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# Three Cases of Castration in Hijra Transgender Community

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## Abstract

We reported three cases of transgender hijra who underwent castration by quacks. Three transwomen of the hijra community, who underwent castration by quacks presented at the endocrinology with biochemical features of primary gonadal failure with a high level of pituitary gonadotropic hormones. Many transwomen of the hijra community in India, undergo traditional but unscientific castration by medically unqualified personnel highlighting the need for widespread competent gender transition services in public hospitals.

**Keywords: Transgender person; Transsexualism; Pituitary gland; Gonadotrophs; India**

## Glossary

### Cisgender

Denoting to a person whose sense of personal gender identity corresponds with their assigned birth sex.

### Gender identity

Internal sense of being male or female or identifying with both or neither.

### Intersex or DSD (a disorder of sexual differentiation)

Denoting to a person born with reproductive or sexual anatomy that does not fit typical definitions of female or male

**Transmasculine:** denoting to a transgender person who was assigned female at birth, but identifies with masculinity to a greater extent than with feminity.

**Transgender:** denoting to a person whose sense of personal gender identity does not correspond with the assigned birth sex

### Transwoman or transfeminine

Denoting to a transgender person who was assigned male at birth, but identifies with femininity to a greater extent than with masculinity.

## Introduction

Hijra [the term is used both in singular and plural sense], the institutionalized third gender community of the Indian subcontinent exists as long as civilization has [1]. With a recorded history of over 4,000 years, the hijra community is a testament to the sexual diversity that is integral and recognized in Indian culture [1]. Recently, Indian law recognized transgender people, including hijra, as third gender (in 2014), and more importantly, recognized same-sex sexual relations in 2018, a longstanding demand of the larger LGBT community.

Although the hijra community is diverse and consists of people of intersex, impotent, homosexuals and, transvestites, etc. however many of them are androphilic (sexually attracted to adult men) transgender people and often do castration [2]. In India, transgender previously had two choices; either they had to ignore their identity, had to get married woman and live in repression, or they had to join the hijra community and undergo castration to live their life as a transfeminine woman [3]. They often joined the hijra group after being forced and evicted by the family. Hijra group is the traditional transwomen support group for thousands of years in the Indian subcontinent, recently popularized LGBT support group of the Western world in the last few decades. As most transgender in India are runaways or evicted by their families, they find solace within a community of like-minded souls and find some way, though unscientific to transform physically. Here, we are

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**Figure 1:** Case report 1.

discussing three cases of transwomen, two voluntarily and one who involuntarily underwent castration in the hijra community. These three hijras came to the endocrine department for further treatment to transform physically and are a part of the cohort we are working on [4].

## Case Series

### Case 1

Thirty-two-year-old transwoman ran away from her family at 16 years of age and joined a hijra community. She underwent castration 14 years ago by a quack in a hijra community quarter. On the night before the procedure, her penis had wrapped with a very tight cord, and testes completely pressed the urethra leading to significant discomfort and pain. In the early morning, she had given a drink to reduce the pain. A village quack emasculated her by a knife swiftly without any local or general anesthesia. As the blood and urine came gushing out, she had told in her semiconscious state of mind that the male essence was leaving her body. She regained consciousness after several hours only to find severe pain in her private parts. She could not work for two months. Post-procedure she irregularly received oral contraceptive pills leading to some breast development.

She was 163 cm tall, 54 kg in body weight with brownish-black colored 32 cm long scalp hair. She looked like a complete woman in a sari with facial makeup and female mannerism. She had enlarged but small breasts with a brownish-black areola of 2.5 cm in diameter and a prominent nipple. She had no hair on her face, chest, and abdomen, and a cleanly shaved axilla. Local genital showed black-colored coarse, curly hair in the pubic region in the shape of an inverted triangle. She had no external genitalia but an irregular, non-tender sagittal long scar of 8 cm (Figure 1) with a small urethral opening in the middle of the scar mark.

### Case 2

A twenty-four-year-old transwoman underwent castration six years ago and had never received any hormonal therapy. She was born as a male child in a low middle-class family of eastern India, bewildered about her sexuality, and joined the hijra community at age sixteen. She was kept confined in a lonely house and supposedly given intoxicants that resulted in unconsciousness, only to find her castrated after regaining consciousness.

She was 160 cm tall, 64 kg weight, and wearing unisexual attire in the form of trousers and a T-shirt. She had 10 cm long scalp hairs with close-shaven beards, and mustaches were 1 mm overgrown. There was a male distribution of hair on the chest and abdomen with evidence of regular shaving. The breasts were male type without any enlargement. Local genital examination showed black-colored coarse hair in the pubic region in the shape of an inverted triangle. She had no external genitalia but an irregular, pale, non-tender sagittal 5 cm

**Figure 2:** Case report 2.

long scar in the genital part (Figure 2). A circular-shaped urethral opening was present in the pubic region, 2.5 cm below the pubic symphysis. Some loose scrotal skin was visible at the lower end of the genital scar.

### Case 3

A twenty-six year- old hijra transwoman was in the business of dancing and prostitution to earn her livelihood. The woman was invited to dance in a small town in North India along with her hijra group. The group took her to an undisclosed temple and offered a drink leads to loss of consciousness. A strong nylon thread was tied around her scrotum and penis. She had severe pain in her private parts and remained drowsy under the influence of intoxicants. Scrotum and penis sloughed off over five days, and the wound took two weeks to heal with regular traditional wound care materials, details of which were not available to her. Despite the procedure, it was impossible to do sexual intercourse, and she had taken for castration without any significant improvement at the esthetical and functional level. About six months back, she did silicon breast implantation in a health care clinic under proper anesthesia and medical supervision.

She was 168 cm tall, 65 kg in body weight with brownish-black colored 32 cm long scalp hair with a ponytail. She was wearing female attire and had bilateral breast implantation with small scar marks underneath the breasts. She had no facial hair, minimal body hair, and a cleanly shaved axilla. Local genital examination showed shaved hair in the pubic region with 1 mm hair overgrowth. She had no external genitalia, and multiple scar marks with one prominent, non-tender and pale 6 cm long sagittal scar was present in the genital region (Figure 3). Her urethral opening was depressed, and at the center was detected along the scar mark.

The hormonal profiles were consistent with male primary gonadal failure in all three cases and not consistent with the female reference

**Figure 3:** Case report 3.

**Table 1:** Hormonal Profile (Case 1, Case 2, Case 3).

| Investigations | Case 1 Value | Case 2 Value | Case 3 Value | Reference range in Female | Reference range in male |
|---|---|---|---|---|---|
| **Testosterone** | 22 | 28 | 34 | 20 to 80 ng/dl | 290 to 1300 ng/dl |
| **Estradiol** | 43.2 | 7.2 | 14.2 | 19 to 160 pg/ml (Follicular phase) | 14 to 55 pg/ml |
| **FSH** | 32.3 | 42.3 | 38.6 | 1 to 11 IU/l (adult premenopausal) | 1 to 8 IU/L |
| **LH** | 26.8 | 34.2 | 28.7 | 3 to 20 IU/l (adult premenopausal) | 1.24 to 7.8 IU/L |

range. Estradiol level was elevated in case-1 possibly due to irregular administration of contraceptive pills (Table 1).

Gender incongruence was diagnosed according to Diagnostic and Statistical Manual (DSM-V) criteria and there was no evidence of body delusion, homosexuality, or transvestism in all three cases.

## Discussion

There are protocols for the physical transformation in the hijra community. The process and the customs are shrouded in mystery within the community and little information is available in the literature. The initiates cannot cut their hair or shave their face and traditional "pluckers" from the community pluck all the hair on the faces of the initiates in a physically traumatic process. This is sometimes but not always followed by irregular oral contraceptive pill administration and is often followed by castration [5]. The practice of castration has its roots before recorded human history and there are several procedures by which the hijra undergo castration and penectomy. We are aware of the two practices described by our patients. Emasculation with a sharp knife under influence of intoxicants or pain killers by a local quack is the most commonly practiced procedure as done in two of our patients. The third patient had a different experience. Sloughing off the scrotum and penis over few days by tying a thin but strong nylon thread around the base of the penis and scrotum was employed in the third patient and is another commonly practiced method in India. Nowadays, the procedure is also done by semi-qualified doctors under proper anesthesia in private health set-ups. There could be more methods practiced elsewhere in India. The exact prevalence or incidence of urethral stenosis or other urological problems or death related to castration and penectomy among hijra in India is not available in the literature [6]. None of the three cases reported any urological problems. Voluntary castration among men of the western world, often not performed by medical professionals, is associated with loss of libido, hot flashes, and insignificant reduction in depression [7]. No such data from India is available at present.

Extreme castration ideations are not only found among Male-to-Female (MtF) transgenders with dysphoria but also among male-to-eunuch with gender dysphoria and among body identity integrity disorder [8]. Though all three cases discussed above were suffering from gender incongruence and dysphoria (transgender women), physicians need to be aware of males who have strong desires for emasculation without a traditional transgender identity. Moreover, progressive decrease in bone mineral density, failure of closure of the epiphyses, reactive pituitary hyperplasia, shrinkage of the prostate, and development of gynecomastia is the long-term consequences of castration in men [9]. However, no valid data is indicating that castration has any effect on the life span of men.

Health care is not easily accessible to the hijra community of India because of the inadequate availability of specialized endocrinologists experienced in transgender care as well as transgender transition-experienced surgeons. Not only in the Indian subcontinent services of transgender care providers is not widely available even in high-income countries [10]. The problem is further compounded by poor awareness and understanding among hijra, general mass and health care professionals in India. Hence, many hijra presents to the endocrinologist with prior complete or incomplete removal of genital organs by crude surgery in the hand of the medically unqualified persons [4,11,12]. Moreover, delayed endocrine treatment may have significant long-term health consequences involving cardiovascular and bone health. Additionally, the use of inappropriate self-medications as well as alternative medicine may lead to significant health risks as well. In a misguided attempt to achieve feminine features, many hijras irregularly consume synthetic estrogens in the form of oral contraceptives, without any monitoring, which can lead to a high chance of venous thromboembolism.

## Conclusion

The transgender community is accepted by Indian society nowadays. However, the hijra, a part of the historical transgender community of India, is still socially excluded. Extreme social exclusion diminishes their possibility to turn to modern medicine for gender affirmative care. With limited resources, most hijra turns to quacks for the so-called gender reassignment are legally ambiguous and performed in miserable conditions by ill-trained persons without any physical and psychological care. They have endocrine dysfunction; however, evaluation, assessment, and improvement of endocrine health of the hijra community remain a distant dream. The cases highlight the need to provide affordable and culturally competent gender transition services in public hospitals in India.

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