

# Lives of Gender Incongruent Community: An Indian Subset Chants “All is Well”

Anirban Majumder, Sudip Chatterjee<sup>1</sup>, Soumyabrata Roy Chaudhuri, Soma Chakraborty<sup>2</sup>

Department of Endocrinology, KPC Medical College and Hospital, Kolkata, India, <sup>1</sup>Park Clinic, Kolkata, India, <sup>2</sup>Diabetes-Obesity-Thyroid and Hormone Clinic, Kolkata, India

## Abstract

**Context:** Gender incongruent individuals are exposed to unique stressors as a result of their minority social position. Poor social support has a further adverse impact on the lives and wellbeing of gender incongruent individuals. There is a paucity of scientific data from India on the socioeconomic status (SES) of gender incongruent community. **Aims:** Aim of the study is to understand and estimate the social support, wellbeing, and SES of gender incongruent individuals in Eastern India. **Subjects and Methods:** Data of 120 gender incongruent patients from the endocrinology outpatient department of a tertiary care hospital in eastern India were collected. We looked at demographic characteristics, social support, underlying psychiatric comorbidities, and SES. SES was calculated by the Kuppuswamy’s socioeconomic status (KSS) scale based on occupation, education, and income. **Statistical Analysis Used:** Microsoft Word and Excel were used to generate tables. **Results:** Most of the gender incongruent individuals were transfeminine. Almost half of them had no history of addiction. Most of them had good support from family and friends and very few (only 3%) had mental health problems. Calculation by KSS scale showed most of the study population lay in the upper middle or lower middle socioeconomic class. **Conclusions:** Strong support from friends and family appears a key factor for protection against psychiatric comorbidities and an all-round impact on the lives and wellbeing of the study population.

**Keywords:** Gender incongruence, hijra, India, Kuppuswamy’s socioeconomic status scale, transgender persons

## INTRODUCTION

Gender incongruent individuals (whose experienced gender does not match their birth-assigned gender) have been the focus of considerable public discourse regarding basic human rights and access to opportunities. However, from an epidemiologic perspective, this transgender (gender incongruent individual who is seeking gender reaffirmation) community is poorly understood. There are at least 4.9 lakhs transgender persons in India as per the last census<sup>[1]</sup> and this appears a grossly underestimated figure. The transgender hijra community is one of the most marginalized communities in the Indian subcontinent.<sup>[2,3]</sup> Being mentioned in many ancient Indian texts, they represent an institutionalized traditional cult and inclusive society.<sup>[4]</sup> They are highly vulnerable to stigma, violence, and discrimination despite their historical acceptance in Indian society.<sup>[4]</sup> Battling stigma and violence (both sexual and physical), they are often left with no livelihood options other than begging or petty extortion or sex work.<sup>[2]</sup> Moreover, transgender people worldwide have poor lifestyle and a poor

quality of life. They are a high-risk group and source population for sexually transmitted diseases and substance abuse.<sup>[5-9]</sup> Research in many geographical settings, including India, has shown an increased risk of poor mental health and suicide among transgender populations.<sup>[6,10,11,3]</sup>

Before independence, the British colonial-era law (377 of the Indian Penal Code, 1860) used to criminalize same-sex behavior. In 2014, the Supreme Court of India upheld the right of all Indian citizens, including the marginalized transgender community, to self-identify their gender and also their right against discrimination based on gender identity, National Legal Services Authority (NALSA) judgment.<sup>[12]</sup> Despite progressive

**Address for correspondence:** Dr. Anirban Majumder, 26A, Gariahat Road South, Kolkata - 700 031, West Bengal, India. E-mail: dranirbanmajumdar@gmail.com

**Submitted:** 13-Aug-2020

**Revised:** 09-Oct-2020

**Accepted:** 10-Dec-2020

**Published:** 12-Jan-2021

### Access this article online

Quick Response Code:



**Website:**  
www.ijem.in

**DOI:**  
10.4103/ijem.IJEM\_501\_20

This is an open access journal, and articles are distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as appropriate credit is given and the new creations are licensed under the identical terms.

**For reprints contact:** WKHLRPMedknow\_reprints@wolterskluwer.com

**How to cite this article:** Majumder A, Chatterjee S, Roy Chaudhuri S, Chakraborty S. Lives of gender incongruent community: An Indian subset chants “all is well”. Indian J Endocr Metab 2020;24:525-31.

legislative developments, mass media often report a wide range of discrimination and inequalities faced by the transgender community of India. There are very few studies that evaluated the socioeconomic status (SES) of the transgender community of India. In this backdrop, this cross-sectional study was done to understand and estimate the social support, well-being, and SES of this population, after seven decades of independence from British colonial rule and five years after passing the NALSA judgment by the Supreme Court of India.

## SUBJECTS AND METHODS

This observational study was carried out on the gender incongruent patients, enrolled at the endocrinology outpatient department (OPD) of a tertiary care hospital in eastern India. The study was approved by the Institutional Ethics Committee, Kolkata.

### Inclusion and exclusion criteria

Patients who were diagnosed with gender incongruence based on Diagnostic and Statistical Manual of Mental Disorders (DSM-V-TR) diagnostic criteria, aged between 18 and 70 years, enrolled between January 2017 and December 2019 and attended endocrinology OPD at least two times during this period.

Patients with missing demographic data and/or socioeconomic data were excluded.

### Data collection

After obtaining written informed consent, the Transgender Health Survey questionnaire<sup>[13]</sup> was handed over and was completed by face-to-face interviews maintaining confidentiality as a standard operating procedure of the endocrinology department. Individual's assigned sex at birth, age, gender identity, sexual orientations, relationship status, and addiction were routinely recorded in Transgender Health Survey. Dressing habits; quality of support from family, friends, or society; occupation of the head of the family; education of the head of the family; and family income were also recorded as per routinely used structured questionnaires of the department. All enrolled patients were routinely advised to attend mental health consultation at baseline for confirmation of the diagnosis of gender incongruence and to exclude other underlying psychiatric comorbidities based on the DSM-V-TR diagnostic criteria. Mental health assessment was routinely done by both a psychiatrist and a psychologist in our institute. All this information was documented in our OPD database both manually and electronically.

### Measures

#### *Transgender health survey questionnaire*

Demographic data (assigned sex at birth, age, gender identity, sexual orientations, and relationship or marital status) were collected from the record of the Transgender Health Survey questionnaire.<sup>[13]</sup> Data about addiction (smoking/tobacco use, alcohol consumption, marijuana use, and intravenous drug use) were also captured from the documentation in Transgender

Health Survey questionnaire. However, the Transgender Health Survey questionnaire was not used in our department for assessment of income as the annual household income categories were based on the US dollar rather than income structure based on Indian currency.

### The mental health consultation document

The following assessments were routinely done for each subject to assess mental health status: projective test (by Thematic Apperception Test), personality test (by Draw-a-Person test and Eysenck Personality Questionnaire), and Bem Sex-Role Inventory test. Data regarding psychiatric comorbidities were captured from the mental health consultation document.

### Structured questionnaire (Annexure 1)

The data regarding dressing habits, social support, occupation of the head of the family, education of the head of the family, and family income were collected from the structured questionnaires administered in our department. Support (both financial or psychological and full or partial) was assessed and captured with the structured questionnaire and entirely depends on the perception of the subject.

### Kuppuswamy's socioeconomic status scale

SES of each patient was calculated based on the Kuppuswamy's socioeconomic status (KSS) scale which takes consideration of the head of the family for calculation.<sup>[14]</sup> The decision-maker in the family was regarded as the head of the family in this study. This scale was extensively used in the Indian urban population, for assessment of the SES by a simple method of scoring.

Scoring for the occupation was independent of the scoring in the education category and was based on the occupation of the head of family only. Occupation levels were categorized as per the KSS scale [Table 1]. Scoring for education also considered the maximum level of education that was attained by the head of the family. Literate and illiterate members were considered as per the definition by Census of India where a person aged  $\geq 7$  years who can read and write with understanding in any language was considered as literate and a person who can only read but could not write or could not read or write with understanding in any language was considered as illiterate. Education levels were categorized as per the KSS scale family income, not per capita income was assessed for categorization of the level of income in the KSS scale. As per KSS scale, the subject himself was considered as head of the family when living away from the family. The income categories used for the scale were determined using the interactive online calculator provided at [www.scaleupdate.weebly.com](http://www.scaleupdate.weebly.com).<sup>[14]</sup> The updated consumer price index value of industrial workers (CPI-IW) was used in the interactive online calculator. For this cross-sectional study where the study population was assessed only once, the latest CPI-IW value available in 2017 before the data collection was used. The final score was calculated adding the score of the individual determinant heads (occupation score, education score, and

**Table 1: Demographic characteristics for total sample (n=120)**

Demographic and identity characteristics	Total sample (n=120)	
	Individuals assigned male sex at birth (n=109)	Individuals assigned female sex at birth (n=11)
Age (year)	25±5.42	24.7±4.63
Gender identity		
Transfeminine	109 (100%)	0
Bigender	0	0
Transmasculine	0	11 (100%)
Male cross-dresser	0	0
Dressings		
Average age of change in dress	15.7	11.4
Unisex dressing	53 (48.62%)	0
Full-time cross-dressing	19 (17.43%)	11 (100%)
Part-time cross-dressing	28 (25.60%)	0
No change in dressing	9 (8.25%)	0
Sexual orientation		
Attracted to males	100 (91.74%)	0
Attracted to females	3 (2.7%)	11 (100%)
Bisexual	2 (1.83%)	0
Asexual	0	0
Don't know	4 (3.66%)	0
Marital status		
Single and no relation	26 (23.85%)	1 (9.09%)
Single and in relation	48 (44.03%)	9 (81.81%)
Single and in multi-relation	33 (30.27%)	1 (9.09%)
Married	2 (1.83%)	0
Married but separated	0	0
Divorced	0	0
Addiction		
No addiction	61 (55.04%)	4 (36.36%)
Presence of addiction	48 (44.9%)	7 (63.63%)
1. Smoking and alcohol	23 (21.10%)	4 (36.36%)
2. Only smoking	11 (10.09%)	2 (18.18%)
3. Only alcohol	14 (12.84%)	1 (9.09%)
4. Marijuana	0	0
5. Intravenous drug	0	0

family income score) of the individual and socioeconomic class was categorized as per the KSS scale.

## RESULTS

We provided data on demography [Table 1], social support [Table 2], mental health status [Table 3], and Kuppaswamy score [Table 4].

### Demography

The demographic characteristics of the study population (N = 120) were reported by the sex assigned at birth [Table 1]. Based on reported gender identity, the study population was categorized into (1) transfeminine (who were assigned male sex at birth but have a strong female gender identity), (2) transmasculine (who were assigned female sex at birth but have a strong male gender identity), (3) bigender (who report that their gender identity is equally male and female), and (4) male cross-dresser (who were assigned male sex at birth, have a male gender identity, and cross-dress in public or in private).

One hundred and nine participants were transfeminine and only eleven were transmasculine. There were no subjects who were bigender or did cross-dressing.

### Social support

Based on the reported social support, the study population was evaluated regarding support from family, support from friends, and support from society and also the level of support (no support, or full support or partial support) [Table 2]. The study population reported receiving more support from their transgender or nontransgender friends and families than from society.

### Mental health

Most of the study population (almost two-third) had completed the mental health evaluation and the counseling process and were evaluated for psychiatric comorbidities [Table 3]. Rest one-third were yet to complete the mental health evaluation and the counseling process. However, all other evaluation processes

**Table 2: Mental health characteristics for total sample (n=120)**

Mental health parameters (total sample n=120)	Individuals assigned male sex at birth (n=109)	Individuals assigned female sex at birth (n=11)
Psychiatry consultation advised	109 (100%)	11 (100%)
In patient hospitalization for psychological reasons in past	0	0
Professional therapy for psychiatry comorbidities (anxiety/depression)	3 (2.7%)	0
Gender counseling done and cleared for cross sex hormone therapy	73 (66.97%)	7 (63.63%)
Gender counseling done but yet to clear for cross sex hormone therapy	36 (33.03%)	4 (36.37%)

**Table 3: Social support**

Demographic and identity characteristics	Total sample (n=120)	
	Individuals assigned male sex at birth (n=109)	Individuals assigned female sex at birth (n=11)
Support		
Family-not supported	18 (16.51%)	1 (9.09%)
Family-full supported	74 (67.88%)	10 (90.90%)
Family partial supported	17 (15.59%)	0
Friend-not supported	15 (13.76%)	0
Friend-full supported	88 (80.73%)	11 (100%)
Friend partial supported	6 (5.50%)	0
Society-not supported	45 (41.28%)	3 (27.27%)
Society-full supported	48 (44.03%)	8 (72.72%)
Society-partial supported	16 (14.67%)	0

were completed to include them in this study. The mental health of the study population was very satisfactory with only 3 out of 80 study population having psychiatric comorbidities in the form of depression/anxiety. However, we are unaware about psychiatric comorbidities among the one-third who were yet to complete the mental health evaluation process.

### KSS scale

KSS scale [Table 4] assessed the socioeconomic standing and the characteristics of the study population. Most of the population belonged to the upper middle or lower middle class SES according to the modified Kuppaswamy classification system.

## DISCUSSION

This study represents a comprehensive analysis of the lives and well-being of self-identified gender incongruent adults in India. The number of transfeminine individuals was 10 times more (109 vs. 11) than transmasculine, a fact observed in our earlier studies as well.<sup>[15-17]</sup> In most of the Western studies, the prevalence of transfeminine and transmasculine individuals are balanced.<sup>[13]</sup> Transmasculine individuals are largely invisible in India. It is difficult to explain such a huge imbalance between the two groups. However, gender practice in Indian culture, absence of transman as a role model, and the patriarchal nature of society are few possible barriers that transmasculine individuals have to cross before reaching a tertiary care center for gender-affirming therapy. Moreover, caste, language, class, education, family, and religious issues may inhibit display of gender identity of transmales. High rates of substance

abuse have been consistently demonstrated among gender incongruent individuals.<sup>[18]</sup> Gender-based harassment at school possibly influences substance use behavior patterns.<sup>[8]</sup> While alcohol, tobacco, cigarette smoking, and electronic cigarette use (vaping) are common, marijuana and non-marijuana illicit drugs are also documented in Western countries.<sup>[18]</sup> Prevalence of addiction among the study cohort (44.9% of transfeminine and 63.63% of transmasculine) was restricted to smoking and alcohol only [Table 1].

Gender incongruent populations are exposed to a variety of social stressors, including stigma, discrimination, and bias and are at a greater risk of depression, anxiety, suicide, substance abuse disorders, and general distress.<sup>[19]</sup> Social support, as a coping resource, has been shown to reduce psychological distress from gender identity-related stigma, discrimination, and violence.<sup>[11]</sup> Most of our study population (67.88% transfeminine and 90.90% transmasculine) acknowledged receiving adequate support from their biological family and even more from their friends (80.73% transfeminine and 100% transmasculine) [Table 3]. These findings are important, as they demonstrate the unique role of social support in reducing the social stressors contributing toward psychosocial ill health. Many studies have demonstrated that social support plays an important role in reducing depression, anxiety, and general distress associated with gender identity-related stigma and discrimination and suicidal ideation.<sup>[20]</sup> In our previous 2015 study, 9.26% of transfeminine and 16.63% of transmasculine persons had support from their family.<sup>[15]</sup> The present cohort received much more full family support (67.88% for transfeminine and 100% for transmasculine). However, 20%

**Table 4: Kuppuswammy socioeconomic status score for total sample (n=120)**

Parameters	Socioeconomic status	
	Individuals assigned male sex at birth	Individuals assigned female sex at birth
Occupation category (head of the family)		
Professional	3 (2.75%)	0
Semi-professional	5 (4.58%)	0
Arithmetic skill jobs	23 (21.10%)	6 (54.54%)
Skilled worker	9 (8.25%)	2 (18.18%)
Semi-skilled worker	65 (59.63%)	3 (27.27%)
Unskilled worker	4 (3.66%)	0
Unemployed	0	0
Education category (head of the family)		
Postgraduate/professional degree	19 (17.43%)	1 (9.09%)
Graduate degree	27 (24.77%)	4 (36.36%)
Higher secondary certificate	27 (24.77%)	0
High school certificate	14 (12.84%)	3 (27.27%)
Middle school certificate	8 (7.33%)	2 (18.18%)
Literate	14 (12.84%)	1 (9.09%)
Illiterate	0	0
Family income		
47,657 and above	17 (15.59%)	2 (18.18%)
23,829-47,656	19 (17.43%)	3 (27.27%)
17,871-23,828	21 (19.26%)	2 (18.18%)
11,914-17,870	17 (15.59%)	4 (36.36%)
7148-11,913	25 (22.93%)	0
2407-7147	10 (9.17%)	0
2406 and below	0	0
Score		
26-29 Upper	4 (3.66%)	0
16-25 Upper middle	33 (30.27%)	5 (45.45%)
11-15 Lower middle	45 (41.28%)	5 (45.45%)
5-10 Upper lower	27 (24.77%)	1 (9.09%)
<5 Lower	0	0

of 2015 study cohort were included in the present study cohort also.

A high prevalence of depression and suicidal ideation is reported in Western studies.<sup>[11]</sup> Though the mental health evaluation report was wanting from one-third of the study population, only 2.7% of the transfeminine subjects seen by a psychiatrist had psychiatric comorbidities. In 66.97% of transfeminine and 63.63% of transmasculine subjects, no mental problem was identified with the mental health questionnaire and evaluation [Table 2]. Indian culture has a general attitude of acceptance and tolerance toward the transgender community.<sup>[4]</sup> Rising social awareness has improved matters further. Psychiatric comorbidities were looked for using the psychiatric record review and not by a unified screening questionnaire. This constitutes a limitation of our study perhaps contributing to the low rate of identified psychiatric comorbidities. Moreover, we are unaware about psychiatric comorbidities among the one-third who were yet to complete the mental health evaluation process and further contribute to the low rate of identified psychiatric comorbidities.

Most of the transgender studies reported poor well-being, self-reported disability, poor general health, and lower quality of life.<sup>[6]</sup> The exposure to physical and sexual violence was repeatedly reported among transgender persons.<sup>[11]</sup> Violence seems to have long-lasting detrimental effects on mental health, substance abuse, and depression, leading to a high prevalence rate of suicidal ideation and attempts. Thus, gender incongruent people constitute a vulnerable group and need to be targeted for multifaceted interventions.<sup>[21]</sup> Assessment of the SES is widely recognized as one of the important tools for health evaluation. To classify the communities and people, varied socioeconomic scales are used in India.<sup>[22]</sup> SES should be a measure of the economic and social position of an individual in the wider community. Usually, profession, education, and income are taken into consideration to determine SES. KSS scale is the most extensively used scale in India.<sup>[22]</sup> Most of the study population belong to the lower middle (41.28% transfeminine and 45.45% transmasculine) and upper middle (30.27% transfeminine and 45.45% transmasculine) SES [Table 4]. A population-based door-to-door survey in four geographically adjacent semi-urban slums in South India (covering 2.2 sq. km

and 7925 households) showed that the majority (72.7%) are in the upper-lower socioeconomic stratum.<sup>[23]</sup> Transgender persons appear to have higher SES [Table 4]. Our observation of optimum SES among the transgender population is not consistent with the previous studies done in different parts of the world. Our cohort lived primarily in urban areas, had better education, and showed enterprise in attending a tertiary care hospital for gender-affirming therapy. This cohort had strong social support, from family and friends, and may not be representative of the larger transgender community in India. Cohorts similar to ours were reported by some other Indian studies.<sup>[24,9]</sup>

There are several studies from the Indian subcontinent, attesting to the discriminatory and exclusionary environments in which transgender people continue to live.<sup>[2,12,7,5,3]</sup> The recent international commitment toward sustainable development goals presents an opportunity to enhance social and medical targets,<sup>[25]</sup> prevent human rights violations, and promote social inclusion for the gender incongruent community.

## CONCLUSIONS

Indian culture tolerates and even embraces contradictions at social, cultural, and sexual levels. The gender incongruent community of India receives adequate support from their biological family members and their friends. This support provides many gender incongruent individuals improved for self-esteem, gender recognition, and self-realization.

## Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

## Financial support and sponsorship

Nil.

## Conflicts of interest

There are no conflicts of interest.

## REFERENCES

1. Census Department, Government of India. Census India 2019. Available from: <http://census2019.co.in/transgender.php>. [Last accessed 2020 Apr 22].
2. Khan SI, Hussain MI, Parveen S, Bhuiyan MI, Gourab G, Sarker GF, *et al.* Living on the extreme margin: Social exclusion of the transgender population (Hijra) in Bangladesh. *J Health Popul Nutr* 2009;27:441-51.
3. Thompson LH, Dutta S, Bhattacharjee P, Leung S, Bhowmik A, Prakash R, *et al.* Violence and mental health among gender-diverse individuals enrolled in a human immunodeficiency virus program in Karnataka, South India. *Transgend Health* 2019;4:316-25.
4. Nanda S. The hijras of India: Cultural and individual dimensions of an institutionalized third gender role. *J Homosex* 1985;11:35-54.
5. Regmi PR, van Teijlingen E. Importance of health and social care research into gender and sexual minority populations in Nepal. *Asia Pac J Public Health* 2015;27:806-8.
6. Nobili A, Glazebrook C, Arcelus J. Quality of life of treatment-seeking transgender adults: A systematic review and meta-analysis. *Rev Endocr Metab Disord* 2018;19:199-220.
7. Hernandez AL, Lindan CP, Mathur M, Ekstrand M, Madhivanan P, Stein ES, *et al.* Sexual behavior among men who have sex with women, men, and Hijras in Mumbai, India--Multiple sexual risks. *AIDS Behav* 2006;10(4 Suppl):S5-16.
8. Coulter RWS, Bersamin M, Russell ST, Mair C. The effects of gender- and sexuality-based harassment on lesbian, gay, bisexual, and transgender substance use disparities. *J Adolesc Health* 2018;62:688-700.
9. Chakrapani V, Newman PA, Shunmugam M, Dubrow R. Barriers to free antiretroviral treatment access among kothi-identified men who have sex with men and aravanis (transgender women) in Chennai, India. *AIDS Care* 2011;23:1687-94.
10. Maguen S, Shepherd JC. Suicide risk among transgender individuals. *Psychol Sex* 2010;1:34-43.
11. Nemoto T, Bödeker B, Iwamoto M. Social support, exposure to violence and transphobia, and correlates of depression among male-to-female transgender women with a history of sex work. *Am J Public Health* 2011;101:1980-8.
12. Bhattacharya S. The Transgender Nation and its Margins: The Many Lives of the Law. *South Asia Multidisciplinary Academic Journal* 2019. Available from: <http://journals.openedition.org/samaj/4930>. [Last accessed on 2019 May 04]. DOI: 10.4000/samaj.4930.
13. Colorado Transgender Health Survey 2014. Available from: <http://www.one-colorado.org>. [Last accessed on 2019 May 04].
14. Sharma R. Revised Kuppaswamy's socioeconomic status scale: Explained and updated. *Indian Pediatr* 2017;S097475591600090. Online ahead of print.
15. Sanyal D, Majumder A. Presentation of gender dysphoria: A perspective from Eastern India. *Indian J Endocrinol Metab* 2016;20:129-33.
16. Majumder A, Sanyal D. Outcome and preferences in male-to-female subjects with gender dysphoria: Experience from Eastern India. *Indian J Endocrinol Metab* 2017;21:21-25.
17. Majumder A, Sanyal D. Outcome and preferences in female-to-male subjects with gender dysphoria: Experience from Eastern India. *Indian J Endocrinol Metab* 2016;20:308-11.
18. Watson RJ, Veale JF, Gordon AR, Clark BA, Saewyc EM. Risk and protective factors for transgender youths' substance use. *Prev Med Rep* 2019;15:100905.
19. Valentine SE, Shepherd JC. A systematic review of social stress and mental health among transgender and gender non-conforming people in the United States. *Clin Psychol Rev* 2018;66:24-38.
20. Bariola E, Lyons A, Leonard W, Pitts M, Badcock P, Couch M. Demographic and psychosocial factors associated with psychological distress and resilience among transgender individuals. *Am J Public Health* 2015;105:2108-16.
21. Zeluf G, Dhejne C, Orre C, Nilunger Mannheimer L, Deogan C, Höjjer J, *et al.* Health, disability and quality of life among trans people in Sweden-a web-based survey. *BMC Public Health* 2016;16:903.
22. Wani RT. Socioeconomic status scales-modified Kuppaswamy and Udai Pareekh's scale updated for 2019. *J Family Med Prim Care* 2019;8:1846-9.
23. Kattula D, Venugopal S, Velusamy V, Sarkar R, Jiang V, S MG, *et al.* Measuring poverty in Southern India: A comparison of socio-economic scales evaluated against childhood stunting. *PLoS One* 2016;11:e0160706.
24. Tamilselvan BP, Mehta N, Shanmugam S, Subramanian K. A study of behavioral and disease patterns among transgenders in a tertiary care center. *Indian J Sex Transm Dis AIDS* 2018;39:18-22.
25. Transforming our world: The 2030 Agenda for Sustainable Development: Sustainable Development Knowledge Platform [Internet] [Last cited on 2015 Oct 13]. Available from: <https://sustainabledevelopment.un.org/post2015/transformingourworld>.

Annexure 1

**Annexure I - Questionnaire for Gender Incongruent Adults**

Thank you for taking the time to fill this questionnaire. Please return the questionnaire after completing all information. The information may be used in full or in part in scientific publications. Your answers will be treated with complete confidentiality. If you have any questions about this questionnaire, please contact Dr. Anshu Majumder (9830078837).

**Section I: Gender expression / Dressing habit**

- In what age did you change your dress (cross dressing)?
  - Month ..... Year .....
  - Age .....
- In terms of cross-dressing, how long would you be dressed like opposite sex personally and socially?
  - No change in dressing
  - Full time (24 hrs in a day)
  - Part time (any day upto 9 hrs in a 12 hours shift)
  - Other (please specify) .....
- Are you a male cross dresser? (Those who were assigned a male sex at birth, have a male gender identity, and cross-dressing in public or private part-time)
  - Yes/ No
- Are you a transsex-dresser?
  - Yes/ No
  - Full time (24 hrs in a day)
  - Part time (any day upto 9 hrs in a 12 hours shift)
  - Other (please specify) .....

**Section II: Support from family / friend and society**

- Did you get family support for changing your sex?
  - Yes/ No
  - If yes, please specify the age ..... yrs
  - Full support at the age of ..... yrs
  - Partial support at the age of ..... yrs
- Did you get friend support for changing your sex?
  - Yes/ No
  - If yes, please specify the age ..... yrs
  - Full support at the age of ..... yrs
  - Partial support at the age of ..... yrs
- Did you get social support for changing your sex?
  - Yes/ No
  - If yes, please specify the age ..... yrs
  - Full support at the age of ..... yrs
  - Partial support at the age of ..... yrs

**Section III: Education/Occupation/ Income (head of the family):**

Reference: Rahul Sharma Revised Kuppavaram's Socioeconomic Status Scale: Explained and Updated *Indian Pediatrics*:2017; 54:867-70

- Whom did you consider as the head of the family of your family? .....

**Education**  
What is the highest degree or level of school your head of the family has completed?

- PG/Professional
- Graduate
- HS
- Madhyamik
- Class 8 (Middle school certificate)
- Literate (less than Middle school certificate)
- Illiterate

**Occupation**  
What is the occupation of the head of the family? (In case the Head of family is currently retired, credit will be given while scoring for his/her last job held)

- Professional (Decision making, formulating policies and execution of policies, creative work: doctors, advocates, engineers, architects, directors, managers, senior administrators, readers and professors, newspaper editors, college principals, architecn, bank managers)
- Semi-Professional (post-high school education but routine nature of job: high school teachers, college lecturers, junior administrators, junior medical practitioners)
- Arithmetic skill jobs (Jobs that require some training in arithmetic and reading, writing, clerk, accountant, typist, elementary school teacher, farm owner, shopkeeper, salesman, insurance agent, news journalist)
- Skilled worker (Long training in complicated work: driver, telephone operator, mason, carpenter & mechanic)
- Semi-skilled worker (Jobs that requiresome training: factory labourer, car cleaner, petty shopkeeper)
- Unskilled worker (No education or training required: domestic servant, peon & watchman)
- Unemployed (irrespective of education level: self explanatory)

**Income**  
(The income categories were as determined using the interactive online calculator provided at [www.scalesonline.in/](http://www.scalesonline.in/))  
Please mark your total monthly income from all sources:

- 47857 and above
- 23329-47856
- 11914-23328
- 7148-11913
- 2407-7147
- 2406 and below