the general population (0.3%). Meanwhile, 40% of transgender adults had attempted suicide at some point in their lives, compared with 4.6% of the general population.

Studies have shown that trasngender people are at a higher risk of chronic diseases which is further exacerbated for those who are marginalized in terms of their race, age, socio-economic status, co-morbidities, housing instability, financial strain, and experiencing violence.

1 https://doi.org/10.1007/s11606-018-4450-6

2 https://www.ohchr.org/sites/default/files/Documents/Issues/SexualOrientation/IESOGI-COVID-19/CSOs/Nazariya.docx

1.2 Challenges in Accessing Healthcare

Even though TGNB persons are at an increased risk of diseases, many of them are discouraged to access healthcare due to the systemic discrimination and encounters they have to face in these settings from health care providers, fellow patients, bystanders, etc. Misgendering, deadnaming, asking inappropriate questions, belittling their identity and health concerns, lack of gender-sensitive treatment protocols and having to educate the health care professionals, etc. are some of the many experiences which make healthcare settings an unsafe space for TGNB persons. Thus, even with laws like The Transgender Persons (Protection of Rights) Act, 2019 which mandates the need to 'facilitate access to transgender persons in hospitals and other health care institutions and centres', there has been insufficient attitudinal and structural changes in healthcare settings. A 2022 study on **Impact of COVID-19 on Transgender Women and Hijra: Insights from Gujarat, India** (Pandya and Redcay) notes that healthcare services in India are not affirmative for transgender persons.

1.3 Pathologisation, Medicalisation and Conversion Therapy

Part of the problem in enabling physicians' lack of knowledge is the inadequate education and training for health professionals in medically treating transgender people. This lack of knowledge reinforces discriminatory attitudes in patient-provider interactions, further diminishing the healthcare experience for transgender people. It was only recently in 2013 that transgender and non-binary gender identification was removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental disorder. In general, the Indian medical education curriculum largely operates within the gender binary and has not worked to include Sexual Orientation, Gender Identity, Expression, and Sex Characteristics (SOGIESC) competencies. Moreover, it pathologizes the queer identities within the curriculum. The aspect of trans-affirmative and inclusive health is not explored or prioritized sufficiently and therefore it is not well equipped to address the needs of TGNB individuals accessing healthcare. This gets linked to the barriers and health disparities faced by the TGNB persons.[3] It has been reported that the Indian medical education curriculum, residency programs and training had little to no content on LGBTQIA+ healthcare. At the same time surgeons have reported an increase in consultations by TGNB individuals for gender reaffirming surgeries on which they might have technical skills but lack the knowledge to provide optimal care for them. TGNB persons thus delay or avoid seeking treatment due to the fear of prejudice and are pushed to face unequal barriers in accessing healthcare despite their higher burden of illnesses. In addition to the practitioner;s lack of knowledge, queerphobic families of gender diverse individuals also turn to these medical practitioners including complementary or alternative medicines for unscientific, illegal and inhumane conversion therapy practices (CTP).

3 https://doi.org/10.1007/s10459-022-10112-y

1.4 Trans-affirmative Healthcare

To overcome one of the greatest barriers that TGNB individuals face while accessing health care, that is the lack of access to informed providers, the medical curriculum and training needs to be trans-affirmative and inclusive.[4] Only if future medical professionals become trained in trans- affirmative care, they will be able to ensure that transgender people benefit from available therapy alternatives and to combat the role of the medical system in the perpetuation of health disparities in TGNB persons. Studies and reports show that there are several barriers to trans affirmative and inclusive healthcare, such as- lack of affirmative educational and training curriculum/ materials, mandatory standards of practices, underrepresentation of faculties and educators from the community. Several international organizations and medical professional organizations have recommended increased and effective attention to health of TGNB persons in medical education but there is no mandate to do so and no structures for accountability through accreditation bodies.

Over the last few years there has been much interest and conversation in making medical education trans affirmative. This is in the backdrop of the Transgender Persons (Protection of Rights) Act, 2019, recent Madras and Kerala High Court judgements and the directive from the National Medical Commission.

- The Yogyakarta principles included in the National Legal Services Authority (NALSA) judgment of the Supreme Court of India (2014) recognizes "PROTECTION FROM MEDICAL ABUSES". It is described that *"no person may be forced to undergo any form of medical or psychological treatment, procedure, testing, or be confined to a medical facility, based on sexual orientation or gender identity". It is described that "no person may be forced to undergo any form of medical or psychological treatment, procedure, testing, or be confined to a medical facility, based on sexual orientation or gender identity". It directs the States to "take all necessary legislative, administrative and other measures to ensure full protection against harmful medical practices based on sexual orientation or gender identity, including on the basis of stereotypes, whether derived from culture or otherwise, regarding conduct, physical appearance or perceived gender norms"; "ensure that any medical or psychological treatment or counselling does not, explicitly or implicitly, treat sexual orientation and gender identity as medical conditions to be treated, cured or suppressed", among many other.*[5]

- The Mental Healthcare Act (2017) ensures Right to equality and non-discrimination *"in the provision of all healthcare…. on any basis including gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class or disability".*[6]

- *Following the NALSA judgement, the Transgender Persons (Protection of Rights) Act, 2019 was passed.*

4 https://doi.org/10.1007/s11154-018-9452-5 , https://doi.org/10.1007/s40670-018-0614-6
5 https://translaw.clpr.org.in/wp-content/uploads/2018/09/Nalsa.pdf
6 https://egazette.nic.in/WriteReadData/2017/175248.pdf

- In a Position Statement Regarding LGBTQ (2020), Indian Psychiatric Society disapproved *"all forms of 'treatment/therapy' (including individual psychotherapies, behaviour therapies like aversive conditioning etc., hypnotherapy, group therapies, pharmacotherapy, physical treatment methods like ECT etc. or milieu treatments) to reverse sexual orientation are based on a premise that is erroneous : that such orientations are diseases"* and urged that they must cease. [7]

- On June 7 2021, the Madras High Court laid down a set of guidelines to protect the members of the LGBQIAP+ community against discrimination. For the sake of creating awareness, the Court suggested the sensitization programs to be conducted for Physical and Mental Health Professionals by the National Medical Commission, Indian Psychiatric Society, and Rehabilitation Council of India. One of the directives read *"Prohibit any attempts to medically "cure" or change the sexual orientation of LGBTIQA+ people to heterosexual or the gender identity of transgender people to cisgender. To take action against the concerned professional involving themselves in any form or method of conversion "therapy", including withdrawal of license to practice; and Sensitization programs as provided by Rule 10(7)(b) of Transgender Persons (Protection of Rights) Rules, 2020"*. It included an array of inclusive policies with regards to infrastructure as well as educational programs and directed for the *"Effective change in curricula of Schools and Universities to educate students on understanding the LGBTQIA+ community"*. [8]

- On December 10, 2021, the Kerala High Court directed the state government to form guidelines for prevention of conversion therapy of LGBTQIA+ people after considering a plea (WP-C No. 21202/2020) and the study report prepared by the Indian Psychiatric Society. The petition read *"The solution to address this issue (conversion therapy) require government policy, guidelines, written protocols and codified treatment plans which are formulated to enable the qualified professionals to handle genuine requests for clinical intervention from individuals concerned and it shall be self-regulatory in nature by ensuring sufficient freedom for professional judgement by the medical practitioners, but not allowed to be misused by anyone with vested interest as a weapon to curtail the individual rights..."*. [9]

- On August 8 2022, the National Medical Commission Postgraduate Medical Education Board revised and published a more LGBTQIA+ affirmative and inclusive 'Guidelines For Competency Based Postgraduate Training Programme For M.D. In Psychiatry'.

- On August 25, 2022, in a notice to State Medical Councils, the Ethics and Medical Registration Board of the National Medical Commission (NMC) decided to notify conversion therapy as a professional misconduct under the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002.

7 https://indianpsychiatricsociety.org/ips-position-statement-regarding-lgbtq/
8 https://www.ungender.in/madras-high-court-judgement-lgbtqiap/
9 https://www.livelaw.in/pdf_upload/queerala-anr-v-state-of-kerala-ors-405920.pdf

- On September 29 2022, the Supreme Court of India in a landmark judgement related to the Medical Termination of Pregnancy Act 1971 noted that the use of the term “woman” in the judgment includes “persons other than cis-gender women who may require access to safe medical termination of their pregnancies”.

There is thus a clear mandate to make medical education trans-affirmative. However, there is a need for a roadmap towards achieving this goal, especially in accordance with the new competency-based medical education (CBME) curriculum. This is where the TransCare MedEd project comes where we have created competencies on trans-affirmative health provision.

ABOUT THE PROJECT

2.1 Building on work in Disability Inclusive Compassionate Care

The TransCare Med-Ed project builds on the work done in the Disability-Inclusive Compassionate Care project which created a set of competencies to bridge the gap in disabilities education, which has been given scant attention in the medical curriculum. Medical schools should play a pivotal role in efforts to produce physicians who are knowledgeable about the needs of patients with disabilities, yet only a handful of medical schools offer formal content about disability and this rarely reaches a broad cross section of students. The idea for TransCare MedEd originated in multiple conversations that occurred in collaboration with the University of Chicago in the context of looking at shared decision making for marginalised communities.

2.2 Sangath and iHEAR

The project was hosted at Sangath Bhopal. Sangath is a non-governmental, not-for-profit organization based in Goa, and other Indian states such as Delhi, Madhya Pradesh, working towards improving health across the life span by empowering existing community resources. Sangath has now blossomed into one of the world's most recognized mental health research NGOs. It works in partnerships with several state governments across India. It has received several national and international awards in recognition of innovative research.

The Sangath Bhopal hub started operations in Madhya Pradesh in 2011 with the PRIME project (PRogramme for Improving Mental Health CarE) and now is involved in more than ten different projects in the intersection of community mental health, bioethics, health equity and marginalisation. The hub has been working with marginalized populations such as the transgender community, disability communities since March 2021 under iHEAR (initiative for Health Equity Advocacy and Research).

iHEAR is a collaborative effort hosted at Sangath that brings together academics, researchers, activists, practitioners and community representatives to conduct participatory research, advocacy and education at the intersection of marginalized identities, health access and mental health. It was born out of the TransCare initiative and currently works with the LGBTQIA+ and disability communities. The projects under iHEAR and TransCare are: iHEAR VaccinEquity, Transcare COVID19, Transcare MedEd, iHEAR Peers for Equity and Transcare Queer Ambassadors. The TransCare MedEd project was the second project under the iHEAR initiative.

2.3 About TransCare MedEd

Transcare MedEd project aims to highlight global best practices in shared decision making for vulnerable communities and to create a set of core competencies on trans-affirmative healthcare in India through a series of regional workshops and a national conference. The stakeholders for the workshops included health professional educators; healthcare professionals providing gender-affirmative healthcare; medical students, faculty and other health professionals identifying as Transgender and Non Binary (TGNB); and TGNB community members. The project builds on a prior successful collaboration with UChicago in incorporating disability competencies into the Indian medical curriculum and another ongoing project by the Indian team studying the experiences of TGNB persons in health facilities.

After the consolidation and refinement of the competencies drafted at these workshops, the project concluded with a national conference and a dissemination meet aimed at highlighting these best practices and discussing methods of teaching, consensus building and national dissemination of this work. In the future, these efforts can inform the development of competencies for providing healthcare that is inclusive of other sections of the SOGIESC population as well as minority caste, religious and ethnic populations in India and regionally in South Asia.

Transcare MedEd is funded by the University of Chicago and the Bucksbaum Institute at University of Chicago. Kasturba Medical College, Manipal, a constituent unit of Manipal Academy of Higher Education is a key collaborator. In the project dissemination national conference Sangath collaborated with UNDP, USAID-PEPFAR and SAATHII. In addition, ACCELERATE, ETI Services and PixStory were outreach collaborators in the conference. Sangath is collaborating with UNDP in developing and producing this advocacy booklet.

TransCare Med-Ed addresses the lack of trans-affirmative content that needs to be a part of the MBBS curriculum through a systematic, participatory, and inclusive effort. It has developed a set of trans-affirmative competencies on trans-affirmative healthcare in India.

There were three main phases for this project.

INDIA

The Project Co-Leaders

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Dr. Ameya Kumar	Volunteer

Phase 1

Consultation Phase

In the first phase, the project held a series of consultative stakeholder workshops conducted in:

1. Hamdard Institute of Medical Sciences and Research, Delhi,
2. Kasturba Medical College, Manipal,
3. Bhopal
4. Virtually

The stakeholders for this workshop included:

1. TGNB community members
2. Healthcare professionals and students identifying as TGNB
3. Healthcare professionals who work with TGNB persons
4. Health professional educators

Workshop with TGNB persons in HIMSR, Delhi in September 2021

Workshop with TGNB community in KMC, Manipal

Workshop with health professional educators in KMC, Manipal

Workshop with health professionals with experience caring for TGNB persons in HIMSR, Delhi, September 2021

Phase 2

Review Phase

In the second phase the audio recordings from the workshops were transcribed and analysed thematically. Then, themes that emerged from the workshops used to draft competencies were organised into categories based on the framework in the competency-based medical curriculum of the Medical Council of India. The competencies were then shared with the different participants for feedback. After being reviewed and evaluated by many different groups of people, these competencies were edited and solidified.

Phase 3

Dissemination Phase

In the last phase of the project, the focus was to disseminate the competencies that were developed. For this different activities were conducted.

1. The TransCare Med Ed national Conference:

The TransCare Med-Ed National Conference was held in New Delhi on May 5th and 6th in Hotel Le Meridien. This conference was aimed at disseminating and discussing the competencies, highlighting the best practices, and building consensus on the way forward. Participants in this conference included project co-leaders from UChicago, Indian collaborators, medical college faculty, and government officials. This included UNDP India, USAID, UNAIDS, NISD, NACO and numerous key NGOs such as C-SHARP, ATHI, Nazariya etc. A draft version of the competency booklet was released in the conference and feedback collected.

2. A Dissemination Meet

A one-day dissemination meet was organised at the University of Chicago Center in Delhi in 18th June 2022. The participants of this meet included health professionals, medical college faculty, lawyers and community representatives.

3. Meetings with key stakeholders

In June 2022 the team met with key stakeholders such as National Institute of Social Defence (NISD), The National AIDS Control Organization (NACO), and the United Nations Development Programme. (UNDP). Subsequently, in July 2022 NACO organised a specific meeting to discuss trans-inclusion in the MBBS curriculum.

Meeting with NISD in June 2022

Meeting with NACO in June 2022

Advocacy meeting with NHRC in September 2021

4. Public engagement

Public engagement and dissemination of the competencies were done primarily through social media and media engagement. A few examples are given below

- Discrimination against transpersons plagues India's health care system. It's time to overhaul it: Aqsa Shaikh, Harikeerthan Raghuram

https://www.forbesindia.com/article/new-year-special-2022/systemic-discrimination-historical-marginalisation-against-transpersons-plague-indias-health-care-system-time-to-overhaul-it-is-now-aqsa-shaikh-harikeerthan-raghuram/72791/1

- NCERT Manual on Transgender Inclusion: A Step Towards Liberation for All

https://www.thequint.com/neon/gender/ncert-manual-trans-affirming-guide-step-towards-liberation-lgbtq-gender-inclusivity-schools

- Step towards more LGBTQIA+ affirmative medical curriculum doesn't go far enough

https://indianexpress.com/article/opinion/columns/medical-education-curriculum-lgbtqia-nmc-7588604/

- Initiative to educate professionals on transgender health

https://timesofindia.indiatimes.com/city/delhi/initiative-to-educate-professionals-on-transgender-health/articleshow/84001394.cms

- Doctors Day: Trans doctors' need for health equity gives birth to Trans Care India; platform to make medical curriculum inclusive

https://www.ibtimes.co.in/doctors-day-trans-doctors-need-health-equity-gives-birth-trans-care-india-platform-make-shift-838221

Outcomes of the project

There are four primary outcomes of this project. The first outcome is an exchange of knowledge on shared decision making in providing trans-affirmative healthcare between UChicago, Indian collaborators, and the TGNB community representatives in India. The second outcome is the creation of a set of competencies necessary for a health professional students to become a trans-affirmative health professional. The third outcome is the advocacy efforts towards inclusion of the drafted competencies into the Indian medical curriculum. The last outcome is to establish a rapport and congeniality between different stakeholders, especially in the empowerment of the TGNB community

COMPETENCIES

3.1 CORE COMPETENCIES ON TRANS-AFFIRMATIVE CARE FOR HEALTH PROFESSIONAL EDUCATION IN INDIA

This section lists out the core competencies as per the five roles of the Indian medical graduate given by the National Medical Commission (erstwhile, Medical Council of India)

1. CLINICIAN

It is crucial for clinicians to properly understand all of the ideas under the SOGIESC framework as well as the societal influences and intersectionalities of TGNB healthcare. If clinicians have a genuine understanding of these concepts, they will be in the best position to provide the best care for those in the queer community. Clinicians should also strive to provide gender affirmative services as well as long-term mental health services to TGNB patients

1.1

Describe and differentiate between the evolving concepts of the SOGIESC framework

"And our training really has not equipped us"

- A health professional in Delhi who works with TGNB clients

"The first reason being everybody must know about transgenders; not just doctors, this whole concept of gender not being binary and Gender Spectrum must be common knowledge. And if it must be common knowledge, all the more important that healthcare professionals must know about it, because they are supposed to be the spearhead of giving this knowledge to society"

- Medical college faculty from Bhopal

"Gender and sex are synonymously used and there is very little understanding about gender and medical curriculum doesn't try to address this I mean, the current medical curriculum doesn't try to address in how to mean how gender is different from sex and mean if you look at the curriculum, the NMC curriculum, all the three volumes I mean, including trans inclusive"

- Medical college faculty from Bhopal

"And the more competency which is required is more than it's that I feel is that the communication skills and how to communicate with them the cultural, understanding their cultural perspective, how, what is their requirement, and what are the sets of behaviors what which prevents them not to avail the general healthcare, the mainstream healthcare benefits that we need to identify"

- Medical college faculty from Bhopal

"One was like, I don't know anything about this, you are the first client that I am seeing"

- Health professional or medical student who identifies as TGNB

Identify the social and structural determinants of health of TGNB patients including their intersectionality

Enlist the gender affirmative Services available for TGNB persons

"We require care to be given which is considered cosmetic for other people bit it is life saving for trans people"

- Health professional in Delhi who works with TGNB clients

"Why can't be you know, estrogen, testosterone artificial hormones introduced in the pharmacology itself as a part of a sex reassignment hormones"

- Health professional or medical student who identifies as TGNB

"It was a whole process, the whole process. Of how a person can actually transition to how a person's gender can actually transition that is and how stressful it can be"

- A medical college faculty from Bhopal

"Psychiatrist, not just a gatekeeper or giving permission for surgery, but psychiatrist actually helps the patient assimilate into the society, it's very important to keep in touch with the psychiatrist" - A health professional in Delhi who works with TGNB clients

- A health professional in Delhi who works with TGNB clients

Discuss the need for mental health services throughout the lifecourse of a TGNB person, particularly, before, during, and after gender affirmative services

2. LEADER AND MEMBER OF THE HEALTHCARE TEAM

It is absolutely important for leaders and members of the healthcare team to be inclusive and encouraging of TGNB students, colleagues, and patients in order to create a safe environment for everyone

"There was one of the persons from my class who actually supported me and then everyone did not really question it"

- Health professional or medical student who identifies as TGNB

"It's not really difficult to live in the boys hostel, but I just, you know, think at times that it would, it would have been very, it would have been better"

- Health professional or medical student who identifies as TGNB

Demonstrate awareness of the need to facilitate the development of a bias and discrimination free environment and inclusive infrastructure for learning, work, and care provision for TGNB students, colleagues, and patients

Describe the importance of an interprofessional team to provide inclusive and affirmative care for trans-affirmative care

"And we should have a secretary of the hospital dedicated to it with the separate entry and exit staff which is sensitized to the needs gender neutral washrooms"

- Health professional in Delhi who works with TGNB clients

"Why don't we have one team member, a doctor or a paramedical staff who is gay or who is transgender, and how we communicate with them"

- Health professional or medical student who identifies as TGNB

Encourage for social inclusion of TGNB persons within the healthcare community

3. COMMUNICATOR

Communicators play a very important role in ensuring that all communication is culturally appropriate, affirmative, and clearly explained to TGNB patients and their families

"Every person, every patient we encounter is different in some way or the other. And just because we are not used to seeing a certain type of let's say, cultural identity or a gender expression, you know, that doesn't mean that as doctors we make that the main point or the center of our interaction with that patient"

- Health professional in Delhi who works with TGNB clients

"They try you know, wantedly or unwantedly, or you know, by mistake, they point me with the old name"

- Health professional or medical student who identifies as TGNB

"You know, because they do so many surveys. This response really stands out in my memory that you never ask anybody their gender. It is something that you take for granted. When filling up a form. So, obviously, you are so tuned into the binary that is it"

- Medical college faculty from Bengaluru

Demonstrate the use of appropriate and affirming verbal and non verbal communication techniques while communicating with TGNB persons

Provide health education to the TGNB patients, caregivers, their families and at the community level in a culturally appropriate manner

"And psychiatrists, a plastic surgeon, endocrinologists, they should understand first everything, whatever the need of these particular people and they should help the parents"

- Health professional or medical student who identifies as TGNB

Explain the need for referral and the referral procedure to a TGNB patient

3.3

4. LIFE LONG LEARNER

Life long learners need to be aware of standards of care and policies that protect TGNB persons at both the national and state level. They should also encourage SOGIESC minority groups to participate in research which would help advocate for further policies to protect them

4.1

Demonstrate familiarity with the Transgender Persons (Protection of Rights) Act, 2019 and keep abreast of the updates such as other policies, provisions, and government schemes related to TGNB persons, both at the national and state level and keep abreast of updates

"We decided to go ahead with surgery, both hysterectomy and top surgery, but the hospital suddenly started having a query, how can we operate without any consent affidavit, all those things certainly propped up basically from the gynecology team"

- Health professional in Delhi who works with TGNB clients

4.2

Describe the Standards of Care for transgender persons

4.3

Encourage the research among sexual and gender minority groups using a participatory approach

5. PROFESSIONAL

Professionals should be respectful, empathetic, and supportive of TGNB identities and privacy especially in clinical spaces. They should also understand the dynamic in the patient-provider relationship in which the healthcare provider has a level of privilege and the patients could be vulnerable to exploitation

"Our medical fraternity failed to treat us as a human"

- Health professional or medical student who identifies as TGNB

Demonstrate empathy, dignity, and respect with consideration for agency, privacy and confidentiality for the TGNB persons especially in clinical settings

Demonstrate integrity in treating TGNB patients who are vulnerable to physical, mental, sexual, social and financial exploitation

"So it is more a competency to do with sensitivity of approach, of acceptance, of respect, that has been the starting point rather than as a specialization"

- Medical college faculty from Bhopal

"But I do remember that when the first person walked into my outpatient department, I immediately felt that the patio come down, you know, I immediately became this other person that I wasn't very proud of"

- Health professional in Delhi who works with TGNB clients

"I feel doctors have this raging urge to tell what was good for us. And instead of asking, what do we want, they have the urge to tell you look like a man. Why don't you conform to that?"

- Health professional or medical student who identifies as TGNB

Demonstrate integrity in treating TGNB patients who are vulnerable to physical, mental, sexual, social and financial exploitation

Demonstrate shared decision making in decisions related to gender affirmative services

"And if we do this simple thing of understanding that we as professionals have the task of affirming whatever is the narrative, we also need to understand that the narrative which is consistent, which is insistent, and which is persistent, has to be supported"

- Health professional in Delhi who works with TGNB clients

3.2 Equivalence between the Competencies of ACGME, National Medical Council and Indian Nursing Council

<table>
<tr><td rowspan="2">ACGME, USA</td><td colspan="2">India</td></tr>
<tr><td>National Medical Commission</td><td>Indian Nursing Council</td></tr>
<tr><td rowspan="2">Medical Knowledge</td><td rowspan="4">Clinician</td><td>Patient centered care</td></tr>
<tr><td>Evidence based practice</td></tr>
<tr><td rowspan="2">Patient care & procedural skills</td><td>Safety</td></tr>
<tr><td>Quality improvement</td></tr>
<tr><td rowspan="3">Systems based practice</td><td rowspan="3">Leader</td><td>Systems based practice</td></tr>
<tr><td>Teaching & leadership</td></tr>
<tr><td>Teamwork & collaboration</td></tr>
<tr><td>Interpersonal & Communication skills</td><td>Communicator</td><td>Communication</td></tr>
<tr><td>Practice based learning & improvement</td><td>Lifelong learner</td><td>Health informatics & technology</td></tr>
<tr><td>Professionalism</td><td>Professional</td><td>Professionalism</td></tr>
</table>

3.3 Problems with the current competency based medical education (CBME) curriculum of the National Medical Council

There is **no mention of transgender** OR gender nonbinary in the entire CBME competencies and ethics module (AETCOM). Competencies in anatomy, physiology, pathology and gynaecology only talk about 'male' and 'female'. Similarly the entire curriculum talks only about the contraceptive methods for male and female and there is no mention of transgender OR intersex people.

Here is a list of competencies that need to be modified to be made trans affirmative

FM3.18	Describe anatomy of male and female genitalia, hymen and its types. Discuss the medico-legal importance of hymen. Define virginity, defloration, legitimacy and its medicolegal importance
FM 3.22	Discuss the causes of impotence and sterility in male and female
FM 3.23	Discuss Sterilization of male and female, artificial insemination, Test Tube Baby, surrogate mother, hormonal replacement therapy with respect to appropriate national and state laws
ANA 46	Male external genitalia
AN52.8	Describe the development of male & female reproductive system
OG 2.1	Describe and discuss the development and anatomy of the female reproductive tract,
AN52.2	Male and Female reproductive system
ANA 53.3	Define true pelvis and false pelvis and demonstrate sex determination in male & female bony pelvis
PY 9.1	Describe and discuss sex determination; sex differentiation and their abnormities and outline psychiatry and practical implication of sex determination.
PY 9.3	Describe male reproductive system
PY 9.4	Describe female reproductive system
PY9.6	Enumerate the contraceptive methods for male and female.

PA30 Female genital tract

Problematic Competencies in Psychiatry and Forensic Medicine that have been removed since July 2022

FM3.16 SEXUAL **OFFENCES** Describe and discuss **adultery** and **unnatural** sexual offences **sodomy**, incest, **lesbianism**, buccal coitus, bestiality, indecent assault and preparation of report, framing the opinion and preservation and despatch of trace evidences in such cases

PS 13.4 Describe the treatment of psychosexual and gender identity **disorders** including behavioural, psychosocial and pharmacologic therapy

MBBS UG CBME
https://www.nmc.org.in/wp-content/uploads/2020/01/UG-Curriculum-Vol-I.pdf

MBBS AETCOM
https://www.nmc.org.in/wp-content/uploads/2020/01/AETCOM_book.pdf

3.4 Methods to teach the competencies on trans-affirmative health provision

"Unfortunately, the medical curriculum does not prepare you at all, at all"
- A health professional with experience working with TGNB clients

"Doctors are very difficult to educate, even through talking nicely or using other methods. It's difficult,"
- A TGNB health professional

These findings from the community members support the logical justification for the inclusion of innovative tools in medical education so that our future doctors do not act as mechanical robots who place differential diagnosis before humans and feelings, ignoring the humane connection. The interdisciplinary field of health humanities explores experiences of health and illness beyond the confines of medicine.

Rather than medical textbooks, more often, storytelling by transgender people, their illness narratives, and their visual arts give students the missing perspectives on how diagnosis, cure, and therapy can result in trans-health disparities. The interdisciplinary field of disability studies helps us by providing a critical lens to understand the concept of medicalization that calls for medical fixing of non-normative bodies and/or minds that do not fit in the typical gender binary. With the help of tools from the humanities, students can learn more about how medicalization is a social issue that affects trans identity.

“But maybe something like that is the intervention that we use in humanities interventions, and the most powerful tool that we find is storytelling and theatre.”

- Group 3 participant

Motivating faculty and students to indulge in critical reflexivity can help in knowing one's own limitations and others' social realities (beliefs, values, and social structures). It examines clinical practice assumptions and how they influence professional behaviour. Another potent tool to stimulate reflection on professionalism is Augusto Boal's Theatre of the Oppressed/Forum Theatre, which one of our collaborators used effectively in imparting disability competencies in the CBME.

“Firstly, we need to create role models, like the ones we have here. Surgeons of repute, endocrinologists who have done so much work.”

- Group 3 participant

"But maybe something like that is the intervention that we use in humanities interventions, and the most powerful tool that we find is storytelling and theater."

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"Firstly, we need to create role models, like the ones we have here. Surgeons of repute, endocrinologists who have done so much work."

- Group 3 participant

Being a leader and member of a team is one of the five goals expected of an IMG. This entails self-awareness of social accountability, which is the capability to address societal needs for health equity. Looking beyond one's own experience (as well as acknowledging our own implicit biases) and embracing the experiences of others without judgement is what structural humility is all about. This is a life-long learning trait which the National Medical Commission expects future doctors to demonstrate. The skills for this cultural competency come from out-of-the-box innovations respecting the lived experience of TGNB as expertise. The table below suggests tools from the humanities which could be used to impart trans-affirmative competencies in CBME.

Roles of IMG	Humanistic competency	Suggested tools
Clinician	Narrative competency	Stories, Narrative medicine (illness narratives, life writings) Medical history, Poetry, Literature, Theology, Philosophy
Professional	Critical reflexivity	Bioethics, Theatre of the Oppressed, Reflections, Critical thinking, Professional identity formation

Roles of IMG	Humanistic competency	Suggested tools
Communicator	Visual literacy	Visual arts, Reading Films, Graphic medicine (Comics), Image theatre, Performance (Street theatre), Creative writing
Leader	Advocacy	Mentoring, Postmodernism, Social Justice studies (disability studies, feminism, gender studies, age studies, dalit rights)
Lifelong learner	Structural humility	Forum theatre, Patients as educators, Identity, Wellness, Music, Dance, Digital humanities

Adapted from:
Singh S, Dhaliwal U, Singh N. Developing Humanistic Competencies Within the Competency-Based Curriculum. Indian Pediatr. 2020;57(11):1060-1066

"And even the students pay very little attention because there's hardly any weightage for psychiatry in the examination system"

- Group 3

One of the important things for educators is to consider these competencies a "must have" rather than an optional one. It is important to use these in the existing curriculum in both formative and summative assessment as well as the longitudinal AETCOM module.

Ref: MSAI//2022/EA/LOE/1

New Delhi, India
Date: 8th September 2022

Endorsement Letter

To whomsoever it may concern,

MSAI India is India's first and largest nationally and internationally represented medical students' organization, comprising over 20,000+ medical students across the country (registered in New Delhi under the Societies Act). Ever since its inception, MSAI has spread its wings to the farthest corners of the country and continues to do so even today. We span over 28 states and 8 union territories in India, as of today. The organization currently works towards advocating for Sexual and Reproductive Health and Rights, Public Health, Human Rights and Peace, and Medical Education including Bioethics. In addition, we participate in Medical Students exchange programs (Professional and Research). We have reached out to help over 2,10,000 people through our on-ground activities in communities in India, in the last year alone, and over 50,000 people through our online initiatives during the pandemic. Our grassroots action and advocacy efforts to accelerate progress in the above-mentioned areas have been represented at High-Level UN and WHO meetings (WHO EB, WHA and WHO RC), among others.

MSAI is affiliated to the International Federation of Medical Students' Association (IFMSA). The International Federation of Medical Students Associations (IFMSA), founded in 1951, is one of the world's oldest and largest student-run organisations. It represents, connects and engages every day with an inspiring and engaging network of 1.3 million medical students from 139 NMOs (National Member Organisations) in 130 countries around the globe. IFMSA is proud of its cooperation with a wide range of stakeholders such as UN bodies, NGOs and youth organizations. We connect Medical Students all over the country, engage them in meaningful change and development, and represent the Youth of Medicos in India.

Our perpetual effort in voicing concerns with the construction of diverse standing committees thrive to deliver knowledgeable, supportive, caring and compassionate future healthcare providers.

There is a specific need to determine the current status of anti-transgender discrimination in the health care system. There is also a specific need to determine if providers receive adequate training in transgender medicine and if not, to determine the gap.

In addition to poorer health outcomes, transgender people also encounter unique challenges and inequalities in their ability to access health insurance and adequate care. The public health and economic crises spurred by the COVID-19 pandemic have only exacerbated existing disparities and barriers to care for transgender people.

Duly realizing equity and equality in healthcare and standing by the hymn that people should feel empowered to take an active role in their health, the spectrum of medical training with regard to transgender medical care and the various financial barriers, discrimination, lack of cultural competence by providers, health systems barriers and socioeconomic barriers faced by them drags the whole healthcare community down.

Transgender people have a unique set of mental and physical health needs. These needs are compounded by prejudices against transgender people within both the medical system and society at large

TransCare MedEd is an important project working towards bridging this inequality by advocating for the addition of Transgender/Non-Binary based outlooks in the present medical curriculum. Under NMC's current proposal of the five competencies of an IMG (Indian Medical Graduate), namely Clinician, Leader & Team Member, Communicator, Life Long Learner and Professional, TransCare MedEd is advocating for the inclusion of criteria that also shed light on Transgender and Non Binary population.

This comes in follow-up of the 2019 Transgender Persons (Protection of Rights) Act which also guides the Government to review medical curriculum regarding the same. MSAI supports this initiative of TransCare MedEd to be inclusive, and have our Medical Education reflect that.

MSAI gives its full throated support to TransCare MedEd in their efforts to include these competencies to the current Medical Curriculum; these competencies will ensure a more holistic, harmonious and non-discriminatory approach to the treatment and counselling of Transgender/Non-Binary people, and instil such values in future doctors and healthcare professionals. We appreciate the rigorous determination of Core Competencies on Trans-Affirmative Care for Health Professional Education in India and will be pleased to proceed in the journey to collectively look for solutions to address identified gaps.

Think globally, act locally!

Sincerely,
On behalf of MSAI Executive Board
and Team of Officials (EBTO) 2022-23

Dr. Prabhat Jha
President 2022-23

Medical Students' Association of India
Suite S-473, Basement, Greater Kailash, Part-One, New Delhi - 110 048, India I E: msai-india@ifmsa.org

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DISCUSSIONS IN THE CONFERENCE

Making healthcare trans-affirmative means a generational unlearning of institutional transphobia that reframes doctor-patient relationships by centering care over implicit biases and perceptions of a person. This section documents firsthand narratives by transgender people by weaving together four recurring themes: how the cisgender-heterosexual gaze of visibilization limits access to daily healthcare needs; the life-threatening risks of accessing lifesaving healthcare; navigating institutionalized transphobia as a trans medical student; and de-centering the medicalization of transness through affirmative healthcare practices.

4.1 The Violence In Visibility: Locating Transgender Persons' Inaccessibility To Daily Healthcare Needs

How does one navigate the violent institutionalisation of transphobia in hospitals when a family member needs care? How does authority misplace and steal agency by creating the "visibility of passing"? How does a sari become weaponized into a denial of care?

"The way we face discrimination is grounded a lot in visuality. I want to demonstrate that by making you think for a moment: I'm wearing a sari; I get a call from my mother or father; they are in an emergency health condition; I need to rush them to the hospital," said Kanmani Ray, Research Associate and Lawyer at the Centre for Justice, Law and Society.

“Do you really think I'm not going to be shamed, or my parents are not going to be shamed? They won't care about my parents getting a heart attack, or my mom getting a giddy spell,” Ray added.

The stealing of agency by authority through a visibility created by the cisgender-heterosexual gaze, is often an instantaneous translation of interrupted healthcare, where the person seeking care is treated through the lens of blame.

“I have skin issues but I don't think I can go to any dermatologist in Delhi as myself. This is what I fear when I transition,” Ray said. “Post-op care is not just about post-op care. It's also about the kind of affirming healthcare we need, for those of us who medically transition.”

Navigating spaces as a gender nonconforming and transgender person means dealing with the consistent possibilities of misunderstandings by imposed binaries.

“For nonbinary people, ‘passing’ is something which does not really factor in. For us, it's about the agency and our desire to just be who we want to be for that moment,” said Pavel Sagolsem, Program Manager at Nazariya.

Sagolsem recounts a hospital visit where the associated femininity with threaded eyebrows had healthcare staff oscillating back and forth between ‘madam’ and 'sir’.

“I felt comfortable in that because I think the ambiguity that we represent was captured there. But then again, the authority and agency is more with the people treating me,” Sagolsem said.

Pavel Sagolsem, Program Manager at Nazariya.

As a psychology student and nonbinary person who is living with mental distress, and is seeing a therapist and psychiatrist, TransCare MedEd Project Assistant Gadha feels like someone who is 'in the system' but doesn't belong to it.

They speak on the disheartening invasiveness of a medicalized gaze that attempts to reduce everyone to their bodies through the context of surgery: "I'm not ready to have the conversation, but it seems like everybody else is. Everybody else has this authority over my body. When it comes to a doctor, I am just a body. I don't have agency. I don't have any kind of identity other than being what's between my legs," Gadha said.

Gautam, Executive Board Member of TWEET Foundation, recounts falling sick and being unable to access the care they because of the misgendering, deadnaming and dysphoria prevalent in medical spaces.

When their friends and family pushed them to reach the emergency room, Gautam encountered invasive questions about his gender that weren't related to the care they needed.

"I was lying on a stretcher and the doctor came in and loudly announced my deadname. He told me I don't look like my deadname and stared at my chest, making me very uncomfortable. I explained my symptoms, but instead of responding to them, he said, 'Why is your chest so flat?'" Gautam said.

This hypervisibility created by the cis-het gaze in medical spaces, exacerbates the latency of mental distress that oscillates back to worsen physical health.

As someone who finds it difficult to narrate their own experience, State Technical Trans Expert Rachana Mudraboyina from Telangana, recounts a story about two trans sisters, Prema and Hema, who came from a remote area of Telangana district, and travelled across to Maharashtra.

"We know that trans people – not only for their livelihood, but also for the freedom of gender expression – travel and migrate to a lot of places," Mudraboyina said.

Somewhere down the line, Hema gets a surgery performed by a non-qualified doctor, and is rushed to the hospital where the doctor wastes four to five hours in attempting to understand what it means to be trans, putting Hema's health at further risk.

A few years later, Hema dies from a sudden brain haemorrhage. Mudraboyina questions the ambiguity and lack of closure in navigating health: What caused the brain haemorrhage? Was it from mental distress, or other undetected health reasons?

“This story of Prema and Hema, narrates a lot of things to us: there is migration, there is no environment for your gender expression, there is poverty, there is no healthcare, there is no care for the value of lives. If we make any sort of risk to transition, what happens to mental health?” Mudraboyina said.

Transgender RTI Activist* Vyjayanti Vasanta Mogli is a survivor of ‘conversion’ and electroconvulsive therapy, and institutional violence that justified itself through an imposed lens of ‘psychosis’ – “they would never write 'homosexuality' in the file or 'transgenderism' in the file,” she said.

Vyjayanti Vasanta Mogli , Transgender RTI Activist

4.2 The Life-Threatening Risks Of Accessing Lifesaving Healthcare Across India

Social worker and leading activist Sanjana Singh explains that the Gharanas in Bhopal, often have strict rules against going to allopathic health centres, with an emphasis on taking treatment from within the Hijra community and their elders.

Along with the wirdespread disrespect and discrimination, attempting to access a health center comes with the risk of compromising privacy, creating a snowball effect that restricts their income sources, livelihood and other forms of well being.

This healthcare inequity persists in states that are considered relatively ‘progressive’ like Kerala, where the erasure of legitimacy that doesn’t recognize chosen family and friends, exacerbates the risks that come in emergency situations, visual artist Naseema explains.

“Health policies keep being assertive of the binaries. It is also extremely difficult to make the medical system understand queerness because it is not defined in terms of binaries,” Naseema said.

There are numerous gaps and intersectionalities compounding the barriers that prevent gender nonconforming and nonbinary people from accessing care.

“I am from the North Kerala, and I am Muslim, so when I go to a health practitioner who's Muslim, I am faced with different kinds of discrimination: I'm not accepted by men, I can't talk to a man. Even women doctors have a problem with touching or looking at someone who looks like a 'man.' So these intersectionalities of religion and caste also come into play,” Naseema said.

The extent of medical negligence that is reproduced by these binaries, was highlighted when Anannyah Kumari Alex, a trans radio jockey in Kerala, died by suicide – a widely considered euphimism for institutionalized murder.

Naseema, a visual artist from Kerala

Sanjana Singh, social worker and leading activist from Madhya Pradesh

“There is a lack of fact-finding practice, and this has to be addressed in the larger scheme of things when it comes to these kinds of murders,” Naseema said. “We need the concept of psychological autopsy, where we have to look at how important mental health is, and how one comes to a stage where there doesn't seem to be any other possible route.”

Shreya Reddy, Clinical Manager in Mitr Clinic, expresses that stigma and discrimination is a normalized cost of accessing gender-affirming healthcare in a cisgender-heterosexual world.

“We are also human beings and have suffered a lot in healthcare. I'm saying ‘human beings’ because we are often considered to be out of the society –they pretend that we are like aliens,” Reddy said.

Along with the stigma and discrimination that Reddy has faced in every experience of accessing healthcare, there have been added risks of misinformation and disinformation in doctors providing gender-affirming care, exacerbating the distress caused by not being able to trust them.

“Despite our efforts to bring gender and sexuality sensitization to healthcare providers, there is still a huge gap in accessing our care. This is having a negative impact on our mental health, and we aren’t able to access adequate support,” Reddy said.

These risks in accessing lifesaving gender-affirming healthcare are prevalent throughout the country – trans people in Kolkata often face barriers in accessing information about transitioning, putting them at risk of paying excessive money to doctors monetizing on the lack of available information.

“Last year, a trans man paid a huge amount of money in exchange for three major surgeries at a go -- all the surgeries were supposed to be done within three weeks... It was a life and death situation for him because the surgeons could not operate properly,” said Neel, a Trustee member of Sappho for Equality.

On intervention, the state transgender board found that the doctors had no experience in gender-affirming surgeries. Despite Sappho’s efforts in creating guidelines on gender-affirming healthcare, having this care implemented in a process full of uncertainty and delays.

Not all trans people need or get gender-affirming care, and some may not be able to access it because of financial, societal, and other health-related barriers. Trans folks whose identity documents reflect inaccurate names, and who aren’t medically transitioning, continue to find themselves in dysphoria exacerbating health systems.

Neel, a Trustee member of Sappho for Equality

"We live in a cisgender-heteronormative and binary world, where it is very difficult for transgender people to access healthcare systems if they haven't started the process of transitioning. If a trans masculine person who has not started transitioning, and has to be admitted to the hospital, he will be kept in a female ward, which increases the dysphoria more," Neel said.

4.3 Navigating Medical Spaces As A Trans Healthcare Provider: Lab Coats Are Stitched By Transmisogyny

One might think that medical schools spaces with medical professionals would be the safest places for trans people, but that's an oxymoron: in India, non-medical schools are more supportive, according to Bhavya Pahwa, a medical student, comes from a family of professional surgeons who captivated her for one month when she came out to them.

"I was taken to a psychiatrist who was totally transphobic, who asked me to try testosterone and masculine things – going to the gym, riding a motorbike," Pahwa said. "But it's just not my cup of tea, I didn't like it."

In med school, Pahwa had to continue navigating the invasive gaze that attempts to reduce trans people to their anatomy, blurring the textures of personality that form every person's identity.

“Everyone saw me as a male. After the lockdown, people could not recognize me because I was all changed,” Pahwa said. “They didn't even make an effort to understand what was going on. So they started using words, they started making fun of me.”

The experience of living in a boy’s hostel as a person who’s transitioning meant a repeated encounter with the violence of visibility produced in cisgender-heterosexual spaces.

“Your body's visible, your breasts are going to be visible to the men, they’re going to stare at you every time you walk inside the mess for food,” Pahwa said. “You cannot have food because you see all those white teeth in front of you. I lost a lot of weight thanks to them.”

Bullying and shaming is not limited to being practised by students – it’s practised by everyone: residents, teachers, administrative staff – the list goes on. The straightjacket labcoat of med school is stitched by transmisogyny that would sterilise any form of liberation that comes from being oneself.

Bhavya Pahwa on ‘Experiences as a medical student’

Dr. Trinetra Haldar Gummaraju, an intern at Kasturba Medical College, on ‘Experiences as an intern and medical student’

In India, the standards of 'professionality' are determined by oppressor caste, privileged class, and cisgender-heterosexual men, said Dr. Trinetra Haldar Gummaraju, an intern at Kasturba Medical College.

"Medical school is not everything that I imagined it to be, it's a very gendered and binary space, where people in power dictate what is professional and what is not, what is appropriate and what is not," Dr. Gummaraju said.

From being mocked out of wearing a sari to being banned from the anatomy department – Dr. Gummaraju's experiences echo the institutionalised policing in medical school that attempts to steal personhood by reducing people to their anatomy.

"A small attempt of being myself could hinder my access to education," Dr. Gummaraju said. "That's very depressing."

Similar to Dr. Gummaraju, medical practitioner Dr. V.S. Priya from Thissur in Kerala, felt that embracing gender would be synonymous to putting one's career at risk.

"I wanted to continue as a practitioner, I wanted to continue as a doctor. But then I wanted to be myself too. There was a constant struggle happening between these two and finally, I decided to give up my profession for myself, for my gender identity, and I started transitioning after I entered my profession," Dr. Priya said.

To address the lack of understanding around transness, Dr. Priya started the process of 'silent sensitisation' – "from the cleaning staff to the management staff. I started conversing with each and every one of them and started silently sensitising them," she said.

After three years of silent sensitisation, Dr Priya started coming out to her colleagues. There were struggles at first, but it gradually became easier to navigate the workspace: "They couldn't reject me, they accepted me because they knew I am the same old person, the same old doctor," Dr. Priya said.

Dr. V.S. Priya, medical practitioner from Kerala

4.4 De-Centering The Medicalization Of Transness Through Affirming Care

As a survivor of invasive medical procedures, including conversion and aversion therapies, private pilot Adam Harry questions the effectiveness of policies that attempt to protect trans people from medical violence.

"The power held by doctors is always a barrier for us. We know we have a policy, which prohibits discrimination against transgender people, including denial of services in healthcare. Yet, we face violence and discrimination," Harry said.

Harry's transness was seen through the institutionalised gaze of mental illness, which prevented him from getting a clearance medical certificate required by the aviation industry, and grounded him for a year.

"They took me through invasive medical, physical and mental procedures to 'prove' that I'm not mentally ill. After that I decided that I wouldn't give up on my identity. I was ready to get surgery at any cost because I was suffocating for years by wearing these binders," Harry said.

Harry expected that the experience of getting gender-affirming healthcare would be a continued legacy of the invasive procedures he'd been through: "When you are at the operation table, sometimes these people make fun of our bodies," Harry said.

For a change, Harry's experience was comforting – from the reception staff to the anaesthesia specialist, everyone asked for consent: something that is repeatedly taken away from trans folks navigating medical spaces.

Jitender from Nazariya QFRG explains how the rarity of gender-affirming experiences shapes perceptions of expectations and bare minimums: "When queer and trans people go to medical facilities, the bad experiences are endless. You go to any hospital, you will face such bad experiences, that the moment you find a little bit of kindness, you're just like, 'Oh my god, this is the best experience I've ever had,'" they said.

Ragi Gupta from Pixstory reflects on how language shapes the way we perceive each other and ourselves, and how mental health diagnoses have an ongoing history of medicalizing transness, and restricting access to gender-affirming healthcare.

"No matter what mental health diagnosis I got, the core of the whole mental distress was that I was a trans person who was trying to erase themself without knowing who they were," Gupta said.

Narrative therapy offered by a trans-affirmative therapist who centred lived experience over diagnoses, created the space for Gupta to unlearn the practice of viewing their transness from a medicalized lens: “It gave me the tools to understand how my transness is not a mental health diagnosis and the tools for how to live,” they said.

Summary

While this section documents perspectives from transgender people, it reflects concepts of control that are internalized and affect cisgender people too – that the implicit practice objectifying a person has an immediate translation to the standard of care that is provided and gatekept. Rather than attempting to find a band-aid for the multitudes of this dehumanisation, maybe it’s more effective to question how we got here: What role does visibility play in providing care? How much of this imposed visibility, is a reflection of gender-associated roles that have been internalised through the lens of shame in a healthcare provider’s understanding of their own gender? How can we end the consistency of delayed treatment that is rooted in gender essentialist concepts of policing bodies? How have we become the torchbearers of a culture that gives healthcare providers the authority to claim and steal agency based on their patient’s appearance? What does it take to stop viewing the body as a site of controversy, and to centre the concept of non-hierarchical caring – from one human to another?

WAY FORWARD

Despite a history of acceptance of diverse gender identities, India has not still ensured equal and equitable access to healthcare for people who are trans or gender nonbinary. This starts from the very ability to have a legal recognition of one's own name and gender identity. Within healthcare, the change needs to start through health professionals' education. That is, in schools, in undergraduate and postgraduate education.

This booklet focussed on the development of competencies on transgender-affirmative health provision that needs to be included into the undergraduate curriculum. The primary stakeholder to get these competencies implemented under the ambit of the medical undergraduate curriculum is the National Medical Commission. However, a 'whole of Government' approach is needed to bring a paradigm shift towards trans-affirmative policy making including medical education and health. The involvement of the various ministries, specifically MoHFW, and MoE; Vice-chancellors of health universities; Deans of medical colleges; and of various medical associations such as IMA, AHPE, IAPSM, IAP, FOGSI will be critical in implementing these competencies in medical education.

Many government organizations which are already working with the transgender community such as NACO, MoSJE, NHRC, NITI Aayog and non-governmental organizations such as ATHI and others need to be brought on board with a focused approach towards the acceptance and uptake of these comptencies in Medical education. Development Partners like UN Agencies and Bilateral Organisations working in this space can play the role of aggregator by bringing together multiple stakeholders to discuss and develop unified strategies and action plans.

Medical teachers and medical students who identify as transgender are critical stakeholders in taking this work forward. Nonetheless, all those involved in medical education and curriculum planning and implementing such as Medical Education Units, Curriculum committees, Students associations will have to do their bit towards building a trans-affirmative medical education system.Bodies such as NIMHANS, Indian Association of Clinical Psychologists, Indian Psychiatric Society, National Medical Commission need to explicitly describe the standards of care for transgender persons. Beyond key organisations, it is important to include persons with lived experience in decision making with regards to their own community. This is in line with the slogan *'Nothing about us, without us'*.

Beyond the health system and educational system, there is a need for the media to change the way of reporting of trans issues and do it in a trans affirmative manner. For example, many newspapers and news channels continue to refer to transgender people as 'transgenders' which is disrespectful.

Need for advocacy

There is a need for advocacy to include the trans-affirmative competencies in the medical curriculum. Advocacy needs to be carried out for all the key stakeholders as mentioned above, and more, through various methods. Direct communication with the NMC, with the various medical professional bodies should be the key component of this advocacy. Reaching out to other ministries and departments involved in making health systems trans-affirmative would also be needed. Conducting seminars, conferences, CME etc on this topic would also help in sensitising the medical fraternity.. The use of various channels such as print media, social media, electronic media is needed to sensitise the different sections of the society through targeted approach. Transgender issues are cross cutting across sectors and this also influences the dimensions of the medical curriculum. Including trans-community in policy making in various medical education related boards and committees would go a long way in designing and implementing a valid and reliable trans-affirmative curriculum.

Publications in peer reviewed journals, and medical and health conferences will boost the advocacy efforts. Reaching the last mile i.e. medical teachers and students in the medical colleges through campus based programs need to be encouraged in this direction. Sharing of lived experiences by members of the transgender community and the medical teachers, medical students who identify as transgender will help in attitudinal changes in building more inclusive centers of medical education.

Need to go beyond the UG curriculum

Within healthcare there is a need to go beyond prioritising gender affirmative services and treatment for HIV and other sexually transmitted infections for TGNB persons. For example, gynaecogists need to be more aware of the extent of how breast cancer and other related complications can affect anyone's body irrespective of their gender and welcome any one who is female assigned at birth into their clinics and expertise.

There is also a need to teach these competencies to health professionals who have completed their education and are currently practising. For example, there is much need for education of mental health professionals in providing trans-affirmative mental healthcare. The Mental Health Care Act 2017 implies that any mental health professional be it a psychiatrist, psychologist or a social worker cannot 'out' as in inform families of TGNB persons about their sexual orientation or gender identity. It is imperative to hold awareness sessions among mental health professionals about queer affirmative counselling practise indcluding but not limited to pronouns, consent, gender expression, gender identity, knowledge of central and state government level schemes with respect to TGNB persons and understanding and acceptance of the diverse, evolving and fluid trans identities.

There is also a need to implement a comprehensive ban on conversion therapy. NIMHANS is currently working on a manual for queer affirmative mental health in collaboration with UNDP which is a welcome move in this direction.

Need for more research

Gender transition and gender affirmative therapies (GAT) are a crucial healthcare intervention that is important, life changing and life-saving for many TGNB persons. While on one side there is lack of affordable, accessible and affirmative service provision on the other side there is lack of knowledge and understanding of the same within the community which often leads to exaggerated expectations and disappointments. Many TGNB persons opt for gender affirmation surgeries without realising the health complications, costs and the societal factors involved in the same. More TGNB persons are likely to access GAT with the TG plus card being introduced under Ayushman Bharat which provides a cover of upto 5 lakh rupees for GAT. The transition itself can be a huge burden on the mental health of a TGNB person. There needs to be more research on studying the effect of gender affirmation surgery on trans persons and their families.

Trans persons having a non-normative gender expression are more vulnerable to be arrested due to a police person's biases. Hence, prisons become another place for them to be discriminated against and ostracised. There needs to be more research done with respect to making health care in prisons and prison spaces trans affirmative.

More research is needed further in generating evidence about the implementation of these trans-affirmative competencies in the teaching learning program of medical institutions. These competencies require a nuanced approach in its implementation as these incorporate knowledge, skill as well as attitudinal domains. Models of development and implementation of modules to teach specific competencies which are aligned with the NMC recommended competency based curriculum need to be researched upon. The effective methods of teaching and assessing these competencies requires more work. Mixed methods approach including both quantitative and qualitative components as well as interdisciplinary research combining approaches from social sciences and medical humanities is imperative when conducting research in this domain. The next step should also be to develop trans-affirmative competencies for specific medical disciplines, and also for AYUSH, Dental, and Nursing curriculum.

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