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Social stigma, legal and public health barriers faced by the third gender phenomena in Brazil, India and Mexico: *Travestis, hijras* and *muxes*

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Abstract

Aim and Methods: The aim of this article is to provide a narrative literature review of the 'third gender' phenomenon in Brazil (*Travestis*), India (*Hijras*) and Mexico (*Muxes*), considering the social stigma, the legal and health aspects of these identities.

Results: These three groups share similar experiences of stigmatisation, marginalisation, sexual abuse, HIV infection, infringement of civil rights and harassment accessing health services. Brazil, India and Mexico public services for the third gender conditions are still very scarce and inadequate for the heavy demand from potential users.

Discussion and Conclusion: Although all three countries have used legislation to promote provision of comprehensive healthcare services for third gender, there is still strong resistance to implementation of such laws and policies. Brazil, India and Mexico face a huge challenge to become countries where all human rights are respected.

Keywords

Transgender, social stigma, health policy development, health services for transgender persons, civil rights

Introduction

The 'third gender' phenomenon has been described since the Middle Ages (V. L. Bullough, 1974). The Brazilian *travestis*, Indian *hijras*, Mexican *muxes* and other similar groups in other cultures such as the F*a'afafine* in Samoa, the *xanith* in Oman, the *yan daudu* of Nigeria and the '*two-spirit people*' in some Native American cultures (Burks, Robbins, & Durtschi, 2011; Lionço, 2008; Nanda, 1999; Petterson, Dixson, Little, & Vasey, 2015; Stephen, 2002) are examples of third gender groups that share certain characteristics since in most countries individuals who exhibit variations in gender identities from the gender binary pattern (male and female) still face discrimination with respect to access to healthcare, work and education (Carrieri, Souza, & Aguiar, 2014; de Lind van Wijngaarden, Schunter, & Iqbal, 2013).

These transgender identities are typically applied to individuals who were born male but present as women, who usually play feminine gender roles and identify as members of a 'third gender'. Although there are behavioural similarities between these groups, they have different ethnographic, cultural and anthropological backgrounds (Aquino, 2014; Vasey & Bartlett, 2007).

The definition of 'transgender' has changed over time and today the term is used as an umbrella term to refer to individuals who do not identify with the sex category assigned to them at birth and individuals whose identity or behaviour falls outside stereotypical binary gender (World Health Organization, 2008). It encompasses an array of gender identities including male-to-female transgender women; female-to-male (FTM) transgender men; people who live part-time in a different gender; people who

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neither identify as male nor female and people who identify as bi-gender or pangender (non-binary gender).

Moreover, the clinical definitions and cultural features of specific gender identities, frequently called as 'third gender', remain under-investigated in scientific literature (Amorim, Vieira, & Brancaleoni, 2013; Muller & Knauth, 2008). Much political, social and ideological controversial debate still surround it mainly due to the categorisation of these individuals within a perspective of psychiatric diagnoses system towards the pathologisation of transgender persons (Beek, Cohen-Kettenis, & Kreukels, 2016; Davy, 2015; Güldenring, 2015; Leite, 2011).

The aim of this article is to provide a narrative review of the 'third gender' phenomenon in Brazil, India and Mexico. We have taken advantage of the interactions between authors of these three low- and middle-income countries to shed light on how these gender identities have been captured in these countries, considering the social stigma, legal and health aspects of these identities.

Travestis, hijras and muxes: who are they?

Travestis, hijras and muxes are female gender identity expressions who have many characteristics in common, in social, political and health aspects; however, they also have individualities that set them apart culturally. Among the features of the Brazilian *travesti* identity, for example, are the claim of androgyny, and the desire for social recognition as a woman. The *travesti* presents herself as a woman and assumes a female gender identity, but may display male sexual behaviour (de Lima Carvalho, 2012; Lionço, 2008). They wish to live their 'transvestility' in social and professional contexts; being neither male nor female, just *travesti* (Peres, 2012). Most of them do not seek sex reassignment surgery (SRS) (Green, 2010) (although they may seek hormone therapy in pursuit of a more feminine phenotype) to avoid sexual dysfunction (i.e. erectile dysfunction) as they are sexually active and satisfied with their genitals (Lionço, 2008).

In Brazil, *travestis* have been as popular as they are demonised. The existence of transgenderism is recorded throughout Latin America, but in no other country are they so numerous and well known as in Brazil, where they have achieved remarkable social and cultural visibility (Santos, 2008). The Group Gay of Bahia estimated that in 2011 there were 50,000 *travestis* in Brazil (Lionço, 2008; Passos & Figueiredo, 2004).

In India, Pakistan and Bangladesh, one finds a group similar to the Brazilian *travestis*, namely the *hijras* (eunuchs or transgender). The first official count put the number of third gender or transgender people in India in 2014 at 490,000; however, transgender activists claim that the real number is six to seven times higher (Nagarajan, 2014). It has been reported that there are more than two million castrated *hijras* in India today (Reddy, 2005). Members of the *hijra* community often identify as an alternative gender, rather than as transsexuals or homosexuals. In India, the *hijra* role is an institutionalised third gender role; the *hijra* identity is neither male nor female, but contains elements of both. As devotees of the Mother Goddess Bahuchara Mata, the sacred powers of *hijras* are dependent on their sexuality. In reality, however, many *hijras* are forced into begging and commercial sex work. This type of sexual activity undermines their culturally valued sacred role. Traditionally, *hijras* held important societal roles in South Asian culture, particularly in ancient Hindu. They are believed to bring good luck to new-born children and newlyweds, as they are believed to have a special ability to bless people with luck and fertility. During the era of Muslim rule in the Indian subcontinent, they were used as bodyguards for royalty and as guards for holy buildings (Nanda, 1985).

In Mexico, there exists another very specific transgender group, the *muxes*. *Muxes* are biologically male individuals indigenous to the *Itsmo de Tehuantepec, Juchitán*, in the state of Oaxaca in southern Mexico (Rubin, 1997) who describe themselves as members of a third gender sharing some of the characteristics of both men and women (Chiñas, 1995; Stephen, 2002). A distinguishing characteristic of *muxes* is that nowadays many of them openly dress in traditional female Zapotec attire – consisting of hand-embroidered and ruffled garments for community festivities (*velas*). This became much more common after the appearance of the gay movement. Indeed, the word *muxe* comes from the Spanish word *woman* and simply means *homosexual* although the ethnic conceptual category is much more complex (Borruso, 2002) and it is clear that gender identity is not the same as sexual orientation (Jackson, 2003). Some *muxes* marry women and have children, whereas others form long-term partnerships with men (Chiñas, 1995). Many *muxes* have long hair and wear makeup and some undergo surgical procedures (breast enlargement; rhinoplasty) to acquire a more feminine phenotype. Most *muxes* assume the identity in their teens. They are encouraged by family and friends to assume traditional female roles such as taking care of babies and the elderly for example (Mirandé, 2014). Muxes play a key socially valued role in the transmission of culture, in religious festivities and in the design and embroidery of traditional garment (way of accumulating wealth) (Mirandé, 2014).

Culture response and stigma

Transphobia is a complex social phenomenon that can be defined as the manifestation of irrational fear, disgust, hatred, loathing, discrimination and other forms of intolerance directed at individuals with a transgender identity. Transphobia may have negative consequences for those who experience it as victimisation, substance use,

depression, suicide and suicide attempts, psychological impairment, low self-esteem and a plethora of human rights violations that in many cases might culminate in homicide and violence (Fernandes, 2013; Lyons et al., 2017; Mizock, 2017). Besides that, transphobia can be related to poor healthcare access for transgender people due to a variety of factors, including a lack of physician and other heath professional's knowledge and education competence in providing care for transgender people (McPhail, Rountree-James, & Whetter, 2016).

Brazil has a regrettable notoriety as a transphobic country since it has accounted for 845 homicide cases reported between January 2008 and April 2016 from a reported global homicide count of 2115 in 65 countries worldwide (Transgender Europe [TGEU], 2016). In spite of this, homophobia and transphobia are not classified as crimes in Brazil. The bill No. 122/2006 (PL 122), which would criminalise homophobia, transphobia and lesbophobia, was introduced to the House of Representatives in 2006, but has not yet become law (Bernardi, 2006).

Brazilian *travestis* typically begin to identify as *travestis* between 10 and 12 years old and the majority are expelled from school, then forced into prostitution due to the difficulty they face finding formal employment (Carrieri et al., 2014). The only social spaces from which *travestis* are not systematically expelled are streets, venues or prostitution scenes. *Travestis* are constantly harassed by public health services, public transport services, the police, the judicial system and universities. Reports of rape, harassment and physical and psychological abuse and demoralisation are common among *travestis* (United Nations Human Rights Office of the High Commissioner, 2012).

The identity of the Brazilian *travestis* is assembled through the assimilation of various fragments of common identities in Brazilian society. The main aspects of female identity assimilated by the *travestis* are the submissive woman, the 'whore' and the temptress; the main aspects of male identity they embrace are the *viado* ('queer'), the *malandro* ('rascal') and the *bandido* ('bandit') (Garcia, 2009). Brazilian *travestis* use a shared language (*Pajubá*) that includes many words from African languages (mostly Yoruba) and Portuguese words which are used with a different meaning. *Pajubá* is a 'secret' language which serves a protective function *travestis* are a vulnerable group and as a form of identification and acceptance in this community (Aquino, 2014). A sociolinguistic analysis of the language used by *travestis* reveals that through the creative use of linguistic features shared by multiple language varieties *travestis* perform an identity that frequently blurs gender boundaries (Mann, 2011).

A study of 110 *travestis* in the north-eastern region of Brazil found high levels of transphobia in many settings: security services, work facilities, family and religious environments, neighbourhoods, schools, stores, leisure spaces and healthcare services. High proportions of the sample reported having experienced verbal aggression (81.8%) and physical aggression (68.2%) (de Sousa, Ferreira, & de Sa, 2013).

Many *travestis* live on the streets and there is a drive for Brazil to adopt policies that promote respect for sexual diversity and enforce gender identity laws that criminalise homophobic and transphobic behaviour. As Pelúcio (2011) points out, Brazilian *travestis* have historically been pathologised, criminalised, ridiculed and killed. A frequent sequence of events in the lives of *travestis* is the engagement in projects which promise initially financial independence and recognition. Many of them associate to live in marginal spaces to build extensive social and business setups to work, mainly in prostitution. Others, after running away from home and to protect themselves, search for role models in furtive trysts at night, which result in domestic alliances and affiliations to older *travestis* who teach them the aesthetic tricks and erotic games to develop their power of seduction and self-defence. This behaviour gives most *travestis* power over their bodies and hence their lives. *Travestis* are nevertheless always targets for violence and coercion (Pelúcio, 2011).

Meanwhile in India, the Supreme Court has ruled out homosexuality as a crime (Sathyanarayana Rao & Jacob, 2014) and has given legal recognition to the third gender and stated that people of the third gender have equal rights to education, jobs and social benefits (Sathyanarayana Rao & Jacob, 2014).

According to de Lind van Wijngaarden et al. (2013), feminised men (*hijras*) in Pakistan lead more public lives than general population and they are subject to stigma, discrimination and sexual exploitation, and sexual, physical and psychological abuse. Young feminised men (*hijras*) are stigmatised even by the families into which they are born and raised. About 34% of *hijras* (*khusras* in Pakistan*)* reported violence from clients, 32% reported violence from the police and 9% reported violence from neighbours. In addition, 27% reported that they had been sexually violated by police and 39% provided sex to the police without being paid for it, whilst 19% had been sexually violated by one or more neighbours. Laxmi and colleagues (2011) stated that the *hijras* of India are stigmatised, discriminated against and vulnerable to bullying by law enforcement agencies and *goonda*s (thugs) as well as often being teased and harassed by the general community (Laxmi et al., 2011). According to Sharma (2012), *hijras* are disowned by their families in childhood and universally ridiculed and abused as *hijra*, or third sex, eunuchs (Sharma, 2012). Altaf, Zahidie, and Agha (2012) reported that most *hijra* sex workers in Larkana, Pakistan (67.8%) were uneducated, 96.5% were unmarried and 60.3% were living at some place other than their family homes (Altaf et al., 2012). *Hijras* frequently have no access to formal jobs, which leads them to become involved in commercial sex work; they also face institutional discrimination by police and

healthcare systems and denial of their right to vote. Hopefully, this situation will begin to change following the new Supreme Court of India's ruling on third gender.

In Mexico, there are both federal and local laws against discrimination on grounds of sexual orientation or gender identity (Mexico. Cámara de Diputados del H. Congreso de la Unión, 2003). Mexico recognises same-sex marriages performed in other countries and in Mexico City and other states same-sex marriage and civil union is legal, as is adoption by same-sex couples. Nevertheless, at least 50% of the population discriminates to some degree against homosexual people and a high proportion of trans people have reported being rejected, excluded or discriminated against because of their gender identity, occupation as sex workers and physical appearance (Arantxa et al., 2013). In this particular sector of society, the most frequently mentioned forms of discrimination are verbal violence, isolation and physical violence, mainly by the police and other public servants, family, friends and classmates. This highlights the need to train healthcare workers, police officers, other public servants and society in general to reduce this problem (Arantxa et al., 2013).

Muxes are generally more accepted by the community than other trans groups in Mexico (Mirandé, 2014). Nevertheless, *muxes* have frequently been used as servants or prostitutes or regarded as friends who can enliven festivities but are destined to remain single and eventually care for their elderly parents although many now have white-collar jobs and are involved in politics. In the late 1980s and 1990s, people in Juchitán accused *muxes* of being the main carriers of human immunodeficiency virus (HIV) and responsible for the spread of the acquired immune deficiency syndrome (AIDS) epidemic (Islas, 2005); this increased the stigma attached to this identity.

In 2009, *muxes* were banned from the traditional *velas* festivities the invitations included the statement that 'entry will not be permitted for men dressed as women'. According to Borruso (2010a), this reflected the emergence of a new form of transphobia related to the *muxe* community, and this was as a response to women's opinion that *muxes* do not conduct themselves like women in the festivities, but behave like other drunk and aggressive men (Borruso, 2010a). It is true that nowadays many m*uxes* cross-dress, but that has not always been the case. It became much more common after the appearance of the gay movement. In addition to caring for ageing parents, they played key socially valued roles in the transmission of culture, in religious festivities and in the design and embroidery of traditional garment (way of accumulating wealth). It is after the appearance of HIV that there is more ambivalence and stigma against *muxes* in Zapotec communities (Borruso, 2010a).

Not surprisingly, *muxes* have repeatedly denounced transphobia, and transphobic crimes have included homicides (victims have been beaten, tortured and killed) (Borruso, 2010a). *Muxes* have demanded recognition and support from national and local institutions (Borruso, 2010b), and come together in a ethnic activism discourse reflecting the perception that these crimes are an attack on the intangible cultural patrimony of the Zapotec, as expressed in tolerance of diversity and sex-gender flexibility (Borruso, 2010a).

HIV and sexually transmitted infections

Health services

In Brazil, the existing ordinance of the 'transsexualising process' (government protocol includes a series of surgical procedures, hormone therapy, psychological, psychiatric, endocrine, social service and other) (BRASIL. Ministério da Saúde. Gabinete do Ministro, 2013) encompasses both transsexuals and *travestis*, the services prioritise those who experience extreme dysphoria, are discontent with their genitals and seek SRS; they thus fail to meet the needs of *travestis*, who do not want to transition fully to another gender and may need a different hormone therapy protocol.

A study conducted with a group of *travesti* sex workers revealed many barriers to access to health services, mostly in relation to public services for drug addiction. The *travestis* reported that services did not take into account the factors specific to *travestis* or even the practical difficulties they face. Barriers ranged from lack of information to transport difficulties and lack of the basic civil documents needed to use services. The study also highlighted the prejudice and discrimination that *travestis* face when they seek public services (Amorim et al., 2013).

Given that the *travestis* face prejudice from professionals and other users when they seek to use public services, health policies that seek to address the specific needs of *travestis* must prioritise initiative that will ensure respect for difference and appreciation of human dignity to discourage this population from resorting to unsafe and unsupervised methods of healthcare such as the application of industrial silicone and excessive intake of female hormones, or abuse of licit and illicit drugs (Romano, 2008).

A qualitative study by Souza, Signorelli, Coviello, and Pereira (2014) showed that Brazilian *travestis* avoid institutionalised health services, choosing other forms of healthcare instead. The majority of *travestis* who participated in this study sought care from African religious groups or *batuque* (drumming). The *travestis* stated that they opted for African religious spaces as they considered them places where they would receive care and protection without being questioned about bodily changes, gender identity or sexual orientation (BRASIL. Ministério da Saúde. Gabinete do Ministro, 2013; Souza et al., 2014).

In India, the ritual surrounding castration (*Nirvan*) more correctly, emasculation surgery is a central part of a *hijra*'s

life and has been viewed as a form of rebirth. The *hijra* emasculation operation consists of removal of the penis and testicles but does not involve construction of a vagina and is often carried out by senior members of the *hijra* community, usually during adolescence or young adulthood, and is associated with considerable morbidity (Nanda, 1999). In some cases, individuals undergo this feminisation procedure out of a personal desire to do so, but in others it is part of the unarticulated code of gender norms in the *hijra* community. Castration or emasculation is often chosen over other procedures as it readily available, cheaper and faster. The use of surgical castration/emasculation, complete SRS, breast augmentation, laser hair removal, hormone treatments and voice therapy is becoming more popular in *hijra* population (and is not hindered by law). However, awareness of these procedures varies across subpopulations of *hijras* and access is limited due to the expense involved. Hormones are usually consumed without consulting doctors, typically in the form of over the counter oral contraceptives (Trust, 2012). India has no legal restrictions on access to health services; however, the specific needs of transgender people are not met within the public healthcare system. The medically unsupervised use of hormones and other procedures clearly exposes *hijras* to significant health risks.

In Mexico, although there is no legal impediment to access to health services, there is only two clinics in the public healthcare system (located in Mexico City; the Specialist 'Condesa' Clinic) which offers specialist treatment for adult trans people, including hormonal treatment and psychotherapy, but not SRS. Surgical procedures are only performed privately by urologists and plastic surgeons in the three biggest cities: Monterrey, Guadalajara and Mexico City. There are only two public psychiatry services (both in Mexico City) which accept referrals for childhood gender incongruence in childhood from generalist clinics, and there is no standard model of treatment for this condition. *Muxes* rarely use these specialist public sector health services; the indigenous community where they live is rather a long way from the very urban zone in Mexico City where those institutions are located. In the past, *muxes* used to use rubber foam to give their bodies a more feminine shape (Borruso, 1998).

Recently, *muxes* have begun to turn to medically unsupervised use of hormones or injections of domestic edible oils or other even more harmful products; and more young *muxes* express a desire to be 'fully female', by which they mean having breast implant and vagina construction surgery to enable them to be 'real woman'. This probably reflects the influence of international models and growing number of plastic surgery procedures on women in the media and in real life (Miano & Gómez-Suárez, 2009).

These clandestine procedures represent new health and social challenges. The medically unsupervised use of hormones and other procedures clearly exposes *muxes* to considerable health risks. Additionally, private specialist body transformation services are expensive, which may increase the *muxe* community's involvement in sex work as they resort to sex work to finance surgeries quickly and easily (Miano & Gómez-Suárez, 2009).

Legal rights and policies

Some bills dealing with transgender rights are already under consideration by the Brazilian National Congress and further bills and proposals for constitutional amendments are under discussion.

The Sexual Diversity Bill (2011) was drafted by a committee appointed by the Order of Lawyers of Brazil () focusing on the protection of the transgender rights (Dias, 2011). Another bill (Law n. 5002/2013, Law project named *João W. Nery*, Gender Identity Law) (Wyllys & Kokay, 2013) which provides for amendments to the record of an individual's name and gender in the civil register irrespective of surgical status and medical and psychological reports, that is, on the basis of an individual's self-declaration is going through the final stages of debate in the National Congress.

Treatment for transgender individuals must be free and provided by the Brazilian Unified Health System (SUS) or health insurance companies, using authorised facilities. The exclusion of coverage or the determination of requisites different from those specified in the current law is forbidden.

In India, in a landmark judgement (on Writ Petition (Civil) No. 400 of 2012 and Writ Petition (Civil) No. 604 of 2013) by the Supreme Court of India in April 2014 recognised the 'third gender' status of *hijras* and other transgender groups and upheld their rights to equal treatment (Article 14), freedom from discrimination (Article 15), self-expression (Article 19(1)(a) and autonomy (Article 21). The Court also stated that stakeholders should look into the specific needs of transgender people (e.g. for public toilets) and medical issues affecting them.

The Supreme Court of India stated 'recognition of transgenders as a third gender is not a social or medical issue but a human rights issue. Transgenders are also citizens of India. The spirit of the Constitution is to provide equal opportunity to every citizen to grow and attain their potential, irrespective of caste, religion or gender'. This verdict dictates that all identity documents, including a birth certificate, passport, ration card and driving licence must recognise the third gender. The Court clarified that gender identification is essential for the recognition of many rights such as the rights to vote, to own property and to marry. Until recently *hijras* did not have a right to vote. The Supreme Court judgement of 2014 sought to end discrimination against transgender people; however, its practical impact on lives of *hijras* needs to be assessed.

The Mexican National Program for Equality and Non-Discrimination 2014 lays down goals which federal public institutions and agencies must pursue: (a) prevention of sexually transmitted infection (STIs) among transgender people, (b) promotion of reforms to civil legislation to give transgender people legal status, (c) elimination of discriminatory criteria in the trans population access in issuing official documents, (d) removal of the barriers to people with disabilities and transgender people exercising their right to vote, (e) promotion of the creation of a National Registry of crimes related to sexual orientation, gender identity or ethnic-national origin and (f) incorporation of provisions that address the specific situation of trans women into the general law on women's access to a life free from violence and in to the General Act on Equality between women and men.

Almost all Mexican states have legislated on equality and non-discrimination and almost half of them have laws which refer specifically to gender identity. Mexico City's local regulations go further and guarantee transgender people's right to health, as well as issuing official documents according gender identify. In 2009, a new Health Law was implemented in Mexico City giving the local Ministry of Health the facility to develop a specialised programme for the sexual attention of transgender people through the supply of hormones, psychotherapeutic support, and implementation of preventive actions and appropriate medical treatment to STI and HIV/AIDS, when appropriate (Mexico. Procuraduría General de Justicia del Distrito Federal, 2010). In 2011, regulations derived from this law were introduced; they specify that persons requiring medical care due to sex-gender reassignment must have access to psychological therapy comprising: (a) counselling on social acceptance and gender identity, (b) individual and group psychotherapy and (c) adequate information on hormone use, HIV/AIDS and other STIs (Mexico. Distrito Federal, 2011). Completing the legislative triad, in 2012, the Centre for Comprehensive Care and Prevention of HIV/AIDS in the Federal District was empowered to develop guidelines for the effective delivery of services described above (Mexico. Distrito Federal, 2012). These services are delivered by the Specialised 'Condesa' Clinic, the first public institution in Mexico to provide to transgender people with free hormonal treatment and other specialist medical treatment. According to information provided by the Clinic, it has treated 1,300 cases under the programme to date, of which 800 are were active cases at the time of writing in 2015.

Regarding laws and regulations related to gender identity and personal status in Mexico, there is not a criminalising law, neither legal restriction related to access to services and, at least in Mexico City, people are allowed to change their documents of identification. Mexico City has recently introduced a new imitative to reform the Civil Code and Civil Procedure to modify birth certificates through an administrative proceeding that is currently under discussion. This initiative is intended to correct the 2008 law, which presents two major obstacles to this process in that a judicial order and two medical examinations are required. The new initiative will lead to legal recognition of the gender identity of transgender people after some purely administrative procedures; this will expedite the production of the documents that allow individuals access to a variety of rights recognised by international treaties and in national and local regulations, for example, voting cards (the main form of official identification in Mexico), passports and professional certificates. Although *muxes* and other Mexican trans communities are entitled to use Mexican City's services to change their identity documents, for many people the distance and cost of travel present serious practical barriers to doing so (Mexico. Secretaría Ejecutiva del Mecanismo de Seguimiento y Evaluación, 2014) (Table 1).

Discussion

In this review, we have seen that *travestis, hijras and muxes* have similar experiences with respect to stigmatisation, marginalisation, lack of civil rights, healthcare disparities (HIV, STI, for example) and poor access to health services (Amorim et al., 2013; García Becerra, 2009; Mirandé, 2014; Nanda, 1985). However, gender identity development and the way individuals relate to their body (including genitals) varies according to culture since there is diversity in the way the transitioning process occur. Transsexual identities encompass people who consider themselves non-male and/or non-female, such as many eunuchs (Brett, Roberts, Johnson, & Wassersug, 2007; Johnson, Brett, Roberts, & Wassersug, 2007; Wassersug & Johnson, 2007).

Using examples from different cultures, such as *travestis, hijras* and *muxes*, it is possible to show that gender identities can be fluid, and that rigid definitions of subpopulations are artificial although they facilitate appreciation of the public health needs of the groups concerned (Reisner, Lloyd, & Baral, 2013).

The focus of research seems to be transgender people who want SRS. Most studies of *travestis, hijras* and *muxes* are epidemiological studies focusing on STIs, substance abuse, psychiatric comorbidity and social prejudice and are based on convenience samples. A significant number of papers originating from Latin America are related to public health policies for the transgender population (Amorim et al., 2013; Aran, Murta, & Lionco, 2009; Muller & Knauth, 2008). These papers differ from research on clinical aspects of transgender conditions, but their main focus seems to be on the psychosocial vulnerability of affected individuals and the importance of implementing interventions to meet their needs. Most of the articles conclude that there is currently a dearth of such policies

Table 1. A cross-cultural comparison of a Travestis in Brazil, Hijras in India and Muxes in Mexico.

	Travestis	Hijras	Muxes
Features	The *travesti* is a man in anatomical and physiological sense, but relates to the world as a woman. Usually, her body is shaped with feminine forms. The striking feature of Brazilian *travestis* is their claim towards androgyny, and not just social recognition as female gender, distinct from assigned sex at birth. A *travesti* presents herself as a woman, sustaining a female gender identity, but may come to assume male sexual practices. Most of them do not wish to undergo a reassignment sex surgery	Hijra is an institutionalised third gender role in India. They claim to be neither male nor female, but contain elements of both. Some may undergo a testicles and/or penis castration without the creation of a neovagina	They are a unique group of indigenous men who openly dress in female Zapotec attire and have been described as a third gender. Many have long hair, apply makeup and some may also have gone under certain procedures to have a more feminine phenotype as having had their breasts enhanced, nose jobs
Human rights	• The Brazilian Legal System does not *clearly* mention transgender persons (including *travestis)* as having any specific rights; however, the lack of any explicit allusion has not prevented the recognition of transsexuals' rights on the part of the Legislature • There is a Draft Bill of the Statute of Sexual Diversity (Dias, 2011), and a Bill of Law n. 5002/2013 • Name changing can be required but depends on the judge appreciation	• This population's ('third gender') rights have recently been guaranteed by the Supreme Court of India in 2014, which guarantees equal rights, non-discrimination and autonomy	• In Mexico City, there have been some more advanced initiatives than in the rest of the country. Although there is a national programme for equality and non-discrimination, which includes health promotion, the right to change one's name and sex on documents, and criminalisation of intolerance to any differences
Social stigma	• This population is generally socially excluded, even rejected by their families, usually are underemployed and get informal jobs, or are sex workers	• Hijras are considered to have a social-religious position, out of the family, as capable of blessing with good luck or cast a spell of bad luck or curse • Hijras have been harassed and ostracised by society and their families • Till before the Supreme Court judgement they could not vote. The judgement suggests that they should be given the right to vote. The impact of the judgement is to be seen	• They assume traditional female roles and are widely accepted by the community • However, *muxes* have been traditionally considered as servants or prostitutes, friends enliven the festivities, and sons destined for singleness and care of parents
Access to health services	• Ministry of Health Directive 2803/2013 redefines e broadens the transsexualising process, which includes *travestis* • Although the State provides healthcare to *travestis*, most of them consider the services unsuitable to their needs, including unprepared professionals regarding transgender issues and discriminatory attitudes within the services. Therefore, some *travestis* seek alternative care, sometimes of religious background	• India has no legal restriction related to access to health services; however, dedicated health services for transgenders are not provided in the public healthcare system • The Hijra emasculation operation, which consists of removal of the penis and testicles (without construction of a vagina), is often carried out by seniors of the Hijra community itself and can be attended by considerable morbidity	• Only one clinic in the public healthcare system located in Mexico City (Specialised 'Condesa' Clinic) covers specialised treatment for adult transgenders, including hormonal treatment and psychotherapy, but not reassignment surgeries. Surgeries are only performed in private settings by urologists and plastic surgeons (Monterrey, Guadalajara and Mexico City)

and a lack of ethical commitment to sexual diversity (Spirrizzi, Azevedo, & Abdo, 2011). Studies on the cultural aspects of the third gender were more common in India than in Brazil and Mexico (Altaf et al., 2012; Reddy, 2005).

Clearly, in Brazil, India and Mexico, public services for the third gender and the 'transsexualising process' are still very scarce and inadequate to the heavy demand from potential users (Miano & Gómez-Suárez, 2009). Although all three countries have used legislation to promote provision of comprehensive healthcare services for third gender and trans persons, there is still strong resistance to implementation of such laws and policies (Muller & Knauth, 2008). The existence of laws does not guarantee that their provisions will be implemented and it is vital that governments intervene to ensure that rights that have been formally secured can, in practice, be exercised.

The rights guarantee is neither an isolated issue nor a quarrel confined to trans militants, but intrinsic to the struggle for human rights, in line with the Declaration of Human Rights which state that 'all human beings are born free and equal in dignity and rights' (United Nations Human Rights Office of the High Commissioner, 2012). A society's respect for sexual diversity reflects its level of education and political maturity. Brazil, India and Mexico face a huge challenge to become countries where human rights are respected (United Nations Human Rights Office of the High Commissioner, 2012).

Limitations

This kind of review approach has limitations, in particular the lack of a systematic literature search and lack of objective criteria for selecting articles for review. In this case, the selection of articles retrieved by specialists in three different countries suggested a scarcity of epidemiological and field studies, and a strong strand of research focusing on the political debate surrounding 'third gender' populations. It was therefore difficult to select a suitable sample of studies for comparative analysis and so a narrative approach to review seemed most appropriate. The authors do not have the intention to conduct a complete literature review nor to provide a systematic review on the issue, but to provide an overview with focus on travestis, hijras and muxes who have many characteristics in common, socially, politically and in healthcare needs.

Implications for clinical practice

Health and social institutional services need to be sensitive to individuals who may be sexually variant. Those providing services need to work for ban negative attitudes as well as prejudices to ensure that services are friendly accessible (Kalra, Ventriglio, & Bhugra, 2015). Training for healthcare workers should be expanded to help them to welcome transgender individuals into health services, to deliver sex education programmes and to promote awareness of gender variations among the general population to achieve a cultural shift towards greater tolerance of gender diversity (Muller & Knauth, 2008).

Implications for future studies

The expansion of research on these populations would help to increase the understanding of how societies and cultures deal with gender variance issues. Comparative research on the clinical features of trans phenotypes would lead to greater understanding of the complexity of gender identity, which might contribute to a reduction in the stigma associated with non-standard gender identities and the active promotion of the human rights of individuals with such identities.

Conflict of interest

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