

# Mental Health Professionals Condemn the Transgender Persons (Protection of Rights) Amendment Bill, 2026

*The Bill Does Not Protect — It Erases. And It Will Cost Lives.*

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We are mental health professionals, researchers, and some of us are members of the transgender community in India. The voices of transgender mental health professionals are not peripheral to this statement — they are central to it. We speak from clinical training and from lived experience of what this Bill means for the people it claims to protect. We are releasing this statement in opposition to the Transgender Persons (Protection of Rights) Amendment Bill, 2026, introduced in the Lok Sabha on 13 March 2026.

We oppose it as clinicians, on the basis of evidence, law, professional ethics, and people with lived experience.

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## 1.

### **This Bill Reverses a Binding Supreme Court Judgment**

#### **WHAT THE BILL DOES**

The 2026 Amendment Bill deletes Section 4(2) of the Transgender Persons Act — the statutory provision that gave the constitutional right to self-identification its legal expression. Critically, the Bill does not merely remove self-identification as a mechanism: it actively excludes "self-perceived" identity as a valid basis for legal recognition, treating subjective gender experience as legally insufficient on its face. It reinstates mandatory medical board oversight and District Magistrate approval before any identity certificate can be issued. It removes the proviso in Section 7(3) that protected a trans person's rights and entitlements even after a change of gender marker — meaning a trans man or trans woman who has updated their documents now has no legal category that protects them. They are no longer legally transgender. They are not legally male or female in the full protected sense either. They cease to exist in law.

This is not administrative clarification. It is the statutory reversal of a binding Supreme Court ruling — and a cascade of legal invisibility that will affect every institution a trans person encounters across their lifetime: hospitals, employers, landlords, courts, and police stations.

The Statement of Objects and Reasons also frames gender identity as an "acquirable characteristic" — a term with significant ideological and clinical implications. This framing treats identity as something externally adopted rather than internally experienced, directly contradicting the clinical literature on gender development and the psychological frameworks that inform every professional body's approach to gender-affirming care. It is not a neutral administrative term. It is a premise about the nature of identity that the evidence does not support.

The delegation of identity gatekeeping to District Magistrates and medical boards does not neutralise discrimination — it institutionalises it. India's experience with the existing certification process under the 2019 Act has already demonstrated what happens when identity recognition is filtered through officials exercising individual discretion: criteria are applied inconsistently, personal prejudice shapes outcomes, and the communities most in need of protection bear the greatest cost. These are not hypothetical risks. They are documented patterns from the decade since NALSA, visible in the testimonies of trans persons, in the work of civil society organisations, and in our own clinical rooms. This Bill does not

reform that system. It expands its gatekeeping mandate, deepens its reach, and removes the constitutional floor of self-determination that constrained it.

### **WHAT IT VIOLATES**

In *National Legal Services Authority v. Union of India* (2014), the Supreme Court held that self-determination of gender identity is a fundamental right under Article 21 of the Constitution, and that no medical procedure can be required as a condition of gender recognition. In *Justice K.S. Puttaswamy v. Union of India* (2017), a nine-judge constitutional bench further held that sexual orientation and gender identity are inseparable from personal identity and are protected under the right to privacy. The 2026 Amendment Bill violates both of these binding constitutional holdings simultaneously.

By removing self-identification and reinstating medical gatekeeping, the Bill infringes upon fundamental constitutional guarantees of freedom, equality, dignity, and equal access to public services protected under Articles 14, 19, and 21.

The Yogyakarta Principles — the foundational international framework on the application of human rights law to sexual orientation and gender identity, updated in 2017 and explicitly cited in the NALSA judgment — affirm that every person has the right to legal recognition of their self-defined gender identity without medical preconditions. This Bill retreats from that framework.

The historical stakes of this reversal cannot be overstated. India's binary categorisation of gender was imposed through colonial administration and weaponised against gender diverse communities through the Criminal Tribes Act of 1871, which criminalised the Hijra and Kinnar communities by treating gender non-conformity itself as a marker of criminality. Independent India inherited that architecture. The work of the decade since the NALSA 2014 judgment has been to dismantle it. This Bill undoes that work. It does not introduce something new. It reinstates something old.

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## **2.**

### **This Bill Criminalises Clinical Care**

#### **WHAT THE BILL DOES**

The amended Section 7(1A) requires hospitals to report details of every gender-affirming surgery to the District Magistrate and a medical board — without the patient's consent, without clinical justification, and without any restriction on how that information is subsequently used. This is mandatory state reporting of a specific surgical category — gender-affirming procedures — that has no equivalent in Indian healthcare law. No other surgical procedure performed in India, including irreversible elective procedures, carries this mandatory state reporting requirement. This disparity is not incidental. It reflects a legislative decision to place the bodies and medical histories of transgender persons under a surveillance architecture that no other patient population in this country faces.

This Bill does not arrive in isolation. It arrives in a healthcare system that already treats transgender persons as suspect bodies. Since 2017, the National Blood Transfusion Council has permanently banned transgender persons from donating blood — a policy with no scientific basis. This Bill extends that logic: it builds a state-controlled surveillance mechanism specifically around transgender healthcare that no other patient group in India faces.

The consequence in the therapy room is predictable and documented: clients will hide their gender history from their doctors. They will delay or avoid care. They will seek treatment outside formal systems, from unqualified practitioners, at greater medical risk. The therapeutic frame depends on a client's certainty that what is disclosed in the clinical relationship stays there. When legislation connects that relationship to a government reporting mechanism, the damage extends to every helping relationship that client has. We will see this. We are naming it before it arrives.

We state this directly: the mandatory reporting architecture this Bill creates makes ethical therapeutic practice structurally difficult and, in many clinical situations, impossible. A therapist working under a

legal framework that connects disclosure of gender history to state surveillance cannot offer the conditions of safety that effective therapy requires. This is not a matter of individual professional judgment. It is a structural incompatibility between this Bill's architecture and the ethical obligations that govern our profession.

#### **WHAT IT VIOLATES**

This directly contravenes Section 23 of the Mental Healthcare Act, 2017, which guarantees every person the right to confidentiality in their mental and physical healthcare and prohibits disclosure of medical information without informed consent. Section 21 of the same Act explicitly prohibits discrimination in mental health services on the basis of gender, sex, or sexual orientation. This Bill is discriminatory under the very statute that governs our profession.

Gender-affirming care cannot be understood purely within a narrow biomedical framework. Transition-related services exist at the intersection of physical and mental healthcare and function in practice as parallel mental health services. A legislative framework that restricts or subjects them to extraordinary scrutiny directly contradicts the spirit and provisions of the Mental Healthcare Act, 2017.

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### **3.**

## **This Bill Creates a Conversion Therapy Pipeline**

#### **WHAT THE BILL DOES**

This Bill creates a medical board empowered to assess a person's gender identity before the District Magistrate can recognise it — with no restriction whatsoever on what that board can recommend. The Bill provides no defined clinical standards, no requirement for trans-affirmative practitioners, and no prohibition on watchful waiting, psychological assessment, or exploratory intervention before certification. The composition and clinical mandate of this gatekeeping body are left entirely open — to be filled by whoever the administrative system appoints, according to whatever standards they choose to apply. This is not an oversight. It is the institutional architecture through which conversion practices enter — not as conspiracy, but as the logical consequence of an unrestricted gatekeeping body operating in a legal vacuum.

Section 18 of the amended Bill introduces imprisonment of up to five years for 'alluring' or 'forcing' individuals to 'become transgender.' There is no empirical evidence for such conduct in India. The framing links transgender identity with criminality in a way that directly echoes the logic of the colonial-era Criminal Tribes Act of 1871. Mental health professionals understand the psychological weight of criminality as a social category — the stigma, the internalised shame, the chilling effect on help-seeking. This provision recreates that architecture.

The framing of Section 18 — with its vocabulary of 'alluring,' 'forcing,' and 'inducement' — goes beyond gatekeeping. It builds, into statute, an image of transgender persons and their allies as people who coerce and exploit others. No evidence base supports this framing. Its effect is to produce a social meaning that the clinical literature does not: that transgender identity is threatening and communicable. Criminalising language in law deepens stigma in everyday spaces — translating into bullying in classrooms, violence in homes, denial of care in hospitals, harassment in workplaces and public spaces. It normalises discrimination that was already occurring and makes it harder, not easier, to challenge.

The clinical downstream of sustained stigma of this kind is not limited to a single adverse event. It accumulates. Pervasive stigma — reinforced by law, enacted in families, replicated in classrooms and workplaces and hospitals — produces depression, self-hatred, self-harm, and a profound and rational distrust of systems and institutions. For a population that already approaches every institution with the knowledge that it has historically been failed, the message embedded in this framing — that who you are is dangerous, suspect, and legally unrecognised — does not produce isolated distress. It produces

a chronic relationship with the world in which help-seeking itself feels unsafe. That is not an incidental harm. It is the precise harm that a decade of clinical work with this population has taught us to recognise and name.

The coercion language is deliberately broad. "Inducement" and "undue influence" carry no defined clinical threshold, and in the institutional contexts trans persons routinely navigate, these terms are available to any authority seeking to classify affirmative support as criminal conduct. Affirming a client's gender identity — a clinical and ethical obligation under every professional standard we work within — can be construed as compelling them to adopt a transgender identity. Criminal liability extends not only to medical professionals but to anyone who affirms a trans person's identity. A mother who uses her child's chosen name. A member of a chosen family who accompanies a trans person to a hospital. A therapist who provides gender-affirming care. Under the open language of Section 18, all of these constitute potential criminal acts.

The practical clinical consequence is a chilling effect on care. Clinicians operating under the shadow of criminal liability for affirming language cannot maintain the conditions necessary for ethical, effective therapeutic practice. Clients whose support networks face potential criminalisation cannot engage in therapy with the safety required for meaningful therapeutic work. The Bill does not incidentally complicate clinical care. It structurally prevents it.

For many transgender persons in India — particularly those estranged from families of origin due to rejection — chosen families are not a social preference. They are a clinical necessity. Research on minority stress, social support, and mental health consistently identifies chosen family as a primary protective factor against depression, suicidality, and isolation for transgender people. Criminalising those relationships does not protect transgender persons. It removes the scaffolding on which their psychological survival often depends.

It is essential to name what this Bill is dismantling. For most transgender persons in India — particularly those rejected by families of origin, expelled from homes, pushed out of schools and workplaces — the safe circle is already vanishingly small. It is a therapist who uses the right name. A friend who accompanies them to a hospital. A chosen family member who answers the phone at 2am. This is not a robust support system. It is the minimum. Under this Bill, that minimum becomes criminal. And when the circle is gone, what remains is isolation — the single most consistent predictor of suicide in the clinical literature. The state is not protecting these people. It is removing the last thing between them and the worst possible outcome.

### **WHAT IT VIOLATES**

Conversion therapy is illegal in India — a position upheld in law and endorsed by every major mental health professional body in the country, including the Indian Association of Clinical Psychologists and the Indian Psychiatric Society, which has affirmed that LGBTQA+ identities are variants of normal human experience, not pathology, and that discrimination — not identity — causes mental health harm.

This Bill's entire architecture is premised on treating gender identity as a medical condition requiring clinical evaluation. That is ICD-10 thinking. India officially moved past it in 2019. As a WHO member state, India endorsed the ICD-11, which explicitly removed gender incongruence from the chapter on mental and behavioural disorders. The WHO's rationale was unambiguous: classifying gender diverse identities as conditions of mental ill-health causes enormous stigma. A Bill that reinstates clinical gatekeeping over gender identity contradicts the international framework India itself endorsed — only seven years ago.

It is also important to recognise the limits of medical authority in matters of gender identity. Gender identity belongs to the domain of subjective psychological experience. Self-identification must therefore remain primary. The role of medical professionals is to provide supportive and transition-related healthcare where required — not to function as gatekeepers who validate whether an individual is truly transgender.

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4.

## **This Bill Produces Compounded Harm at the Intersections of Disability, Caste, Religion, and Gender**

### **WHAT THE BILL DOES**

The Bill also conflates intersex and transgender identities within a single definition — treating two fundamentally distinct experiences as interchangeable. Intersex refers to people born with sex characteristics that do not fit typical binary definitions of male or female bodies. Transgender refers to people whose gender identity does not align with the gender they were assigned at birth. Conflating them is not a technical error. It is clinically harmful: it produces inappropriate treatment pathways, creates diagnostic confusion, and generates stigma for both communities. Mental health professionals and endocrinologists working with these populations require distinct clinical frameworks for each.

The proposed changes to Section 7 introduce multiple layers of validation from medical doctors, the District Magistrate, and medical boards — each of which represents an additional threshold that transgender persons with disabilities must cross. Rather than streamlining access, the Bill places an elevated burden on this group and creates more sites for discrimination.

What the Bill imposes on transgender persons is not a single barrier but a compounding accumulation of them — each requiring time, money, emotional labour, and psychological resources to navigate. This accumulation does not fall equally. A transgender person from a Dalit, Bahujan, or Adivasi background, with a disability, living outside a major city, without a legally literate support network, faces a qualitatively different burden than someone with financial resources, family acceptance, and access to legal aid.

The Bill's narrow definitional framework compounds this further: those whose identities do not map neatly onto the four socio-cultural categories the Bill recognises are forced to reshape how they describe themselves to institutional gatekeepers — performing an identity that is legible to the system rather than honest to their experience. It is worth noting that these four categories are drawn predominantly from dominant-caste Hindu mythological and cultural frameworks. This is not a neutral choice. It means that transgender persons from Muslim, Christian, Sikh, Dalit, Bahujan, Adivasi, and other marginalised religious and caste communities — whose gender identities exist within entirely different cultural vocabularies — are rendered invisible in the Bill's own definitional architecture. The legal category available to them requires adopting a cultural framing that is not their own. Clinically, we recognise this as a form of institutionalised self-erasure. It causes harm. And it falls hardest on those already marginalised by caste and religion.

The Bill's overly broad coercion language also criminalises caregivers and support networks — the very infrastructure many transgender persons with disabilities depend on. Under the Bill's new penal provisions, a caregiver accompanying a trans person to access gender-affirming care could be construed as unduly influencing them.

### **WHAT IT VIOLATES**

The Rights of Persons with Disabilities Act, 2016 guarantees accessibility of services and individual autonomy — including the freedom to make one's own choices — for all persons with disabilities, in accordance with the United Nations Convention on the Rights of Persons with Disabilities. This Bill directly contradicts those protections.

Further, by imposing narrow and culturally specific frameworks of recognition, the Bill disproportionately affects those at the intersections of disability, caste, religion, and gender — risking the deepening of structural exclusion in ways that run counter to the intent of laws meant to protect marginalised communities. The harm this architecture produces is not incidental. It is compounding, and it falls hardest on those who are already most exposed.

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## 5.

### **Withholding Affirming Care Kills People. The Evidence Is Unambiguous.**

#### **WHAT THE BILL DOES**

This Bill's surveillance architecture, its mandatory reporting requirements, and its chilling effect on prescribing clinicians will not merely delay access to gender-affirming care. It will interrupt ongoing hormone therapy for people already mid-regimen. Abrupt cessation or forced interruption causes acute hormonal withdrawal: mood instability, depression, anxiety, fatigue, and sleep disruption are well-documented immediate effects. In trans men on testosterone, interruption can trigger the return of menstruation and associated dysphoria. In trans women, cessation of oestrogen therapy reverses feminising changes and reinstates androgenic effects, precipitating significant distress. Beyond the acute phase, prolonged disruption affects bone density, cardiovascular health, and metabolic function.

The clinical harm is not theoretical. It is pharmacologically predictable and medically preventable. We are naming it as such.

This Bill intensifies every stressor simultaneously: it removes legal recognition, creates surveillance around healthcare, exposes providers to criminal liability, and opens the door to conversion practices under state authority. When we oppose this Bill, we are not taking a political position. We are applying our clinical training to a predictable, preventable, documented public health outcome.

#### **WHAT THE EVIDENCE SHOWS**

The psychological harm caused by this Bill is not incidental. It is structurally predictable. Minority stress theory — one of the most robustly replicated frameworks in the field of sexual minority mental health, first developed by Ilan Meyer and extensively validated across populations — establishes that stigma, discrimination, legal exclusion, and the anticipation of rejection generate chronic psychological stress that directly produces elevated rates of depression, anxiety, and suicidality among marginalised groups. This Bill simultaneously intensifies every one of those stressors. Each is a documented minority stressor. Their cumulative effect is not speculative. It is clinically established.

Across 29 peer-reviewed studies involving 2,789 participants, gender-affirming care significantly reduces depression and suicidality. A 2024 study in JAMA Network Open found gender-affirming care associated with lower odds of depression and suicidal ideation over 12 months. In India, between 30 and 50 percent of transgender persons attempt suicide before the age of twenty — driven not by their gender identity, but by legal exclusion, documentation barriers, and denial of care.

We now have Indian clinical data that confirms what international evidence has long shown. A 2025 cohort study conducted at the Government Rajaji Hospital, Madurai — a Tamil Nadu government facility — tracked 842 transgender individuals over 3.5 years. Using the Beck's Depression Inventory (BDI) before and after gender-affirming hormone therapy and gender-affirming surgery, the study found that both procedures improved psychological wellbeing and reduced depression in gender-incongruent individuals. This is Indian data, from an Indian government hospital, about Indian patients. A Bill that dismantles access to that care will produce the inverse effect.

Research on transgender children and adolescents shows that when psychosocial gender-affirming care is initiated early, it produces measurable improvements in wellbeing sustained through adolescence. Family acceptance is among the strongest protective factors; family rejection and social non-acceptance are among the strongest predictors of mental health crisis. The Adolescent Health Academy of the Indian Academy of Pediatrics, in its 2023 statement on transgender care, affirmed that conversion or reparative approaches cause substantial mental and social harm and are both clinically contraindicated and legally prohibited.

Medical science itself has a documented history of pathologising marginalised groups. The history of psychiatry demonstrates how diagnostic frameworks have often reflected prevailing social attitudes rather than the lived realities of the communities being classified. Medical institutions should be entrusted with the provision of care — not the validation of identity.

There is a formulation that has emerged from trans-led advocacy that clinical professionals recognise as clinically accurate: Trans Rights are Suicide Prevention. Legal recognition, the right to self-identification, access to affirming care, protection from discrimination in homes and schools and hospitals — these are not political abstractions. They are the documented, evidence-based determinants of whether a transgender person lives or dies. Every provision this Bill dismantles is, in clinical terms, a suicide prevention mechanism being removed. We are naming it as such.

#### **WHAT AN AMENDMENT SHOULD HAVE DONE**

A rights-protective amendment to this Act would have moved in the opposite direction entirely. The evidence on what actually reduces harm, improves mental health outcomes, and prevents suicide among transgender persons is not ambiguous. It points consistently toward: reducing stigma and transphobia through strong social protection systems; universal access to public services — education, physical healthcare, mental health care, and emotional support — without documentation barriers or discrimination; skill development and employment protection, including active measures against workplace exclusion; and safe housing provisions for transgender persons who have been expelled from homes. The 2019 Act itself made some of these promises. The government's own data shows they have not been kept. This Bill does not attempt to keep them. It does not suggest any of these. Instead, it adds surveillance, gatekeeping, and criminal liability — moving in the direction of greater harm rather than greater protection.

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## **6.**

### **On the Welfare Misuse Claim: Where Is the Evidence?**

#### **WHAT THE BILL CLAIMS**

The government's Statement of Objects and Reasons asserts that the existing definition of transgender person is so broad that it enables undeserving persons to acquire protected status and access welfare benefits — and that identity protection cannot be extended to characteristics that are 'acquirable.' This is a serious empirical claim. It is also one for which the government has produced no data. We are demanding it do so.

We also note the absence of any documented consultation with mental health professionals during the drafting of this Bill. Drafting legislation premised on psychological and clinical judgements without consulting the professionals who work in those fields is not an oversight. It reflects a decision to treat medical authority as a tool of administrative gatekeeping rather than a source of clinical evidence. We reject that use of our profession.

We also note a clinical concern with the framing of the welfare misuse claim itself. The Bill's Statement of Objects frames its restriction as protecting a particular 'class' of transgender persons — implying that welfare protections were always meant for a specific, bounded group, and that broader recognition enables misuse. In our clinical rooms, we witness daily what this framing erases: transgender persons across every class background — working-class, Dalit, rural, urban poor, middle-class — navigating the same documentation barriers, the same denial of healthcare, the same distress. Class background does not determine whether a person's gender identity is real or whether their suffering is clinically significant. The need for protection and care is not conditional on economic position. To suggest otherwise is not a welfare argument. It is a mechanism for excluding the most vulnerable — those who lack the resources to navigate the gatekeeping that this Bill expands — while presenting that exclusion as targeted precision.

Harm of this kind — produced by legislative changes to identity categories that affect marginalised populations — is not inevitable. It is foreseeable, and therefore preventable, when those who will bear it are consulted before changes are made. The harm this Bill will produce is not something we are speculating about. It is something we are naming now, from clinical experience, before it arrives.

## WHAT THE EVIDENCE SHOWS

The government's own portal and parliamentary records tell a different story. Since the National Portal for Transgender Persons was launched, approximately 30,000 identity certificates have been issued against a community the 2011 Census counted at nearly 490,000 — itself a significant undercount. That is certification of less than ten percent of the estimated population. Parliamentary data shows zero transgender beneficiaries under the PMAY housing scheme in multiple states across multiple financial years, despite trans persons being listed as a priority group. The government allocated Rs. 365 crore for transgender welfare under the SMILE scheme between 2021 and 2026; as of April 2025, less than Rs. 7 crore had been utilised.

These are the government's own numbers. They describe not a community hoarding benefits — but a community being systematically denied access to schemes that exist in legislation and nowhere else.

What we hold instead — in clinical records, in community testimony, in the documented cases we encounter in our professional practice — is evidence of the opposite. Trans persons denied hospital care because their documents did not match their presentation. Trans persons turned away from Ayushman Bharat coverage because their identity certificates did not align with a binary the scheme required. Trans persons whose mental health crises were directly precipitated by documentation barriers. The crisis this community faces is not excess access to welfare. It is the severe, measurable, and clinically documented harm caused by the near-total inaccessibility of welfare that exists on paper and not in practice.

If the government has evidence of welfare fraud at scale, we call on it to publish that data publicly and immediately, before using the allegation to strip legal recognition from hundreds of thousands of people. Making a serious empirical claim without evidence, then legislating on the basis of it, does not meet the standard that evidence-based governance requires.

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## 7.

### This Bill Erases People Who Already Exist

#### WHAT THE BILL DOES

The government's Statement of Objects implies that self-perceived transmasculine and transfeminine identity is a Western import — that people transitioned because they encountered foreign ideas, not because their experience of gender was real. On this basis, the Bill narrows the definition of transgender to exclude trans men, trans women, non-binary and genderqueer persons from legal recognition.

The government is not correcting a definition. It is deciding that certain people — people who exist, who work, who are in therapy, who are raising families, who are conducting research, who are treating patients — do not have a legal category. For those people, this is not an administrative matter. It is a question of whether they can access a hospital, correct a document, file an FIR, or sit in a therapy room without fear.

The level of scrutiny proposed in this Bill is not required in other areas of medical practice. Individuals seeking cosmetic or elective surgeries — many of which are irreversible — are not required to undergo comparable levels of state oversight. This disparity raises serious concerns that what is presented as protection may in fact be institutional bias operating through administrative mechanisms.

#### WHAT THE RESEARCH SHOWS

Research from India shows that many transgender people's identity preceded any exposure to Western frameworks, any medical system, any community network. A doctoral research currently underway at TISS Mumbai documents the same across participants — people whose experience of gender emerged in specifically Indian contexts, in Marathi, Hindi, Bengali and other languages, in households and neighbourhoods, long before any foreign vocabulary existed for what they were living. Research published in PLOS Global Public Health in 2024, involving 377 transmasculine participants across India

with interviews conducted in Hindi and Marathi, documents this consistently: identity formation preceded any contact with Western trans frameworks.

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## Silence Is Not Neutral

We are mental health professionals. We took an oath to do no harm. We are bound by law — the Mental Healthcare Act, 2017 — to treat every person without discrimination on the basis of gender or sexual orientation. We are bound by evidence to provide care that the research shows reduces suffering and saves lives.

This Bill asks us to work inside a legal architecture that surveils our clients, exposes us to criminal liability for affirming their identity, criminalises the chosen families that keep them alive, and hands a gatekeeping authority to a board with no defined clinical standards, no trans-affirmative mandate, and no professional obligation toward the people it is assessing. We are unambiguous about what that means: it is not possible to provide ethical, evidence-based care to transgender clients under the conditions this Bill creates. This is a clinical statement, not a political one.

We will not be silent about what this means clinically, legally, and for the lives of the people in our care.

**This Bill must not pass.**

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## WE CALL ON THE GOVERNMENT TO —

- **Withdraw the Amendment Bill** in its current form and restore the self-determination framework established by the Supreme Court in NALSA 2014.
- **Restore Section 4(2)** — the right to self-perceived gender identity — which is the statutory expression of a constitutional right the Supreme Court has already affirmed.
- **Restore the Section 7(3) proviso** ensuring that trans persons who change their gender marker retain all rights and protections under the Act.
- **Remove the medical board mechanism** from the identity certification process entirely. Gender identity falls outside the epistemic authority of any medical body. If a clinical body is established, its mandate must be strictly limited to ensuring accessible, affirmative transition-related care — with no role in identity verification, certification approval, or any gatekeeping function.
- **Ensure accessibility** for transgender persons with disabilities in any revised certification or welfare framework, in compliance with the Rights of Persons with Disabilities Act, 2016. Caregivers and support networks must not be exposed to criminal liability for providing care.
- **Withdraw the amended Section 18 provisions** which criminalise affirmation of transgender identity and expose chosen families, allies, and healthcare providers to imprisonment. No evidence base exists for the conduct these provisions purport to address.
- **Rectify the conflation of intersex and transgender identities** in the Bill's definition. These are distinct experiences requiring different clinical and legal frameworks.
- **Revise the four recognised socio-cultural categories** in the Bill's definition to include the full diversity of gender identities across India's caste, religious, and cultural communities — not only those legible within dominant-caste Hindu frameworks. Legal recognition must not require a person to adopt a cultural vocabulary that is not their own.
- **Publish all data** on which the welfare misuse claim is based — including documented cases of fraudulent identity claims, scheme utilisation rates, and internal audit findings — before the Bill proceeds further.

- **Refer any revised legislation** to a parliamentary standing committee with mandatory consultation with transmasculine persons, transfeminine persons, non-binary persons, intersex persons, transgender persons with disabilities, and the mental health professionals who serve them.
- **Clarify which medical professionals, mental health experts, and transgender community members** were consulted during the drafting of this amendment. Legislation premised on clinical and psychological claims, drafted without consulting the relevant professions, lacks the evidentiary foundation required for law affecting a marginalised population.

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### Notes to Editors

The Transgender Persons (Protection of Rights) Amendment Bill, 2026 was introduced in the Lok Sabha on 13 March 2026 by Dr. Virendra Kumar, Minister of Social Justice and Empowerment, Government of India. All legal citations refer to publicly available judgments and statutes. All research citations are available on request. Clinical case details referenced have been anonymised in accordance with professional confidentiality obligations. Spokespeople are available for interview.

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*Issued on behalf of mental health professionals, researchers, and members of the transgender community in India.*