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Understanding The Physiological Knowledge Of The Third Gender Community From Their Perspective In The State Of Maharashtra And A Comprehensive Information Of Their Physiological Characteristics

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Abstract
In The Last Ten Years, Several Countries Have Developed A Third Gender Classification To Formally Classify Individuals Who Are Sex Incongruent. However, Little Is Known About How Individuals Who Identify As Non-Conforming Genders React To The Legal Categorization Of Third Gender. In An Attempt To Close This Gap, This Paper Analyses Fundamental Understanding Of The Psychological Aspects Of The Third-Gender Community. Human Cells Have 23 Pairs Of Chromosomes, And The 23rd Combination Determines The Sex Of The Child. Male Sperm Can Have Either The Y Or X Genome, But Only The Y Chromosome Confers Masculinity. Female Eggs Contain Only The X Chromosome, Giving Birth To Feminine Traits. When A Standard DNA Is Produced, XX Couples Produce Female DNA And XY Pairs Produce Male DNA.

In Some Cases, The "X" Chromosome Of The Ovary Multiplies, Or The Sperm Releases An Abnormally Large Number Of "X" Or "Y" Chromosomes. Despite Displaying Both Male And Feminine Traits, The Newborn With This Anomaly Is Initially Classified As Male. (Hermaphrodite). A "Third Gender" Child Is One Who Is Born Either Male Or Female, And With Ambiguous Genitals But Subsequently Attempts To Transforms Into A Female. It Is A Significant Setback For The Third Gender When Society And Families Discover That A Person's Gender-Related Identity, Appearance, Or Behaviour Is Independent Of Their Assigned Sex At Birth. Family Members Despise Such Transition And Try To Suppress The Strange Behavior, But The Third Gender Changes Their Bodies To Appear As Much Like The Preferred Gender As Possible. They Reject Their Family And Align With The Third Gender Group In Order To Alter Their Anatomy And Live The Life They Want. This Paper Will Look Into How The Third Gender Responds And Is Aware Of Their Physiological Capabilities And Knowledge In The State Of Maharashtra. The Findings Will Emphasize The Molecular Understanding Of Gender Nonconforming People's Ignorance And Uncertainty Through Academic Curriculum And Alsosecondary Statistics On Sex Development Disorders, Chromosomal Anomalies, And Other Sexual Anomalies Related To Gender Will Be Traced Out.

Key Words:*Hermaphrodite, Chromosomes, Third Gender, Physiological Characteristics, Psychological Awareness*

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I. Introduction

Their faces are their assets. Caked in inexpensive red lipstick, kajal, perfume, neon color nail polishes, and makeup, they dress in unfitting revealing blouses and colorful saris in a grotesque womanhood parody as they wander the crowded marketplaces in groups, terrorizing people, hustling for ten or hundred rupees. These aren't the average street beggars. With masculine voices yelling expletives, palms meeting cross-ways in a trademark clap, they prey on vulnerable passers-by, who will part with their money sooner than be handled to the group's gaze jointly raising their saris and showing castrated genital areas straight in their faces. India is today the only nation in which the Hijra tradition prevails, although their function in life has dramatically shifted from that of royal servants, confidants and colleagues. Hijras as they are known, have become something to be feared. No one likes to be accosted by one of them-be pushed with their hips, rubbed on the cheek, taunted, shouted and flashed.

Indian Hijra, which is known as the Third Gender (TG) globally, is considered physically and psychologically ambivalent. Due to this ambivalence people consider them anomalies (hiding their sexual identity). They are physically, verbally, and sexually abused and have been stigmatized and marginalized. Indian society has made distinct differentiation since the ancient India to the present day between Hijra and predefined gender category. The term Hijra embodies a wide range of identities, appearances, and behaviors that blur and cross the biological gender lines in India, (Kalra, 2012).

Hijras are physiological males who have a feminine gender identity in most cases; they adopt and relate to the feminine gender role, and wear women's clothing. They do not comply with standard male or female gender concepts, but merge or move between the two. Mainstream society has historically overlooked their vulnerabilities, frustrations, and insecurities. They are therefore a marginalized and stigmatized community. On the other hand, in an evolving relationship framework, marginalized masculinity is explained by specific reference to the set-up of practice generated in a particular situation. The Hijra assert that the mainstream society does not understand their culture, gender, mentality, and sexuality. In the development society, dimensions of their social deprivation and harassment have never gained Page 2 attention. There are many legends, rituals, religious roles, and themes in Hinduism, which entertain the notion of ―sexually ambiguous or dual gender manifestations‖, (Jami, 2005).

If it can be understood that hijras are clearly not men by virtue of anatomy (physiology), appearance, and psychology, they are also not women, though they are "like" women. They imitate or acquire the female dress and their mannerisms are often exaggerated almost to the point of falsification. They act in sexually evocative ways that would be considered unfitting, and even outrageous, for ordinary women in their significant and traditional female roles as daughters, wives, and mothers. Most recently, the picture has changed. What is currently evolving is a transgender movement and community that appears to be in the process of not just creating a third gender, but multiple gender identities, within the Euro-American gender system.

The transgender movement views gender and sex as improperly imposed by society and its "sexual identity gatekeepers," that is, the mental health professionals just referred to (Bolin, 1996a:447) transgenderists challenge and stretch the boundaries of the American bipolar system of sex/gender oppositions, and renounce the American definition of gender as depending on consistency of genitals, body type, identity, role behaviors, and sexual orientation. In India, too, the definition of the hijra indicates that male genitals are an essential defining criterion of a man. A man who dresses and acts like a woman is still a man; unless he has had his genitals removed he is "only" a man impersonating a woman, a jankha, not a hijra (see Cohen, 1995). But sexual and reproductive capacity is also important in defining who is man and who is woman: In India an impotent man (whatever the source of his impotence) may be labeled a eunuch. Because hijras do not have reproductive capacities as either men or women, they are neither men nor women. This definition of a third sex or third gender as an impotent male has a long history in India, both in Hinduism and other religions, such as Jainism (Zwilling & Sweet, 1996, 1998).

In some cultures, however, it is not the genitals, nor the reproductive capacity of a man that is central in defining alternative gender roles.

II. CONTEMPORARY PERIOD

The third gender in India is possibly the most well-known and popular third type of sex in the modern world. The Supreme Court of India declared for third gender as third gender. The thirdgender in India has emerged as a powerful group in LGBT rights. In contemporary times,India's government introduced so many welfare policies and schemes such as census, documentation, issuance of citizenship ID cards, issuance of passports, social-economicgrowth, and constitutional safeguards for third gender individuals. The Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) is a major initiative of the 11thFive Year Plan period, which brought employment opportunities for third gender people. The Ministry of Housing and Urban Poverty Alleviation is the National Urban Livelihood Mission and Healthcare facilities. The social, economic, political transformation, Housing, legal measures, Police Reforms, legal and constitutional safeguards to prevent human rights violations of the third gender community and institutional mechanisms to address specific concerns of third gender people.

Through, the third gender community was given high position in Mughal period and facing many problems obstacles in British colonial rules. But now to safe guard the third gender communities there are many policy and schemes implemented by the government. Through this social economical status of the third gender community will be developed. The government should be eradicated the stigma, discrimination and human rights violation for the betterment of third gender community. If all this were brought in their day-to-day life, it would enlarge the growth of third gender community in India.

III. THIRD GENDER IN INDIA

The Indian Census has never acknowledged third gender while gathering census information for years, but in 2011, third gender information were gathered with information of their jobs, literacy and caste. In India, total population of third gender is around 4.88 Lakh as per 2011 census. The data of third gender has been clubbed inside "Males" in the primary data released by Census Department. For educational purpose, separate data of third gender has been curved out from that. The 2011 Census was the first major census accounting of third gender persons in India. It showed us that over 490,000 third gender individuals live in the country, with Uttar Pradesh ranking first with 137,465, Bihar second with 40,827, Andhra Pradesh third with 43,769 and Maharashtra fourth with 40,891.

IV. GENDER IDENTITY CONFLICT

Most individuals experience their gender identity as being correlated with or in line with their physical sex. However, for a transsexual individual there is a conflict between one's physical sex and one's gender identity as a man or a female. Female-to-male transsexual people are born with female bodies but have a predominantly male gender identity. Male-to-female transsexual people are born with male bodies but have a female gender identity. Many, but not all, transsexual people undergo medical treatment to change their physical sex through hormone therapy and sex reassignment surgeries.

At least one in every 2000 children is born with a sexual anatomy that mixes male and female characteristics in ways that make it difficult, even for an expert, to label them male or female. Although no one is ever born with two complete sets of genitals, male and female, some intersexed babies may have ambiguous genitals, such as a "too tiny" penis or a "too big" clitoris. The “unusual” growth of a feminine boy or masculine girl is not tolerated in schools, family, and society where the informants often encountered a hostile environment for

incompatible sex-gender roles and attitudes. They often experienced loneliness and abusive treatment. Unable to adapt within hostile civic environments, most became reluctant to continue schooling. Deprived from family, school environment, and neighbors the informants reported that, as Hijra, they were often told that their attitudes, body gestures, and behaviors were unlike other boys or girls. The informants became confused about their sex-gender alignment. Many Hijra claimed to have a soul of a female trapped in a male body. One Hijra described with metaphor, meaning that the Hijra have penis like men and breasts like women to show that they are not males or females but a blend of both.

Influenced by predominant norms and values of society and societal "decorum," their human dignity and self-esteem were diminished. They feel themselves worthless and unfit to society searching a place where they live peacefully. Therefore they want to leave their family. This choice to leave home was completed when they became strongly linked with female male colleagues where they were psychologically, sexually, and socially fit. When a Hijra met a Hijra guru and became a Chela of that guru, he found a place to live. At the time of their dubious feeling, they cannot accept their gender differentiation properly. Due to mental stress, some of them attempted suicide where others get mental satisfaction.

Dr Piyush Saxena in his book titled Life of a Eunuch, 2011 an explorative work, in the chapter Disorders Of Sexual Differentiation he extensively discuses genitalia and identity crisis; the state of being neither male nor female can be understood with respect to the biological sex, gender role, gender identity or sexual orientation of the individual. Gender identity in sociology defines the gender with which an individual defines him / herself, i.e. whether he / she sees him / herself as a man, a woman or defines him / herself based on other parameters, e.g. clothing, hairstyle, etc. In most instances, it is simple to determine sex and gender. Based on our biological gender, we are either male or female. Until a millennium ago, the sex of a person would be completely determined by the genital appearance, but as chromosomes and genes came to be known, these were the words used to assist to determine sex.

Gender identity formation is a complicated method that begins with conception but includes critical mechanisms of development during gestation and even after its experiences after birth. He further mentions that even though there are some differentiation points along the path, but in many cultures, language and tradition individuals are categorized as male or a female. Society assigns a particular class and social roles to male and female as per their sexes are perceived. The connection between gender identity and the gender is unclear in some cases. Society assigns some classes of social roles to male' individuals and some classes of social roles to female' individuals (as their sexes are perceived). The link between gender identity and the role of gender is sometimes uncertain. It can be simplified and said that there exist male and female human beings who categories as unambiguous.

V. LITERATURE REVIEW

The present paper focuses on delineating the theoretical frames within which the analysis of third gender identity locates itself. This process requires an excursion into the varied historical and cultural representation of third gender people whether in the ancient, medieval, colonial, or contemporary context. The paper has explored the role of the third gender people as an alternative gender category and examines what it means to be neither man nor woman in the context of Indian culture- a culture in which third gender roles and gender transformations are important mythological themes and real life possibilities. Later,it gives a detailed account of third gender people's emasculation ritual and its importance in the life of a third gender, mainly based on the secondary sources.

The works of Serena Nanda, Gayatri Reddy, Rekha Ojha, S.K. Sharma and others were very helpful. Hijras traces their origins to myths in the Ramayana and the Mahabharata while Rama, was leaving for the forest upon being exile from the kingdom for 14 years, he turns around to his followers and asks all the `men and women'

to return to the city. Among his followers, the hijras alone do not feel certain by this direction and decide to stay with him. Rama, impressed by his allegiance, gave them the authority to bestow blessings on individuals at favorable times, such as birth and marriage, as well as on inaugural celebrations. This laid the stage for the badhai custom of hijras singing, dancing and giving blessings. The legend in the Mahabharata is that Aravan, the son of Arjuna and Nagakanya, offers to be sacrificed to Goddess Kali to ensure the victory of the Pandavas in the Kurukshetra war. The only condition that he made was to spend the last night of his life in matrimony. Since there was no woman who was willing to marry the one who was destined to be killed Krishna adopted the form of a beautiful woman called Mohini and marries him. The hijras of Tamil Nadu consider Aravan their progenitor and call themselves aravanis.

Reddy (2006) studied a very simple point: the notion that sexual difference is not the only lens through which hijras perceive the world and expect in turn to be perceived. In other words, hijras are not only a sexual or gendered category, as is commonly contended in the literature. The axis of sexual difference through which hijras have traditionally been understood is intersected by a variety of other axes of identity, including religion, gender, kinship and class. He further stated that the social structure dictates an unquestioned binary role for its members, i.e. male and female, and groups all others' into the category of Hijra.

VI. THIRD GENDER: NEITHER MAN NOR WOMAN

Saxena, 2011, in his book 'Life Of A Eunuch' seeks to find solutions to some of physiological problems while objectively examining those that society as a whole finds difficult to address. It addresses the fundamental question of how this complicated situation of neither man nor woman came to be in the first place, the underlying physical causes of the issue, and how to recognises the problem in order to acknowledge it and maybe take action. Following that, his study primarily focuses on the many facets of gender transformations, including the medical treatments needed and the financial effects of such transitions. He states that "If the rest of us abandon prejudice and criticism and finally accept them as "one of us," it help us", look into their substantial societal duties. In the same manner that we accept and empathise with the deaf, stupid, blind, and lame, we do not do the gender-deprived who do not even have a family, which is the unit of love, care, and devotion that is most vital for human life."

O'Flaherty (1980) studied that the view of hijras as an ―in between gender begin with their being men who are impotent, therefore not men, or as aptly puts it, ―As eunuchs, hijras are man minus man. However, Nanda (1999), further stated that, being impotent is only a necessary and not sufficient condition for being a hijra. Hijras are men who are impotent for one reason or another and only become hijras by having their genitals cut off. The core meaning of the hijra role centers on the aberrant male genitals, as stated by a third gender (hijra) respondents in Jammu region, who on being asked, ― "Who is a hijra?" has showed the mutilated genitals of a 4 year old child living in their dera. Hijras' expression of what they are, often take the form of stating that they are in-between, neither man nor women, but the term hijra itself is a masculine noun suggesting, as does the word eunuch, a man that is less than perfect man as has been stated by Nanda (1999) in her study.

Nanda (1999), stated that in Indian society, the hijra, as an impotent man, is ―useless, an empty vessel, and fit for nothing‖because he cannot reproduce. However, in Hindu mythology, their Sexual ambiguity or impotence can be transformed into the power of generativity through the ideal of tapasaya, the practice of asceticism. Tapas, the power which results from ascetic practices and sexual abstinence, becomes an essential feature in the process of creation. In one of the version of the Hindu creation myth, Shiva carries out an extreme, but legitimate, form of tapasaya, that of self-castration. Brahma and Vishnu had asked Shiva to create the world. Shiva agreed and plunged into water for a thousand years. Brahma and Vishnu began to worry, and Vishnu told Brahma that he, Brahma, must create and gave him the female power to do so. So Brahma created all of the gods

and other beings. When Shiva emerged from the water, and was about to begin the creation, he saw that the universe was already full. So Shiva broke off his linga (phallus), saying, ―there is no use for this linga‖ and threw it on the earth. His act results in the fertility cult of linga and worship, which expresses the paradoxical theme of creative asceticism. Consistent with the paradox of creative asceticism, it is the castrated phallus that is the embodiment of creative tapas is associated with Shiva. The falling to earth of Shiva's linga in castration does not render him asexual, but extends his sexual power to the universe.

VII. CONCLUDING REMARKS

Reviewing the third gender literature in search of areas in need of more investigation was the goal of this study. In the medical world, we have changed our perspective from one where we saw third genderism as a mental illness to one where we now consider it as a variation of normal. Though there is still work to be done in terms of healthcare education and stigma reduction, third gender healthcare has seen significant advancements in the medical community from a clinical perspective. However, from an academic perspective, the medical field is suffering from a dearth of published data on the care of third gender patients and outcomes associated to this care, especially in core medical publications. This is probably due to a shortage of submissions from physicians who are also researchers as well as a general dearth of high-quality research. Our analysis shows that there are very few studies that examine long-term consequences, and the majority of the published material is not primary research. While we understand that such study designs are not always practical or ethical, carefully designed studies will eventually be the driving element in shifting the discipline towards a more evidence-based paradigm of medicine. This, combined with longer patient follow-up and more prospective trials, will improve our overall quality of research and allow us to better care for third gender.Thus, this articles discusses about the third gender as neither man nor woman and brings out the reasons for which third gender people are not considered as complete man or woman.

VIII. DISORDERS OF SEXUAL DIFFERENTIATION ACADEMIC CURRICULUM

In order to obtain the fundamental degree of MBBS in India, a student must enter a medical college after completing 10+2 years of study. The majority of students are first exposed to this information at the MBBS level; neither the majority of school nor junior college curricula during this 10+2 stage provide any knowledge about sex, sexual orientation, or disorders. "Disorders Of Sexual Differentiation" are a topic covered in the Anatomy, Physiology, and Medicine courses for the MBBS programme. Additional information is covered in surgery and gynaecology courses as well as those for the MD in medicine, MCh in urology and plastic surgery, and DMC in endocrinology. However, because eunuchs often do not seek their help with hormonal difficulties, there is little interest among potential medical practitioners. The lack of adequate medical treatments and poverty are the key factors contributing to eunuchs' lack of interest.Academic Curriculum: 24 Sexual Differentiation Disorders Academic Curriculum 301, the goal of this book is to provide readers with a general understanding of these diseases and disorders in order to create a framework within which the most significant social and other issues affecting the eunuch community should be addressed, disorders related to a third gender are listed below for knowledge.

IX. AMBIGUOUS GENITALIA - GENETIC CAUSES

All fetus have a non-specific genitals up to 8 weeks when conceived. In an XY foetus without Androgen Insensitivity Syndrome (AIS), the non- specific genitals develop into male genitals under the influence of male hormones (androgens) and female genitals in its absence. In AIS, the child is conceived with male (XY) sex chromosomes. Embryonic testes develop within the body and begin to supply androgens that cannot complete the

male reproductive organ development because of a rare inability to use the androgens that the testes produce thus internal genitals continue to develop along woman lines. However, another secretion (Anti-Mullerian hormone or AMH) created by the foetal testes suppresses the event of feminine internal organs. Thus, someone with AIS has external reproductive organ that in Complete AIS (CAIS) are fully female or in Partial AIS (PAIS) are partially female. Internally, however, they are testes rather than a womb and ovaries. In regarding two-thirds of all cases, AIS is transmitted from the mother, where as in the other third, there's a spontaneous mutation within the egg. The mother of the fetus, who doesn't have AIS, however has the genetic error for AIS on one of her X chromosomes, is termed a carrier.

X. AIS - CAUSE AND TREATMENT INTERSEX AND ANDROGEN INSENSITIVITY SYNDROME

Androgen inability Syndrome (AIS) is one a biological intesex/hermaphrodite conditions. It could be a variant from the standard embryological development of the reproductive tract, typically determined by a noted genetic mutation. It‘s a condition that affects the event of the procreative and reproductive organ organs. Sometimes, a baby is born with reproductive organ that can't be classified as either female or male. A genetically female offspring (with XX chromosomes1) is also born with external genital organ that seem to be those of a standard male or a genetically male child (with sex chromosome chromosomes) is also born with external genital organ that look feminine. In terribly rare cases, a baby is also born with each female and male genitalia. As a result of these conditions are in a sense in-between‘ the two sexes, they're jointly observed as Intersex‘. Intersex is that the gray area between the sexes, wherever there's a major presence of the characteristics of the other sex, in either a male or a female. This presence is critical enough to cause the sufferer to not want to belong to either the male or female gender cluster or be classified as either gender, typically at great cost and hardship to him/her.

The term intersex‘ refers to the elements of this complete alignment (the sex chromosomes, the gonads and therefore the reproductive organ) and not simply to the looks of the external genitalia. A patient with the entire type of AIS (CAIS) or with Swyers Syndrome (XY gonadal Dysgenesis) can perpetually seem outwardly feminine (no ambiguity) however she remains intersexed as a result of she has XY chromosomes and internal testes (testicular streak gonads within the case of Swyers) that are at odds together with her external femaleness.

FOETAL DEVELOPMENT

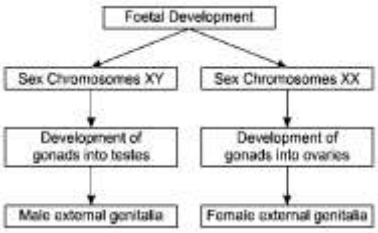

Fig.1FoetalDevelopment

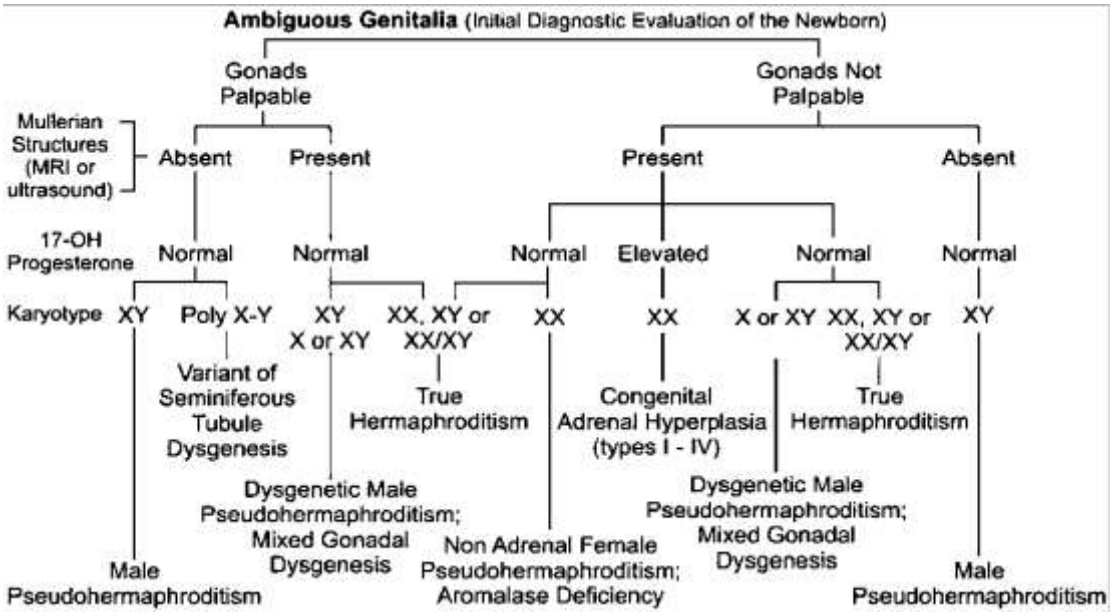

Fig.AmbigousGenitalia

Male foetuses typically have a Y chromosome that initiates the formation of testes (and the suppression of female internal organ development) throughout gestation. Testes are the sites of production of masculinizing hormones (specially androgens) in massive quantities.

Masculinization is an active process; it wants the positive or active intervention of the male hormones so as to require place. If these male hormones are either absent or the tissues don't respond to them (as happens to differing degrees within the numerous kinds of AIS), then the passive tendency is for the external reproductive organ to differentiate into feminine external organs that are indistinguishable from those of normal girls, within the complete variety of AIS. This female physical development isn't due to the presence and influence of female hormone estrogen however to the powerlessness of androgens.

In alternative words, the inherent trend for any foetus is to develop feminine external privates and general body type, within the absence of the masculinising effects of male hormones. Both male and female foetuses have a minimum of one X chromosome that contains a factor that provides their body tissues the capability to recognize and react to androgens. At puberty, ladies react to the relatively little amount of androgens (that return principally from their adrenal glands) by developing pubic and underarm hair and dark pigmentation round the nipples. Individuals with AIS have a functioning Y chromosome (and thus, no feminine internal organs) however an abnormality on the X chromosome that renders the body fully or partly incapable of recognizing the androgens produced. in the case of CAIS, the external reproductive organ development takes a female type. In the case of PAIS, the external reproductive organ look might lie anyplace on the spectrum from male to feminine alternative connected conditions, ensuing from changes on totally different chromosomes, additionally disrupt the traditional pathway of androgenic hormone action, resulting again in a feminised composition (body form). Thus, individuals with these XY conditions‘ might determine as feminine, intersexed or male.

SEX DETERMINATION - HUMANS

XX-XY sex determination

SRY gene on Y chromosome determines maleness

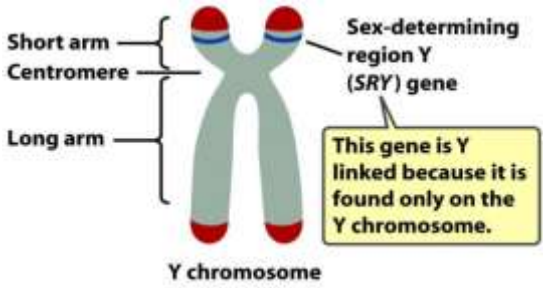

Fig.SexDeterminationof humans

ROLE OF SEX CHROMOSOMES - HUMANS

- X includes vital gender genetic info
- Male determining gene on Y Choromosome – Even if multiple X's, still male
- Absence of Y results in female
- Genes influencing fertility – on both X and Y
- 2 copies of X needed for female fertility
- Additional X may upset normal development in both male and female

SRY – SEX DETERMINING REGION Y

- Rare males with XX?
- Small piece of Y attached to another chromosome
- Y chromosome becomes active at week 6
- Gonad tissue develops into testes
- Produce testosterone and Mullerian-inhibiting substance
- SRY codes for protein that binds and bends DNA
- Affects expression of genes encoding testes formation
- Other genes also essential for fertility and sexual features

AMBIGUOUS GENITALIA

Clear genitalia, or atypical genitalia, is a birth defect in sex growth (or birth variety), which leaves it uncertain if an impacted child is a woman or a child.It happens roughly once every 4,500 births. A mixture between the females and the males seems to be present for the baby-for example; both vulvas and testicles can be present. The intersex circumstances associated with masculine children include hypospadia in which the urethral opening is in an exceptional situation, such as the base of the penis.A big (penis-like) clitoris in baby girls or undescended testicles in boys can characterize mild types of ambiguous genitalia.

TYPES OF AMBIGUOUS GENITALIA

The different types of ambiguous genitalia include:

- The baby has ovaries and testicles, and the external genitals are neither clearly male nor female.
- The child has ovaries, a penis-like structure or phallus.
- The infant has undescended testes and has external female genitals including a vulva.

CAUSES OF AMBIGUOUS GENITALIA

The' message' of gender has to be transmitted from sex chromosomes to gonads in typical genital growth. The Gonads must then create adequate hormones and the genital tissues and structures must meet these hormones. Differences along the manner can trigger ambiguous genitals. Some particular causes include:

XI. ANDROGEN INSENSITIVITY SYNDROME (AIS)

A genetic condition characterized by the fetal tissue's insensitivity to male hormones. This affects genital development. A newborn, for example, may have some of the female reproductive organs but also testicles. Appear as normal females – but XY
– Lack uterus, oviducts and ovaries
– Abdominal cavity testes generate masculine testosterone levels
– Androgen receptor is defective so cells insensitive to testosterone –
develop female characteristics
– Gene for receptor- on X inherited maternally
– Genes for most secondary sex characteristics on autosomal
chromosomes – key in control of expression

CONGENITAL ADRENAL HYPERPLASIA (CAH) - An hereditary disease that impacts hormone production. A kid with CAH lacks specific enzymes and this defect causes excessive production of male hormones. For instance, female genitals are masculinized.

SEX CHROMOSOME DISORDERS - A child may have a combination of both ('mosaic' chromosomes) instead of getting either XX or XY sex chromosomes; or particular genes on the Y chromosome may be inactive; or one of the X chromosomes may have a small Y section connected to it. Research at Los Angeles University of California (UCLA) shows that splitting the sex chromosome of a specific gene (named WNT-4) can create ambiguous genitalia. This change is likely to interfere with male sex so a genetically modified male child appears to be female.

MATERNAL FACTORS - the pregnant mother may have had an androgen secreting tumor while pregnant, and the excess of this male hormone affected her baby's genital development. In other cases, the placenta may have lacked a particular enzyme, which failed to deactivate male hormones from the baby as a result, both the mother and the female baby were masculinized by the excess of these hormones.

DIAGNOSIS OF AMBIGUOUS GENITALIA

There are presently no prenatal tests capable of detecting ambiguous genitalia. American study into the WNT-4 gene indicates that one day a prenatal test could be created. Tests conducted at birth to determine the gender of the baby may take about one week and may include:

- physical examination
- hormone tests using blood, urine or both
- genetic tests using blood, urine or both
- ultrasound scan and x-rays.

XII. TREATMENT FOR AMBIGUOUS GENITALIA

PARENTAL COUNSELING - successful sex assignment and identity for the child depends largely on the attitude of the parents. It is essential that both mother and father are completely aware of the situation of their child. Support groups may provide help in this area.

SURGERY - However, the assignment of surgical gender relies strongly on the genital structures with which the surgeons must operate. There may be some operations, typically started in the first year of the child. Additional operation during adolescence may be necessary. Some intersex support groups do not always feel that surgery is the solution, especially when the child's gender is not apparent. Others indicate that surgery should wait for the child to decide for himself. Most medical experts, however, support early surgery and hormonal intervention in order to obviously establish the gender and feeling of belonging of the child in society.

COUNSELING FOR THE CHILD - the child needs to be informed and talked to about their diagnosis in a very careful way.

HORMONE THERAPY - The child may need a hormone supplement treatment to assist with puberty during its adolescence years. A child with CAH will need regular hormone therapy

POSSIBLE LONG-TERM PROBLEMS- Some of the potential issues a individual born with ambiguous genitalia may face may include:

- Infertility
- Problems with sexual functioning
- Feelings of insecurity and uncertainty about their gender identity

XIII. RESULT AND DISCUSSION

Hijras are individuals of third gender who do not fall into the established definitions of male or female. Physiologically, hijras could be born with ambiguous(hermaphrodite) genitals, male genitals or female genitals. Scientifically,abnormal levels of sex hormones duringcthe fetal development is said to be the main factor giving birth to Hijra. My study reflected that majority of 77.8 per cent respondents were not aware of the physiological causesof how a third gender is born. Similarly with further findings, a set of question were prepared to understand the knowledge of hormones, chromosomes and anomaly associated with sexual disorders and other concealed sexual disability. It was found that that majority of the (71.04%) respondents believe that a TG is born neither male nor female while 28.96 per cent respondents feel that born as either male/female and feels opposite to its gender assigned at birth but have non-functional genitals.

Further more to elaborate more, oestrogen and testosterone, the two primary sex hormones, have a variety of physiologicalconsequences. These hormones, which are largely produced by the ovaries (oestrogen) and testes (testosterone), have an impact on your bones, brain, and blood vessels in addition to your sexual function.“Sex Hormones and Your Heart.” Harvard Health, 1 May 2019. Testosterone is generated by gonads (by Leydig cells in men's tests and by women's ovaries), although tiny amounts are also generated by both sexes'adrenal glands. It is an androgen, which means it stimulates the growth of masculinefeatures.Thedistinction between gender identity disorder, where the individual thinks they were born in the incorrect gender, and sexdevelopment disorders is essential torecognize. This term covers a range ofbirth-related conditions where the development of one or moreanatomical, chromosomal or gonadal sex components is unusual, but the person generally does not feel that they were born in the wrong sex. Different anomalies may interfere with the operation of the testes. This may includestructural testing issues, male hormone testosterone manufacturing issues, or

cellularreceptorissues that react to testosterone.Estrogens are a set of sex hormones that encourage the growth and preservation of woman features in the human body. They play an important part in the growth and development of secondary sexual female features, such as breasts, pubic and armpit hair, and menstrual cycle and reproductive system regulation.Oestrogen produces an environment suitable for an early embryo's fertilization,implantation, and nutrition during the menstrual cycle.

According to the survey, only 40.30% of respondents said that testosterone is a sex hormone present in males alone, and only 7.70 respondents knew that oestrogen is a sex hormone present only in females, despite the fact that these hormones have important roles in both sexes and all of their activities. Given that the respondents completed high school before joining the hijra group in pursuit of acceptance and safety. They don't have the fundamental understanding of human anatomy that is taught in schools. The study found that majority of (79.6%) respondents think sex is Biological differences while 12.7 per cent respondents thinks that it is a natural phenomena while 7.7 per cent respondents states that sex is Biological differences as well as Chromosome profiling. From the above data it can be analyzed that majority of respondents think that Sex is only biological differences while very some respondents think that it is but it is biological as well as chromosomal profiling, while few respondents think it‘s it a natural phenomena. It can be observed that the respondents have a clear understanding of what sex means, which is nothing but the biological difference, i.e. the difference between genetics (chromosome profiling) and genitals.

Knowledge regarding the physiological aspects of the respondents Knowledge is the cognitive behavior of an individual. The body of knowledge is the product of learning process. Once the knowledge is acquired, it produces changes in the thinking process of an individual, which would lead to further changes in attitude and helps the farmers in making rational decisions. It is prerequisite for adoption of any innovation. With this view, attempt has been made to determine the level of knowledge of third genders about their physiological aspects (as to how and why they are born the way they have). Keeping this fact in view the data regarding level of knowledge of respondents towards physiological aspects were collected, analyzed and presented.

KNOWLEDGE REGARDING THE PHYSIOLOGICAL ASPECTS OF THE RESPONDENTS

Human body study dates back to ancient times but was not referred to as the "physiology" discipline until the 16th century by the French physician Jean François Fernel, who introduced the term to describe the study of bodily functions. Since that time, physiologists have contributed fundamental and critical information needed for the evidence-basedpractice of modern medicine. However, like all science disciplines, physiology and physiologists are not immune from political, societal and cultural developments and for many years except for research linked to reproductive physiology, most human and animal physiological surveys have enrolled male volunteers and used male animals.

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Overall Physiological Knowledge of the respondents

Level of knowledge	Frequency	Percentage
Low (1-7)	172	77.80

Medium (8- 15)	20	9.00
High (16-21)	29	13.20
Total	221	100.00

According to the above table, 77.80% of respondents in the low level category had the least amount of physiological knowledge, while 9.0% of respondents in the medium level category had a moderate level of knowledge, and 13.0% of respondents in the high level category had all of the necessary knowledge. It is obvious and understandable that the community is unaware of their physiological wellness. There are numerous reasons for this, but the most significant are the community's inability to walk freely to hospitals for checkups, their difficulty in finding a doctor who is knowledgeable about their problems and has the necessary resources,lack of financial support, and, most importantly, their refusal to accept the problem. In India, not many NGO who work for the third gender community place significant emphasis on increasing knowledge and awareness of the physiological problems and sexual disorders. If this is done, this community will be easily accessible for treatments and the community can be de-stigmatized.

This segment of the population has faced a slew of social, psychological, physiological, and medical issues. However,even though there is enough information available regarding their health and other vital issues, there is very less awareness and access in all types of educational institutions, hence most times people use the internet to research them and sometimes this information is biased and stigmatising.

XIV. CONCLUSION

The ever-changing, complex, and multi-faceted matrix of class, caste, religious, and regional identities and practices that underpin third gender people can be traced from ancient society to the shifting social and cultural landscapes of modernity and nationalism, and finally to contemporary neo-liberalism, where one can say that third gender people cannot be seen solely through the lens of gender and sexual difference because that is not how they understand themselves. Furthermore majority of the respondents are born male third gender which brings to the fact that this anomaly is common among the males, while there are 1/3rd of respondents been with ambiguous genitalia, which is a confirmation of the child being born as a third gender.It was further found that majority of the respondents had low level of knowledge about their physiological aspect i.e. (77.8%) respondents are not aware of the causes of how a third gender is born however. It can be evaluated that most respondents are uninformed about their anatomy and birth-related abnormalities as a third gender. The probable reason is that these are sexual disorders, some of which are recognizable soon after birth for families and are very distressing to acknowledge them. Genetic counseling is recommended. However, because of their poor socio-economic status and education, it is very difficult for respondents to understand the disorder. It is uncommon for any of the individuals to be familiar with a genetic disorder. Hijras face multiple forms of subjugation due to which there is extreme stigma associated with their biological profile due to which they are pushed into perpetual poverty and low standard of living.

LIMITATION OF THE STUDY

The study begins an investigation of research scholar has the following limitations:

1. The investigation's data gathering approach was primarily limited to personal interviews, and the conclusions were based solely on the respondents' verbally expressed opinions and reactions.
2. Respondents' responses aren't always illuminating or trustworthy, either. It's also possible that answers are provided without giving them much thought, and occasionally incorrect information is provided as a result of cultural stigma or a difference in perspective between the respondents and the investigator.

3. There is a paucity of transgender-related literature in the Indian setting.
4. Obtaining primary respondents for the interviews was one of the study's significant problems.
5. In order to comprehend the field circumstances, the researcher solely relied on the interview transcripts of both primary and secondary respondents.
6. Secondary sources, however, such as newspapers, websites, G.O.s, documentaries, scholarly books, journals, articles, and others, were helpful throughout the research study.
7. Primary respondents gave their full cooperation throughout the data collection process, but they were also extremely restless, taking frequent breaks and getting distracted.

SUGGESTIONS FOR BETTERMENT OF THIRD GENDER COMMUNITY

1. Inclusive approach for third gender must be planned and adopted by the Government and Society. Though, policies have been framed but are poorly implemented.
2. Focused approach should be there to provide protective shields to their problems.
3. Strict action must be taken against parents who neglect, abuse or leave their child because of their biological difference.
4. Provision of free legal aid must be ensured for the third gender community at ground level.
5. School and colleges need to play a supportive and encouraging role in providing education and value-system to Transgender.
6. Separate policies related to health care must be framed and communicated in all private and public hospitals and clinics.
7. Awareness programmes must be organized at mass level to outreach public and this community.
8. A comprehensive sex-education program should be incorporated in school curriculum and college syllabus to aware students at ground level.
9. Mental health professionals have an extremely important role for gender expansive amongst the youth and their (third-gender) families to help them navigate their experiences. Hence there is need of the intervention of Public Health and Psychiatric professionals to build a extensive policy to address the and safeguard the Mental Health of the third gender community.

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