Transgender and Hijra Communities

Pehchan Training Curriculum
MSM, Transgender and Hijra Community Systems Strengthening

Facilitator Guide

Transgender and Hijra Communities
Pehchan Consortium Partners

India HIV/AIDS Alliance (www.allianceindia.org)

*Pehchan Focus: National coordination and grant oversight*

Based in New Delhi, India HIV/AIDS Alliance (Alliance India) was founded in 1999 as a non-governmental organisation working in partnership with civil society and communities to support sustained responses to HIV in India. Complementing the Indian national program, Alliance India works through capacity building, technical support and advocacy to strengthen the delivery of effective, innovative, community-based interventions to key populations most vulnerable to HIV, including men who have sex with men (MSM), transgenders, hijras, people who use drugs (PWUD), sex workers, youth, and people living with HIV (PLHIV).

**Alliance India Andhra Pradesh**

*Pehchan Focus: Andhra Pradesh*

Alliance India supports a regional office in Hyderabad that leads implementation of Pehchan in Andhra Pradesh and serves as a State Lead Partner of the Bill & Melinda Gates Foundation.

The Humsafar Trust (www.humsafar.org)

*Pehchan Focus: Maharashtra, Madhya Pradesh, Goa, Gujarat and Rajasthan*

For nearly two decades, Humsafar Trust has worked with MSM and transgender communities in Mumbai, Maharashtra. It has successfully linked community advocacy and support activities to the development of effective HIV prevention and health services. It is one of the pioneers among MSM and transgender organisations in India and serves as the national secretariat of the Indian Network for Sexual Minorities (INFOSEM).

**Pehchan North Region Office**

*Pehchan Focus: Punjab, Delhi, Uttar Pradesh and Bihar*

Alliance India supports a regional implementing office based in Delhi that leads implementation of Pehchan in four states of North India.

Solidarity and Action Against The HIV Infection in India (SAATHII) (www.saathii.org)

*Pehchan Focus: West Bengal, Manipur, Orissa and Jharkhand*

With offices in five states and over 10 years of experience, SAATHII works with sexual minorities for HIV prevention. SAATHII works closely with the West Bengal’s State AIDS Control Society (SACS) and the State Technical Support Unit and is the SACS-designated State Training and Resource Centre for MSM, transgender and hijra.

**South India AIDS Action Programme (SIAAP) (www.siaapindia.org)**

*Pehchan Focus: Tamil Nadu*

SIAAP brings more than 22 years of experience with community-driven and community development focussed programmes, counselling, advocacy for progressive policies, and training to address HIV and wider vulnerability issues for MSM, transgender and hijra community.

Sangama (www.sangama.org)

*Pehchan Focus: Karnataka and Kerala*

For more than 20 years, Sangama has been assisting MSM, transgender and hijra communities to live their lives with self-acceptance, self-respect and dignity. Sangama lobbies for changes in existing laws that discriminate against sexual minorities and for changing public opinion in their favour.
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About this Module

This module is designed to help training participants: 1) understand the basics of transgender and hijra identity; and 2) become familiar with the challenges facing transgender and hijra community members in the current context. In the Pehchan programme, this module is used to familiarise CBO Programme Managers, Counsellors, and Outreach Workers on the specific needs of transgender and hijra-identified individuals.

About Pehchan

With financial support from the Global Fund, Pehchan is building the capacity of 200 community-based organisations (CBOs) for men who have sex with men (MSM), transgenders and hijras in 17 states in India to be more effective partners in the government’s HIV prevention programme. By supporting the development of strong CBOs, Pehchan addresses some of the capacity gaps that have often prevented CBOs from receiving government funding for much-needed HIV programming. Named Pehchan, which in Hindi means ‘identity’, ‘recognition’ or ‘acknowledgement,’ this programme will reach 453,750 MSM, transgenders and hijras by 2015. It is the Global Fund’s largest single-country grant to date, focused on the HIV response for vulnerable sexual minorities.

Training Curriculum Overview

In order to stimulate the development of strong and effective CBOs for MSM, transgender and hijra communities and to increase their impact in HIV prevention efforts, responsive and comprehensive capacity building is required. To build CBO capacity, Pehchan developed a robust training programme through a process of engagement with community leaders, trainers, technical experts, and academicians in a series of consultations that identified training priorities. Based on these priorities, smaller subgroups then developed specific thematic components for each curricular module.

Inputs from community consultations helped increase relevance and value of training modules. By engaging MSM, transgender and hijra (MTH) communities in the development process, there has been greater ownership of training and of the overall programme among supported CBOs. Technical experts worked on the development of thematic components for priority areas identified by community representatives. The process also helped fine-tune the overall training model and scale-up strategy. Thus, through a consultative, community-based process, Pehchand developed a training model responsive to the specific needs of the programme and reflecting key priorities and capacity gaps of MSM, transgender and hijra CBOs in India.
Preface

As I put pen to paper, a shiver goes down my spine. It is hard to believe that this day has come after almost five long years! For many of us, Pehchan is not merely a programme; it is a way of life. Facing a growing HIV epidemic among men who have sex with men (MSM), transgender, and hijra communities in India, a group of development and health activists began to push for a large-scale project for these populations that would be responsive to their specific needs and would show this country and the world that these interventions are not only urgently needed but feasible.

Pehchan was finally launched in 2010 after more than two years of planning and negotiation. As the programme has evolved, it has never stepped back from its core principle: Pehchan is by, for and of India’s MSM, transgender and hijra communities. Leveraging rich community expertise, the Global Fund’s generous support and our government’s unwavering collaboration, Pehchan has been meticulously planned and passionately executed. More than just the sum of good intentions, it has thrived due to hard work, excellent stakeholder support, and creative execution.

At the heart of Pehchan are community systems strengthening. Our approach to capacity building has been engineered to maximise community leadership and expertise. The community drives and energises Pehchan. Our task was to develop 200 strong community-based organisations (CBOs) in a vast and complex country to partner with state governments and provide services to MSM, transgender and hijra communities to increase the effectiveness of the HIV response for these populations and improve their health and wellbeing. To achieve necessary scale and sustain social change, strong CBOs would require responsive development of human capital.

Over and above consistent services throughout Pehchan, we wanted to ensure quality. To achieve this, we proposed a standard training package for all CBO staff. When we looked around, we found there really wasn’t an existing curriculum that we could use. Consequently, we decided to develop one not only for Pehchan but also for future efforts to build the capacity of community systems for sexual minorities. So began our journey to create this curriculum.

Building on the experience of Sashakt, a pilot programme supported by UNDP that tested the model that we’re scaling up in Pehchan, an involved process of consultations and workshops was undertaken. Ideas for each module came from discussions with a range of stakeholders from across India, including community leaders, activists, academics and institutional representatives from government and donors. The list of modules grew with each consultation. For example in Sashakt, we had a single training module on family support and mental health; in Pehchan, we decided that it would be valuable to split these and have one on each.

Eventually, we agreed on the framework for the modules and the thematic components, finding a balance between individual and organisational capacity. Overall, there are two main areas of capacity building: one that is directly related to the services and the other that is focused on building capable service providers. Then we began the actual writing of the curriculum, a process of drafting, commenting, correcting, tweaking and finalising that took over eight months.
Once the curriculum was ready to use, trainings-of-trainers were organised to develop a cadre of master trainers who would work directly with CBO staff. Working through Pehchan’s four Regional Training Centers, these trainers, mostly members of MSM, transgender and hijra communities, provided further in-service revisions and suggestions to the modules to make them succinct, clear and user-friendly. Our consortium partner SAATHII contributed particularly to these efforts, and the current training curriculum reflects their hard work.

In fact, the contributors to this work are many, and in the Acknowledgements section following this Preface, we have done our best to name them. They include staff from all our consortium partners, technical experts, advocates, donor representatives and government colleagues. The staff at India HIV/AIDS Alliance, notably the Pehchan team, worked beautifully to develop both process and content. That we have come so far is also a tribute to vision and support of our leaders, at Alliance India and in our consortium partners, Humsafar Trust, SAATHII, Sangama, and SIAAP, as well as in India’s National AIDS Control Organisation and at the Global Fund to Fight AIDS, Tuberculosis and Malaria in Geneva.

We would like to think of the Pehchan Training Curriculum as a game changer. While the modules reflect the specific context of India, we are confident that they will be useful to governments, civil society organisations and individuals around the world interested in developing community systems to support improved HIV and other health programming for sexual minorities and other vulnerable communities as well.

After two years of trial and testing, we now share this curriculum with the world. Our team members and master trainers have helped us refine them, and seeing the growth of the staff in the CBOs we have trained has increased our confidence in the value of this curriculum. The impact of these efforts is becoming apparent. As CBOs have been strengthened through Pehchan, we are already seeing MSM, transgender and hijra communities more empowered to take charge, not only to improve HIV prevention but also to lead more productive and healthy lives.

Sonal Mehta  
Director: Policy & Programmes  
India HIV/AIDS Alliance  
New Delhi  
March 2013
General Acknowledgements

The Pehchan Training Curriculum is the work of many people, including community members, technical experts and programme implementers. When we were not able to find training materials necessary to establish, support and monitor strong community-based organisations for MSM, transgenders and hijras in India, the Pehchan consortium collectively developed a curriculum designed to address these challenges through a series of community consultations and development workshops. This process drew on the best ideas of the communities and helped develop a responsive curriculum that will help sustain strong CBOs as key element of Pehchan.

We would like to take this opportunity to acknowledge the contributions of those who helped in taking this process forward, including (in alphabetical order): Ajai, Praxis; Usha Andewar, The Humsafar Trust; Sarita Barapanda, IWW-UK; Jhuma Basak, Consultant; Dr. V. Chakrapani, C-Sharp; Umesh Chawla, UNDP; Alpana Dange, Consultant; Brinelle D’Sourza, TISS; Firoz, Love Life Society; Prashanth G, Maan AIDS Foundation; Urmia Jadav, The Humsafar Trust; Jeeva, TRA; Harleen Kaur, Manas Foundation; Krishna, Suraksha; Monica Kumar, Manas Foundation; Muthu Kumar, Lotus Sangama; Sameer Kunta, Avahan; Agniva Lahiri, PLUS; Meera Limaya, Consultant; Veronica Magar, REACH; Magdalene, Center for Counselling; Sylvester Merchant, Lakshya; Armita Nanda, Lawyers’ Collective; Nilanjana, SAFRG; Prabhakar, SIAAP; Priti Prabhughate, ICRW; Nagendra Prasad, Ashodaya Samithi; Revathi, Consultant; Rex, KHPT; Amitava Sarkar, SAATHII; Dr. Maninder Setia, Consultant; Chetan Sharma, SAFRG; Suneeta Singh, Amaltas; Prabhakar Sinha, Heroes Project; Sreeram, Ashodaya Samithi; Suresh, KHPT; Sanjhati Veul, JHU; and Roy Wadia, Heroes Project.

Once curricular framework was finalised, a group of technical and community experts was formed to develop manuscripts and solicit additional inputs from community leaders. The curriculum was then standardised with support from Dr. E.M. Sreejit and streamlined with support from a team at SAATHII, led by Pawan Dhall. This process included inputs from Sudha Jha, Anupam Hazra, Somen Acharya, Shantanu Pyne, Moyazzam Hossain, Amitava Sarkar, and Debjyoti Ghosh Dhall from SAATHII; Cairo Araijo, Vaibhav Saria, Dr. E.M. Sreejit, Jhuma Basak, and Vahista Dastoor, Consultants; Olga Aaron from SIAAP; and Harjyot Khosa and Chaitanya Bhatt from India HIV/AIDS Alliance.

From the start, the Government of India’s National AIDS Control Organisation has been a key partner of Pehchan. In particular, Madam Aradhana Johri, Additional Secretary, NACO, has provided strong leadership and steady guidance to our work. The team from NACO’s Targeted Intervention (TI) Division has been a constant friend and resource to Pehchan, notably Dr. Neeraj Dhingra, Deputy Director General (TI); Manilal N. Raghvan, Programme Officer (TI); and Mridu, Technical Officer (TI). As the programme has moved from concept to scale-up, Pehchan has repeatedly benefitted from the encouragement and wisdom of NACO Directors General, past and present, including Madam Sujata Rao, Shri K. Chandramouli, Shri Sayan Chatterjee, and Shri Lov Verma.

Pehchan is implemented by a consortium of committed organisations that bring passion, experience, and vision to this work. The programme’s partners have been actively engaged in developing the training curriculum. We are grateful for the many contributions of Anupam Hazra and Pawan Dhall from SAATHII; Hemangi, Pallav Patnaik, Vivek Anand and Ashok Row Kavi from the Humsafar Trust; Olga Aaron and Indumati from SIAAP; Vijay Nair from Alliance India Andhra Pradesh; and Manohar from Sangama. Each contributed above and beyond the call of duty, helping to create a vibrant training programme while scaling up the programme across 17 states.
India HIV/AIDS Alliance's Pehchan team has been untiring in its contributions to this curriculum, including Abhina Aher, Jonathan Ripley, Yadvendra (Rahul) Singh, Simran Shaikh, Yashwinder Singh, Rohit Sarkar, Chaitanya Bhatt, Nunthuk Vunghoihkim, Ramesh Tiwari, Sarbeshwar Patnaik, Ankita Bhalla, Dr. Ravi Kanth, Sophia Lonappan, Rajan Mani, Shaleen Rakesh, and James Robertson. A special thank-you to Sonal Mehta and Harjyot Khosa for their hard work, patience and persistence in bringing this curriculum to life.

Through it all, the Global Fund to Fight AIDS, Tuberculosis and Malaria has provided us both funding and guidance, setting clear standards and giving us enough flexibility to ensure the programme’s successful evolution and growth. We are deeply grateful for this support.

Pehchan’s Training Curriculum is the result of more than two years of work by many stakeholders. If any names have been omitted, please accept our apologies. We are grateful to all who have helped us reach this milestone.

The Pehchan Training Curriculum is dedicated to MSM, transgender and hijra communities in India who for years, have been true examples of strength and leadership by affirming their pehchán.
Module Acknowledgments: Transgender and Hijra Communities

Each component of the Pehchan Training Curriculum has a number of contributors who have provided specific inputs. For this component, the following are acknowledged:

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**Compilation**
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**Technical Input**
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**Coordination and Development**
Vahista Dastoor, C4D Consultant
Pawan Dhall, SAATHII

**References**
- *From the Third Eye* (2010), Film-based research project, SAATHII and United Nations Development Programme, India.
# About the Transgender and Hijra Communities Module

<table>
<thead>
<tr>
<th>No.</th>
<th>C5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Transgender and Hijra Communities</td>
</tr>
</tbody>
</table>
| Pehchan Trainees | • Project Managers, Project Officers  
• Counsellors  
• Outreach Workers (ORWS) |
| Pehchan CBO Type | Pre-TI, Ti Plus |
| Training Objectives | At the end of the day’s training, the participants will:  
• Understand the experiences of transgender and hijra communities in various local contexts; and  
• Understand and address the sexual and general health needs of transgender and hijra Communities. |
| Total Duration | One day. A day’s training typically covers 8 hours. |

## Module Reference Materials

All the reference material required to facilitate this module has been provided in this document and in relevant digital files provided with the Pehchan Training Curriculum. Please familiarise yourself with the content before the training session.

**Attention:** Please do not change the names of file or folders, or move files from one folder to another, as some of the files are linked to each other. If you rename files or change their location on your computer, the hyperlinks to these documents in the Facilitator Guide will not work correctly.

If you are reading this module on a computer screen, you can click the hyperlinks to open files. If you are reading a printed copy of this module, the following list will help you locate the files you need.

### Audio-visual Support
1. PowerPoint presentation ‘Transgender and Hijra Communities’.
2. Audio-video clip from the movie ‘From the Third Eye’.

### Annexures
1. Annexure 1 on ‘Working Definitions of the Terms Transgender and Hijra’.
2. Annexure 2 on ‘The Transgender Umbrella’.
3. Annexure 3 on ‘Aspects of Transformation and Feminisation’.
## Activity Index

<table>
<thead>
<tr>
<th>No.</th>
<th>Activity Name</th>
<th>Time</th>
<th>Material</th>
<th>Audio-visual Resources</th>
<th>Take-home material</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Knowing Transgender and Hijra Communities</td>
<td>45 min</td>
<td>Chart</td>
<td>Refer to the slides ‘Working Definition of Terms’ from the PowerPoint presentation ‘Transgender and Hijra Communities’</td>
<td>Annexure 1 on ‘Working Definitions of the Terms Transgender and Hijra’</td>
</tr>
<tr>
<td>2</td>
<td>Typology of Transgender and Hijra Groups</td>
<td>50 min</td>
<td>Chart</td>
<td>Refer to the slides titled ‘The Transgender Umbrella’ from the PowerPoint presentation ‘Transgender and Hijra Communities’</td>
<td>Annexure 2 on ‘The Transgender Umbrella’</td>
</tr>
<tr>
<td>3</td>
<td>Vulnerability of Transgender and Hijra Communities to HIV</td>
<td>30 min</td>
<td>Chart</td>
<td>Refer to the slides titled ‘Vulnerability to HIV and Risk Factors: Some Findings’ from the PowerPoint presentation ‘Transgender and Hijra Communities’</td>
<td>N/A</td>
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<tr>
<td>4</td>
<td>Sexual Health, STI and HIV in Transgender and Hijra Communities</td>
<td>40 min</td>
<td>N/A</td>
<td>Refer to the slides titled ‘Sexual Health, STIs and HIV in Transgenders and Hijras’ from the PowerPoint presentation ‘Transgender and Hijra Communities’</td>
<td>N/A</td>
</tr>
<tr>
<td>5</td>
<td>Transformation and Feminisation Processes</td>
<td>1 hour</td>
<td>N/A</td>
<td>Refer to the slides titled ‘Case Studies in Transformation and Feminisation’ from the PowerPoint presentation ‘Transgender and Hijra Communities’</td>
<td>Annexure 3 on ‘Aspects of Transformation and Feminisation’</td>
</tr>
<tr>
<td>6</td>
<td>Reaching and Mobilising Transgender and Hijra Communities</td>
<td>30 min</td>
<td>Chart</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>7</td>
<td>Mobilising Transgender and Hijra Groups to Access Quality Treatment and Care</td>
<td>45 min</td>
<td>Chits</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>8</td>
<td>Social Exclusion, Rights and Entitlements</td>
<td>55 min</td>
<td>N/A</td>
<td>Audio-video clip from the movie ‘From the Third Eye’</td>
<td>Annexure 4 on ‘Journey towards Social Inclusion’</td>
</tr>
</tbody>
</table>

1 Overhead projector, laptop, sound system and whiteboard should be provided at every training.
### Activity 1: Knowing Transgender and Hijra Communities

**Time** 45 minutes

<table>
<thead>
<tr>
<th>Learning Outcomes</th>
<th>By the end of this activity, the participants will:</th>
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<tbody>
<tr>
<td></td>
<td>• Understand the distinctions and commonalities between the terms ‘transgender’ and ‘hijra’ and their traditional/cultural contexts; and</td>
</tr>
<tr>
<td></td>
<td>• Learn about the national-level working definitions of the terms ‘transgender’ and ‘hijra’ as developed under the National AIDS Control Programme of India.</td>
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</tbody>
</table>

**Materials** Chart papers and markers.

**Audio-visual Support** Refer to the slides ‘Working Definition of Terms’ from the PowerPoint presentation ‘Transgender and Hijra Communities’.

**Take-home Material** Annexure 1 on ‘Working Definitions of the Terms Transgender and Hijra’.

### Methodology

Divide the participants into groups and distribute chart paper and markers to each group.

Write the words ‘Transgender’ and ‘Hijra’ on the board, and ask the participants to close their eyes for a couple of minutes and think about what comes to their mind when they hear these terms.

Ask each group to spend the next 15 minutes creating two visual representations, one for the term ‘Transgender’ and the other for the term ‘Hijra’. They can draw whatever comes to their mind, including symbols. However, the graphics should contain no words or phrases.

After they complete the exercise, ask them to work in the same groups for another 15 minutes. This time each group should write words and/or phrases that they feel describe the two terms best. Ask the participants to use their own experiences while selecting the words and phrases.

Ask each group to present their findings to the larger group. After the presentation, lead a discussion in which the participants identify the distinctions between the two terms on the following parameters:

- Gender versus culture or profession; and
- Global versus Indian.

Create working definitions for each term. Display the PowerPoint slides ‘Working Definition of Terms’ from the PowerPoint presentation ‘Transgender and Hijra Communities’ and read out the working definitions of the terms ‘Transgender’ and ‘Hijra’ developed under India’s National AIDS Control Programme IV (NACP IV). Distribute copies of Annexure 1 on ‘Working Definitions of the Terms Transgender and Hijra’ to each participant.

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**Note to Facilitator**

Definitions that the participants develop during the training may vary slightly from the programme’s standard ones.

Resolve any confusion by saying that for the moment Pehchan definitions should be used by CBOs to maintain consistency, and that CBOs can bring up concerns during Pehchan SSR coordination meetings with their SRs and Alliance India.
Background Information
(NACP IV working groups, May 2011)

Hijra
Hijras are individuals who voluntarily seek initiation into the hijra community, whose ethnic profession is Badhai (ritual of clapping hands and asking for alms when blessing new-born babies, or dancing at auspicious ceremonies such as weddings). Due to the prevailing socio-economic and cultural conditions, a significant proportion of them have been forced to enter into begging and sex work for survival.

These individuals live in accordance to the hijra community’s norms, customs and rituals which may vary from region to region.

Transgender
- TG is a gender identity.
- TGs usually live or prefer to live in the gender role different from that which they are born into.
- This has no relation to an individual’s sexual preferences.
- TG is an umbrella word which includes transsexuals, cross-dressers, intersexed persons, and gender-variant persons.
- TG includes people who have not undergone any surgery or physiological changes.

Note: The above definitions are adopted under the Pehchan programme.
Activity 2: Typology of Transgender and Hijra Groups

<table>
<thead>
<tr>
<th>Time</th>
<th>50 minutes</th>
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<tbody>
<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, the participants will be able to:</td>
</tr>
<tr>
<td></td>
<td>• Identify various region-centric typologies of transgender and hijra groups in India.</td>
</tr>
<tr>
<td>Materials</td>
<td>Chart papers and markers.</td>
</tr>
<tr>
<td>Audio-visual Support</td>
<td>Refer to the slides titled ‘The Transgender Umbrella’ from the PowerPoint presentation ‘Transgender and Hijra Communities’.</td>
</tr>
<tr>
<td>Take-home Material</td>
<td>Annexure 2 on ‘The Transgender Umbrella’.</td>
</tr>
</tbody>
</table>

Methodology

Part I: Understanding Typologies

Divide the participants into groups, preferably each group comprising of participants from a particular state or district. Distribute chart papers and markers to each group and give the participants 15 minutes to do the following:

• Identify the transgender/hijra communities in their region; and
• For each type of transgender/hijra community identified, briefly describe:
  • Where these communities are located (geographically); and
  • The basic characteristics of each community – what kind of vocation are the members involved in, and what differentiates this community from others.

Ask each group to present their discussions. During each presentation do the following:

• Expand on their findings of each region or local scenario.
• Relate the findings with the participants’ understanding of gender and identity, and the variations therein.
• On the whiteboard, draw a horizontal line, marking one end of the line as male and the other as female. Explain to the participants that this line represents the range of gender identity that lies between sexual binaries of male (or man) and female (or woman), and ask them where they would place transgender and hijra identities within this range.
• Facilitate the discussion to see if participants can identify hijras as belonging to a separate culture or profession and not as a gender identity.
• Explain to them how a third sex has come to be recognised to fit with the Indian cultural traditions wherein hijras are considered as a ‘third sex’ (as per NACO).
• Explain how, for the purpose of HIV interventions, both trangenders and hijras are classified under one umbrella.
• Point out that the transgender and hijra identities defined by participants and others cannot be rigidly delineated, and that gender and gender identities can be fluid, both within the communities, as well as at the individual level.
Display the slides titled ‘The Transgender Umbrella’ from the PowerPoint presentation ‘Transgender and Hijra Communities’, and wrap up the activity with the message that despite the differences in typology, the socio-economic status and marginalisation that these communities experience are largely common. Participants need to respect all identities and work towards a common betterment cause.

Distribute copies of Annexure 2 on ‘The Transgender Umbrella’ to each participant.

**Some Major Typologies of Transgender and Hijra Identities in India**

**Hijras**

Hijras are biological males who reject their masculine identity at some point in their lives to identify as women, or ‘not-men’, or ‘in-between man and woman’, or ‘neither man nor woman’. Hijras can be considered as the western equivalent of transgender/transsexual (male-to-female) persons, however, they have a long tradition/culture and have strong social ties formalised through a ritual called ‘reet’ (becoming a member of the hijra community).

There are regional variations in the use of the term ‘hijra’. For example, the term *kinnar* is used in Delhi (North India) and the term Aravani is used in Tamil Nadu (South India). Many hijras earn through traditional work called ‘badhai’, as mentioned earlier. Some hijras engage in sex work for lack of job opportunities, while some may be self-employed or work for non-governmental organisations (NGOs).

**Aravanis and Thirunangi**

Many hijras in Tamil Nadu call themselves as Aravani. The Tamil Nadu Aravanigal Welfare Board, a state government initiative under the Department of Social Welfare, defines aravanis as biological males who self-identify as women who feel trapped in a male body. However, some aravani activists want the public and the media to use the term thirunangi (respected women) rather than aravani while addressing them.

**Shiv-Shaktis**

Shiv-Shaktis are males who claim to be ‘possessed’ by, or are considered close to, a goddess. Usually, males are inducted into the Shiv-Shakti community by senior gurus who teach them the norms, customs, and rituals of the community. During the ‘induction ceremony’, Shiv-Shaktis are ‘married’ to a sword (symbolising male power or Shiva) and from then on, are seen as the bride of the sword. Occasionally, Shiv-Shaktis cross-dress and use accessories and ornaments meant for women. Most of the people in this community belong to lower socio-economic class and earn their living as astrologers, soothsayers, and spiritual healers; some also seek alms.

**Jogappas**

Jogappas are males who are ‘dedicated’ to ‘Yellamma’, a deity in Southern India, by their family members. Also, some males who express feminine gender characteristics themselves choose to join this community. Joining the Jogappa community is subjected to the acceptance by the community. An initiation ritual formalised by the guru marks the acceptance of a person as a jogappa. Most jogappas wear female clothes but some choose to wear lungis\(^2\). All grow their hair long and use ornaments and accessories meant for women. Jogappa community norms discourage both emasculation and getting married to a woman. Those community members who transgress the community norms cannot perform religious rituals, and this may affect their social standing within the Jogappa community.

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\(^2\) A lungi is a traditional garment worn around the waist mostly by men of the Indian subcontinent
Launda Dancers

Laundas (a slang word in Hindi for ‘boys’) are groups of young men who entertain guests at marriages in North India, especially in Bihar and Uttar Pradesh. Weddings in these regions are usually elaborate, marked by revelry, alcohol, music and dance. Launda dancers are seen as essential to an age-old tradition of laundanaach – an integral part of the weddings in this region where young effeminate boys dress in women’s clothing and dance during marriage processions and other revelry.

The dancers usually belong to the lower middle class and poor families and come to Bihar and Uttar Pradesh from nearby states during peak marriage seasons (April to June and November to February). During marriage celebrations, they often live in unhealthy conditions, sometimes sharing the living space with goats and cows kept for domestic use. They are fed poorly and sanitation standards are almost non-existent.

In many rural parts of Bihar and Uttar Pradesh, it is relatively common practice for men to have sex with these effeminate young men. This usually happens because these boys are easily recognisable and having sex with them is often seen as a test of manliness (referred to as mardangi in local parlance). In some households with strong feudal mindsets, landlords keep laundas in the house and is seen as prestige and sign of virility and power. After the marriage season, some of the older boys join their peers and travel to other parts of the country while others return home.

Note: Questions might come up regarding the inclusion of kothis under transgender and hijra definitions. The facilitator should explain that some proportion of those who call themselves hijras may also identify themselves as kothis. But not all who call themselves kothi identify themselves as transgenders or hijras. Kothis are a heterogeneous group and can be best described as biological males who show varying degrees of femininity. Some kothis may be bisexual and some may also be married. Kothis are generally seen to be coming from a lower socio-economic status, and some engage in sex work for survival.
Activity 3: Vulnerability of Transgender and Hijra Communities to HIV

<table>
<thead>
<tr>
<th>Time</th>
<th>30 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, the participants will be able to:</td>
</tr>
<tr>
<td></td>
<td>• Identify the factors which make transgenders and hijra communities vulnerable to HIV.</td>
</tr>
<tr>
<td>Materials</td>
<td>Chart papers and markers.</td>
</tr>
<tr>
<td>Audio-visual Support</td>
<td>Refer to the slides titled ‘Vulnerability to HIV and Risk Factors: Some Findings’ from the PowerPoint presentation ‘Transgender and Hijra Communities’.</td>
</tr>
<tr>
<td>Take-home Material</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Methodology

Ask the participants why, in their view, the transgender and hijra population are important for HIV prevention and care.

List their responses on the whiteboard or on flip-charts, and use this opportunity to discuss and clarify issues of vulnerability and risk to HIV in these populations.

Display the slides titled ‘Vulnerability to HIV and Risk Factors: Some Findings’ from the PowerPoint presentation ‘Transgender and Hijra Communities’ and use the graphs in the slides to augment the discussion.

Discuss how in the NACP, transgender and hijra groups are considered to be high-risk groups (HRGs) and why they are the focus in the Pehchan programme.

Background Material

(Lakshmi et al, 2011)

Vulnerability to HIV and Risk Factors

In India, hijras and transgenders are seen as a separate socio-religious and cultural group. Primary and secondary data suggest that transgenders and hijras are not a homogeneous population but have various sub-groups, such as those who earn their living from sex work, from begging, and by living in a dera and who are into traditional occupation of toli-badhai.

Each sub-group has different health needs and concerns that call for different approaches. Some key findings from the study are given below:

- Most hijras and transgenders are still a hidden population and largely out of reach. This makes it difficult to meet their HIV prevention needs, which continue to remain largely unaddressed.
- The primary sexual practice among transgenders/hijras is unprotected anal sex, and on most occasions they perform the role of a receptive partner.
• Transgenders/hijras have very limited access to water-based lubricants and report low condom usage. Such practices make them more vulnerable to HIV and other STI infections.

• In a study on transgenders and hijras, nearly 7 out of 10 members interviewed felt that their community was at a higher risk of HIV transmission because of unsafe sexual practices by many members of the community. Also, nearly 8 out of 10 persons interviewed reported that they had their first sexual activity by the age of 15. A significant number of them had multiple commercial partners in a month (UNDP, 2010).

• Hijras and transgenders are a mobile population involved in sex work in various environments and places. Hence they are at risk of infecting themselves and their partners.

• Nearly 4 out of 10 members interviewed in the study reported having multiple commercial partners in a month. Nearly a half did not remember the number of male partners they had in the past month. A little more than half earned their livelihood through sex work. About 8 out of 10 reported staying away from their primary area of residence for long periods, with more than half of them (60%) migrating for sex work.

• Data also suggests that about 3 out of 4 transgenders/hijras interviewed were not accepted or supported by their families and society due to their gender status, forcing them to move out of their homes.

• Only 2 out of every 10 trangender/hijras were illiterate. However, half of them dropped out of the school between classes 6 and 12.

• Transgender/hijras are stigmatised and discriminated by law enforcement agencies and rowdies and are often teased and harassed by the general public. They usually do not report incidents of sexual harassment and rape to the police. A little more than half (57%) reported violence by police, rowdies or others.
The social hierarchy and community norms among hijra communities have both positive and negative influences on the members’ HIV-risk behaviours. In eastern and northern India, there is no talk about sexuality in certain hijra gharanas or clans, and this increases their vulnerability to HIV transmission. For example, hijras from certain gharanas are not supposed to have sex as they are dedicated to the goddess and, in some cases, gurus may not allow distribution of condoms to them.

All these factors make the transgender/hijra communities extremely vulnerable to HIV. According to the data, over half the respondents (53%) reported the need for a separate intervention programme for transgenders.
Activity 4: Sexual Health, STI and HIV in Transgender and Hijra Communities

<table>
<thead>
<tr>
<th>Time</th>
<th>40 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, the participants will be able to:</td>
</tr>
<tr>
<td></td>
<td>• Identify safer sex options for transgenders and hijras.</td>
</tr>
<tr>
<td>Materials</td>
<td>N/A</td>
</tr>
<tr>
<td>Audio-visual Support</td>
<td>Refer to the slides titled ‘Sexual Health, STIs and HIV in Transgender and Hijras’ from the PowerPoint presentation ‘Transgender and Hijra Communities’.</td>
</tr>
<tr>
<td>Take-home Material</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Methodology

Part I: Case Discussions

Display the slides titled ‘Sexual Health, STIs and HIV in Transgender and Hijras’ from the PowerPoint presentation ‘Transgender and Hijra Communities’ and conduct a brief interactive session on each question or scenario given in the slide.

Question: Why do transgender and hijra people have a higher risk of contracting HIV?

- It is not by choice or as a result of any ‘sin’ or ‘mistake’ or being a ‘bad person’.
- The increased vulnerability is the result of social marginalisation and discrimination in all areas of life, including employment, family, education and healthcare settings. This in turn results in: (i) opting for sex work; (ii) having poor literacy levels; (iii) having a low sense of self-worth; and (iv) being vulnerable to physical and sexual assault.

Case Scenario

A transgender sex worker complains: ‘Whenever I ask my clients to use condoms, they run away thinking I have AIDS. I am losing my business because of this’.

Ask the question: How should the ORW respond?

Use this occasion to reinforce the importance of condoms during sex work and other sexual interactions. Make the session lively by providing examples of ‘tricks’ on how a transgender can stay safe and also at the same time not turn away potential clients for want of condoms.

What can a transgender or hijra sex-worker do if she does not have a condom and a client comes to her?

- Try a trick called ‘Talk More, Do Less’: She should keep the client engrossed in conversation peppered with erotic talk, gestures and physical stimulation (but not sex) so that he (client) is in a state of constant arousal. She should not mention condoms at all. In most instances, the client is content with this form of arousal and may not press for full sex, in which case the transgender can avoid the dilemma of using a condom.

Participants could be encouraged to share some of their own experiences.
Ask the question: What can a transgender or hijra sex-worker do when she does not have a condom but is already at a sex solicitation site?

- The trainer should encourage the participants to think of ways by which they can address her dilemma. The trainer can use the example given above to lead the discussion. Explain: How the hijra sex-worker in question can be creative and delay penetrative sex by asking the client to ‘save it’ (sex) for another time. The sex worker can, in the mean time, give a massage, indulge in ‘small sex’ by bringing him to orgasm by masturbating him with her hands, thighs or breasts. She can also use oral sex to stimulate him.

Participants may be encouraged to share some of their own experiences. Transgenders and hijras may often state: ‘I don’t want to go for HIV testing. At both public and private hospitals, they always laugh at me.’

How should they be counseled and guided?

- The project worker should first acknowledge that such situations do happen at these centres and she/he should empathise with the community member.
- She/he should point out that the only way to know the HIV status is to get tested.
- Indicate that HIV testing is free and done with strict confidentiality procedures in place and that the information on her status is not revealed to others without the permission of the individual concerned.
- Remind the client that counsellors in the project can help in accessing services and also explain risk-reduction strategies.

A hijra was heard saying: ‘Anyway AIDS means death. Also if my Guru comes to know that I have AIDS, I will no longer be able to stay with her. My friends will ignore me so it is better not to know my HIV status’.

How should they be counseled and guided?

- Being HIV positive does NOT mean a ‘death sentence’. Highly effective treatment for HIV is available and provided free of cost at government centres. Test results are not shared with anybody by the centre. Like anyone else, a transgender/hijra who tests positive can choose to keep the test results to herself without informing others. It is important to get tested as it helps towards living a productive life and for starting early treatment.
- You can also tell the participants that ‘Positive Living’ – living a meaningful, productive life with HIV – will be covered in another module.

**Part II: Information Sharing on Various Issues**

**Some Common Symptoms of STIs**

- Pain or burning sensation during urination.
- Discharge from the penis, anus or vagina.
- Frequent or dark urination.
- Pain or itching in the genital area, buttocks, inner thighs, or abdomen.
- Pain during intercourse.
- Sores, warts, blisters, bumps or swelling of the penis, scrotum, anus, vagina or genital area.
- Rashes on the palms or soles.
- Skin and the white area of the eyes turning yellow.
**Issues Related to Transgenders and Hijras Living with HIV**

- Most transgenders and hijras living with HIV in India do not know their HIV status.
- Counselling and testing services are rarely targeted or sensitive to the transgender/hijra community needs.
- Negative experiences in healthcare also make testing less accessible.
- Furthermore, knowing one is HIV positive and living with HIV means bearing additional and unwanted stigma.

**Sexual and Mental Health Among Transgenders and Hijras**

**Sexual Health**

Hijras/Trangenders communities face several sexual health issues, including HIV. Both personal and contextual factors influence sexual health conditions and access to and use of sexual health services. For example, most tranngenders and hijras are from the lower socio-economic strata and have low literacy levels that pose a barrier to seeking healthcare. Consequently, these communities face unique barriers in accessing treatment services for STIs.

**Mental Health**

Remind the participants that the issues of mental health have been dealt with in detail in Module C3: Mental Health.

The mental health needs of these communities are barely addressed in the current HIV programmes. Their problems, reported in different community fora, include depression, suicidal tendencies, stigma, lack of social support, and violence-related stress.

Many tranngenders, especially youth, face great challenges in coming to terms with their gender identity and/or gender expression since it is not consonant with socially prescribed gender roles and identities. They face several issues: shame and internalised transphobia; fear of disclosure and coming out; adjusting, adapting or not adapting to social pressure to conform; fear of relationships or loss of relationships; and self-imposed limitations on gender expressions.

**Alcohol and Substance Abuse Among Transgenders and Hijras**

Available evidence suggests the need to address alcohol and substance use/abuse among hijras and tranngenders. A significant proportion of them consume alcohol, possibly to escape the stress and depression they face in their daily life. Hijras give several reasons to justify their alcohol consumption, ranging from the need to ‘forget worries’ (because there is no family support or no one cares about them) to managing rough clients during sex-work. However, as a result, their alcohol use is also associated with the inability to use condoms or to insist that their clients use condoms. This increases the risk of HIV transmission and acquisition.

**Transphobia**

Transphobia is an irrational fear of, and/or hostility towards, people who are tranngenders, hijras or who otherwise transgress traditional gender norms. The most direct victims of transphobia are people who are transsexual – those who are labeled one sex at birth but transition into another sex later.

The cause of transphobia is still a subject of research and debate, but it is believed that it reflects the fragile nature of gender identity. Males and females are genetically and physically not so different. The fact that someone can convincingly identify as a member of the opposite sex calls the concept of gender into question. People who are quietly struggling with their own gender identity and people for whom gender identity is especially important to them might be frightened, even angry, when confronted with the fragility of gender.
Part III: Visibility Game

Given below is a communication game which helps participants understand the vulnerability that stems from the visibility of transgenders and hijras and understand social exclusion and transphobia. Ensure that participants do this exercise in a calm environment with no distractions.

Divide the participants into groups of four to five people. Form an even number of groups so that groups can be paired. Give each group a name like A, B, C, D, or 1, 2, 3, 4 and pair the groups – for example, pair Group A with Group B, and Group C with Group D.

The exercise is done with two groups forming one unit. Ask members from Group A to stand up and those from Group B to sit in front of them. Make sure there is sufficient distance between the two groups.

Give two minutes for the participants of Group B to carefully observe all the members of Group A. Tell them to observe the participants of Group A and note:

- What they are wearing?
- How they are standing?
- Are they trying to show or hide anything?
- Who is feeling comfortable?
- Who is looking shy?
- Any other special observations?

Do the same with the other groups. After letting one set of groups act as observers, reverse the roles – the group that was sitting and being observed now becomes the observer group.

After two minutes, ask the groups to reconvene and ask participants to share their feelings. Although not all participants will react similarly, most people feel uncomfortable when they are under scrutiny, and some participants will report feelings of discomfort at being watched. Relate this discomfort to the visibility of transgender and hijra communities and the scrutiny that they are subject to in public places, and ask the participants to consider the price that these communities pay for such scrutiny.

End the session on a positive by pointing out that while visibility may come at a cost, this visibility is also about one’s identity and dealing with the discomfort in the present paves the path for future acceptance and social integration.
Activity 5: Transformation and Feminisation Processes

**Time** | 1 hour
--- | ---
**Learning Outcomes** | By the end of this activity, the participants will be able to:
- Identify safer methods for transformation and feminisation for transgenders (male-to-female).
**Materials** | N/A
**Audio-visual Support** | Refer to the slides titled ‘Case Studies in Transformation and Feminisation’ from the PowerPoint presentation ‘Transgender and Hijra Communities’.
**Take-home Material** | Annexure 3 on ‘Aspects of Transformation and Feminisation’.

**Methodology**

**Part I: Transformation**
Ask participants to either list down on a sheet of paper, or to share within small groups, answers to the following questions:
- What do you understand by the terms ‘transformation’ and ‘feminisation’?
- What are the needs of individuals who are considering a ‘transformation’ or a ‘feminisation’ process?
- What do you think are the processes involved in ‘transformation’?

List the responses of the participants on a flip-chart and clarify any misperceptions and queries by discussing the following:
- Issues related to the transformation process.
- Castration.
- Hormone replacement therapy (male-to-female).
- Sex-reassignment surgery (SRS).
- Other methods of transformation.

**Part II: Becoming More Feminine**
Divide the participants into smaller groups of four to five persons and share with each group the case studies. Refer to the slides titled ‘Case Studies in Transformation and Feminisation’ from the PowerPoint presentation ‘Transgender and Hijra Communities’.

Ask each group to spend five minutes to discuss among themselves what they would say and do to help reassure somebody from the community who may want to undergo similar procedures. Tell them that their responses should cover:
- Various treatment options;
- Processes involved in transformation/transitioning; and
- Health hazards that are associated with these procedures.

**Note to Facilitator**
Guide the participants through the exercise by asking them to think about the male and female body characteristics.
Ask them what they feel they would want to ‘change’ and how they think such a change can happen (such as through surgery, medicines, etc).
Also, ask them if they have heard about the availability of such methods in the areas they live.
Ask each group to choose a volunteer to present their findings to the larger group. Use this activity to make sure that participants have understood the key concepts in safer transformation and feminisation. Distribute copies of Annexure 3 on ‘Aspects of Transformation and Feminisation’ to each participant.

**Background Material**

*(Brown and Rounsley, 1996)*

### Aspects of Transformation and Feminisation

Transitioning is a complicated process that involves any or all of the gendered aspects of a person’s life. People will choose elements based on their own gender identity, body image, personality, finances, and sometimes on the attitudes of others. A degree of experimentation is used to know what changes best fit them. Transitioning also varies between cultures and sub-cultures, according to differences in the societies’ views of gender. Given below are some of the key elements of transitioning:

- Legally and/or socially changing their name to something consistent with their gender identity.
- Asking others to use ‘she’ and ‘her’ while addressing them, instead of ‘he’ or ‘him’.
- Having one’s legal gender changed on the driver's license, ID cards, etc.
- Personal relationships take on different dynamics in accordance with gender.
- Changing the type and style of clothing, jewellery, accessories, and make-up.
- Adopting the mannerisms or gender role.
- Surgery and/or hormone therapy.
- Changing their pitch.

When a person undergoes changes (some or all) as stated above, and the person believes that his transition to the opposite gender is complete, that stage is referred to as ‘transformed’. Transitioning is sometimes confused with sex-reassignment surgery (SRS), which is just one element of transitioning. Many people who transition choose not to have SRS. Whereas SRS is only a physical change, transitioning is a physical, social, and emotional change. Some gender-queer and some intersex people have little or no desire to change their body but will transition in other ways.

Medical and surgical procedures exist for transsexual and transgender people. Treatments include hormone replacement therapy for fat distribution and breasts; laser hair removal or electrolysis to remove excess hair; surgical procedures, such as SRS, for feminising the body and its functions, such as voice, skin, face, breasts, and waist.

The choice of these procedures depends on the degree of gender dysphoria, presence or absence of gender identity disorder and standards of care. Most categories of transgenders are not known to seek these treatments.

Treatment such as hormone therapy and other procedures related to transitioning from male to female can be very expensive and the process may need a lot of time. Lack of proper knowledge and information in the community make many seek alternative or traditional methods.

### Castration

The most commonly practiced way of transformation by hijras is through castration or removal of testicles (called *nirvani* in transgender and hijra community parlance). Surgeries are often carried out under septic conditions by *dai’s* (a local community member or
self-taught nurse) who plays the surgeon based on her experience of operating on other hijras. Hijras sometimes call this operation nirbaan or nirvana (also called mukti in Hindi, which means ‘release’, suggesting ‘transition’ of a person from one ‘life’ to another).

Indian legal statutes do not permit the forced castration of males; therefore, there is secrecy around nirvani. The operation is always conducted in the early hours of the day and the whole process is seen as a religious ritual, although it is often viewed as a barbaric and brutal custom.

Most hijras in India are forcibly castrated, but a few submit themselves to the process. In almost all the cases, breasts develop after castration because the source of male hormones – the testicles – are removed and the female hormones, which are normally suppressed, will take over, ensuring emergence of secondary sexual characteristics (sparse growth of facial hair, change in voice, etc).

**Hormone Replacement Therapy (male-to-female)**

Taking hormones causes changes such as growth of breasts and smoothing of skin. It does not usually stop facial hair growth or cause the voice to change. Irreversible changes caused include breast development, enlarged nipples and stretch marks.

Reversible changes include decreased libido, redistribution of body fat, and reduced muscle development. The psychological changes with hormone replacement therapy are hard to define, because the therapy usually causes physical changes first. If not taken in appropriate dosages, hormone replacement therapy can cause various side effects, including death.

Estrogens used in hormone replacement therapy typically have side-effects that include mood swings, headache, nausea, dizziness, acne, skin darkening, high blood pressure, fatigue, depression, obesity, blood clotting, heart disease, diabetes, gallstones, liver disease, weakening of bones, advanced age, brain damage, and infertility. Excessive estrogens can cause blood clots and strokes. This is especially important to consider and monitor if the person is living with HIV.

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**Participants should also know:**

- Taking more hormones does not mean the hormones will work faster.
- Taking too many hormones pills can damage the liver, which means that hormones will not work in future because body will not be able to process them.
- Hormones will not change the body immediately and the effects may take more than a year to show.
- Use of hormones should not be treated lightly. Dosage may depend on factors such as age, body size, smoking habits, alcohol use and whether the testicles are present or have been removed surgically.
- For better effect, hormones should be taken in a combination of estrogens and anti-androgens. Estrogens help people become more feminine and help in developing breasts and large nipples, and anti-androgens block the male hormones produced in the body, even if the testicles have been removed. They also reduce facial and body hair.
- Birth control pills such as Mala D, Sukhi, etc., are NOT the same as female hormones or hormone therapy.
- Hormones should only be taken with a prescription and under the supervision of a physician.
Sex-reassignment Surgery (SRS)

SRS refers to the surgical and medical procedures undertaken to align the physical appearance and genital anatomy of intersex and transsexual individuals with their gender identity. SRS encompasses surgical procedures that reshape a male body into a body with a female appearance (or vice versa) and refers to the procedures used to make male genitals into female genitals and vice versa.

Most transgenders and hijras receive no professional counselling before surgery, and they sometimes have surgeries without understanding the consequences. A transgender should take hormones before any sex-related surgery. Someone who is unhappy with the effects of hormones may decide not to have surgery or even stop taking hormones.

SRS can be completed in one or two surgeries, depending on the surgeon’s technique. Possible complications due to this surgery, regardless of the type of surgery performed, include:

- Post-operative infections (as with any surgical procedure);
- Blood loss;
- Deep-vein thrombosis (clot in the leg veins, which is preventable with compression stockings and/or drugs);
- Vaginal stricture (the narrowing of the opening of the vagina) and urethral stricture (urethra is the tube through which urine is conveyed out of the male body from the bladder; urethral stricture is the narrowing of that opening);
- Pubic hair in undesirable places;
- Numbing of the external genitals (vulva, clitoris) due to severing and lack of healing of nerve tissue during surgery;
- Excess erectile tissue, resulting in sexual side effects;
- Rectovaginal fistula (a hole between the ‘new’ vagina and the colon, this is rare); and
- Urethral fistula (a hole in the urethra, again this is rare).

Post-operative care is important for better healing and results.

Note: Other related procedures for transformation and feminisation include facial feminisation surgery, breast augmentation (in cases where hormones fail to work), voice feminisation surgery (to alter the pitch of the voice), and buttock augmentation.
Activity 6: Reaching and Mobilising Transgender and Hijra Communities

<table>
<thead>
<tr>
<th>Time</th>
<th>30 minutes</th>
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</thead>
<tbody>
<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, the participants will:</td>
</tr>
<tr>
<td></td>
<td>• Understand the different structures prevalent within transgender and hijra communities; and</td>
</tr>
<tr>
<td></td>
<td>• Understand the key steps in reaching out to and mobilising these communities.</td>
</tr>
<tr>
<td>Materials</td>
<td>Board and chart papers with markers.</td>
</tr>
<tr>
<td>Audio-visual Support</td>
<td>N/A</td>
</tr>
<tr>
<td>Take-home Material</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Methodology

Part I
Divide participants into small groups, giving each group chart papers and markers. Ask each group to consider the following questions:

• What are the barriers to reaching out and mobilising transgender and hijra communities?
• What are the possible ways to deal with the barriers?

After 15 minutes, ask each group to share their findings, writing their responses on the board.

Introduce the following two approaches through which these communities can be reached, and conduct an interactive discussion on their advantages and disadvantages of the following:

• Approach 1: CBO-led interventions – working with gharana and hijra leaders in dera\textsuperscript{3}-jamath\textsuperscript{4} settings; and
• Approach 2: Melas (fairs) and event-based interventions.

Part II
Ask the groups to plan out an intervention and its activities based on the approaches discussed. (They could plan these interventions on hypothetical cases or using cases of communities in their intervention areas.)

After 15 minutes, ask each group to share its intervention plan to the larger group. Ask the other groups to give feedback to the presenting group, pointing out gaps and giving recommendations.

\textsuperscript{3} The space or location that a group of hijra gharana members, live in as a community.
\textsuperscript{4} The place where the deras gather
Approach 1: CBO-led Interventions

- For effective implementation of an intervention, it is important to understand how the gharana\(^5\) systems work. Remember that each gharana is different from the other and different rules apply within each of them.
- Peer educator (PE) should ideally be recruited after consultation with the guru (head of gharana, as mentioned earlier). Saukens\(^6\) of certain gharanas could be recruited as PEs.
- Capacity-building initiatives and some of the communication messages should be vetted by the gurus. It is important that the guru understands the content of these messages.
- It is important to develop only such interventions which can clearly show benefits to the gharana and its members, and do not come across as threatening to the authority of the guru.
- In interventions for hijras living with gurus in deras, PE should be aware of the protocols and rules of the deras. Outreach timings should match the availability of hijras in deras. Also it is important that the project build rapport with the guru.
- In interventions for hijras not living in deras, attention should be paid to seeking out those areas where they live or congregate. For hijras living with panthis and outside the deras, rapport-building with their partners is extremely important. Involving the partners in a programme activity could help in many ways.

Essential Components of a Gharana Intervention

Psychological Support

A support group from within the community will give members a sense of belonging and security. A helpline can also be started to provide assistance to hijras. The helpline can serve as a crisis support and information centre and provide appropriate information on sexual and reproductive health and sexual-reassignment surgery issues. This would help prevent visits to quacks for their sexual health problems and to discuss SRS.

Health Referrals

The interventions should establish linkages with local health facilities so that clients with complaints such as STI may then be referred for treatment. Also, hijras with sexual and reproductive health problems should be referred to appropriate specialists.

Drop-in Centers (DICs)

DICs can be set up to provide a platform for psycho-social support to hijras and for providing information on linkages to services. Information and counselling on nutrition, adherence and legal issues may also be provided. DICs should be created with the objective of providing a safe space for community members to drop-in any time and be their true selves. In case of gharanas registered as CBOs, the DICs could be the dera-jamath itself.

Vocational Training and Literacy

Alternate income-generation activities should be planned with the support of vocational training centers of various government departments for the hijra population who are willing and interested in vocational training. Training could be provided after assessing their interests.

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5 Hijra clans are called gharanas.
6 Sauken – elders who officiate over functions and rituals in a gharana. They guide the community members on the ways of the clan and maintain the sanctity of the same. In a colloquial sense they are also ‘facilitators’ for managing disputes, settlement of claims and payments of dues. The saukens is the single most important catalyst for overseeing events, activities and rituals. Members of the Lashkar gharana, wherever they live in India, are known to be the saukens for the hijra community.
Self-help and Support Groups
In order to increase awareness, address stigma and discrimination, and empower hijras to protect themselves, self-help groups (SHGs) can be formed through a systematic process involving state institutes and NGOs.

Outreach and Peer Education
Outreach should be peer-led. Every PE should be from the hijra community and preferably from the same dera-jamath. Their capacity should be built in areas of communication and social skills. They should also be able to provide regular counselling to the target community and motivate them for regular medical check-ups. They should lead the outreach process in interventions where the community prefers to stay invisible to save themselves from stigma and discrimination. Through outreach, the PE should be able to assess the needs of the community and plan services accordingly. Effective outreach helps in successful implementation of the project activities and in better service-delivery.

Possible Advantages of Dera-based Intervention
- In deras, where the guru is convinced about the usefulness of an intervention, the activities are implemented effectively, as members of the dera comply with the directives given by the guru.
- There is greater ownership of the intervention by the dera and in the larger context, the gharana.
- This approach is likely to reach all current and future hijra-members of that dera and the associated gharana.
- An effective way to reach hijras is by using the nayak or guru as a focal person.

Possible Challenges in Dera-based Intervention
- Convincing nayaks or gurus may take a long time and may require the help of one or more saukens.
- Developing specific communication material for hijras.
- The package may need to pay adequate attention to issues which are a priority to the hijra community, such as taking a rights-based legal approach, general health measures, capacity development components, etc.

Approach 2: Melas (fairs) and event-based interventions
Large numbers of transgenders and hijras often congregate at special festivals and community melas (fairs). These can be occasions when they are involved in multi-partner sex and sex-work. These gatherings, which are periods of intense sexual activity as well as a platform for networking, present a rare opportunity for reaching out to transgenders. Few approaches that can be planned during these gatherings are:
- Development of messages and materials appropriate for such settings.
- Mapping of all festivals in the state with help from SACS.
- Understanding how festivals/melas are organised in order to plan the intervention.
- Development of a mechanism to create opportunities for creating advantageous positions in such melas. It may be necessary to use CBOs or NGOs to ensure that peer workers are placed in vantage positions in fairs. These organisations would be better-off if they had prior familiarity with such events but since this intense activity may only be for a few days in each place, their expertise may be used for many such events.
- Build the capacity of PEs so that they are effective in these settings.
In order to sustain the work done at such melas, as well as to maximise the benefit from this approach, a follow-up strategy should be created where efforts are made to network with willing transgenders by reaching out to them through mobile phone and also by sharing information about drop-in facilities, ICTCs, etc.

**Possible Advantages**

- It is well known that many transgenders remain hidden and are difficult to reach through gharanas or NGOs, and that some transgenders only indulge in multi-partner sexual relationships during melas/festivals. Hence melas provide a good platform for reaching out to them.
- Transgenders come from far and near to these fairs/melas and for some of them being part of such events is considered sacred. Hence, an approach like this may well end up as the only meaningful way of reaching them.
- Such events also serve to reach the clients of transgenders.

**Possible Challenges**

- It may well be a one-time intervention or sensitisation for some transgenders/hijras, especially when there is no possibility of a follow-up.
- Transgenders may not be receptive to HIV or other health messages in the environment of a fair/mela. Therefore, a clearly thought-out process is needed for the success of this approach.

**Some of these events in India are:**

- Ajmer Sharif (in Rajasthan);
- Haji Malam, Thane (in Maharashtra);
- Kaliyath Sharif, Haridwar (in Uttar Pradesh);
- Udhavaru (in Gujarat);
- Koovagam, Kothadai and Bannari (in Tamil Nadu);
- Shahkap Poora(in Maharashtra);
- Mahashivarathri (in Odisha and Gujarat);
- Sambalpur Mela(in Odisha);
- Ghutiary Sharif (in 24 Parganas, West Bengal);
- Surajpur Mela (in Haryana);
- Meeraj, Bannarghetta Jatra and Yellamma Jatra (in Karnataka); and
- Kuttikulangara (in Kerala).
Activity 7: Mobilising Transgender/Hijra Groups to Access Quality Treatment and Care

<table>
<thead>
<tr>
<th>Time</th>
<th>45 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, the participants will be able to:</td>
</tr>
<tr>
<td></td>
<td>• Identify the barriers that transgenders and hijra communities face in accessing treatment and care services; and</td>
</tr>
<tr>
<td></td>
<td>• Explore solutions at individual and organisational levels.</td>
</tr>
<tr>
<td>Materials</td>
<td>Blank paper for listing characters.</td>
</tr>
<tr>
<td>Audio-visual Support</td>
<td>N/A</td>
</tr>
<tr>
<td>Take-home Material</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Methodology

**Note:** As this activity needs a large space, outdoors are preferred for this activity.

Tell the participants that they are going to play the ‘Health Walk Game’. Give each participant a piece of paper and assign a character from a context she/he can identify with (e.g. location where she/he works or lives). A tentative list is given below (based on the participant inputs, add or modify this list):

- Hijra guru or jammath leader
- Housewife, spouse of a local business man
- Transgenders or hijra activist
- PE of a transgender intervention project
- Primary school teacher
- Young transgender in school
- Primary school girl, aged 13
- Nurse in a local clinic
- Expat community worker from NGO
- Chief of police
- Trucker
- Transgender in a wheel chair, aged 19
- Widow with three children, aged two to 12
- Panthi
- Transgender sex-worker
- Head of hijra gharana
- Editor of a local newspaper
- Hijra living in a dera
- Transgender who begs in the train
- Gay man
- Social worker at a local community center
- Transgender living with HIV, aged 21
• Landless farmer and father of two
• Lesbian
• Mother of two small children who is a victim of domestic violence

Ask the participants to stand in a row, with enough space in front of each to take at least a dozen steps. Instruct them that you will read out certain statements one-by-one. Each participant is to consider whether or not the statement applies to the ‘character’ she/he is portraying.

If the participant feels that the statement applies to her/his ‘character’, the participant takes one step forward towards the finished line. If she/he feels that the statement does not apply to her/his ‘character’, she/he does not move.

Read out the statements one-by-one, giving time for participants to consider whether they should take a step forward or not.

Suggested statements:
• I can go easily to an ICTC centre for testing.
• I can influence decisions made by my community.
• I get to meet visiting officials from government offices.
• I have time, and access, to watch TV, go to the movies, and spend time with my friends.
• I am not in danger of being sexually abused or exploited.
• I get to see and talk to my parents.
• I can speak at meetings or a public forum and express my opinion.
• I can pay for treatment in private hospital, if necessary.
• I went to or expect to go to secondary school.
• I went to or expect to go to college.
• I will be consulted on issues affecting my health and rights.
• I am not in danger of being physically abused.
• I sometimes attend workshops and seminars.
• I will be consulted on decisions about my mobility.
• I have access to plenty of information about HIV.
• I have access to social assistance if I need it.
• I can vote in local elections.
• I could be interviewed on radio about my views.
• I can access free ART.
• I can access DOTS.
• I have access to condoms according to my need.
• I can carry condoms freely wherever I go.
• I have information about SRS and other related issues.
• I can seek proper and prompt treatment and diagnosis.
• I have access to lubes.
• I can have health insurance.
• I have access to safe drinking water.
• I have mosquito nets in my house and can protect myself from malaria.
After the exercise, assess where each participant is standing. Ask the following questions to the whole group (without moving them from their positions) as prelude to a discussion on ‘empowerment’:

- How do you feel about your own position and that of others?
- What do the start and finish lines represent?
- Why do you think some people were closer to or crossed the finish line and some were left behind?
- Did your identity influence your access to rights?
- Had you been playing your real-life identity, would you have been in an advantageous position or a disadvantageous position?
- Do you think that the ones who are closest to the finish line have any responsibilities towards the ones closer to or at the start line? If yes, what can they do to empower them?

If any participant says ‘No, this statement does not apply to the character I am playing’. See if she/he is staying at the same place, or is one actually moving backward?’ Explain with the following examples:

- The 21 year old transgender living with HIV, without access to an ICTC centre or ART, for example, would actually be adversely affected and therefore be moving backwards in life, not remaining at the same position.
- A transgender activist, whose parents want to have nothing more to do with her, would suffer emotionally and socially, so while moving forward in attaining her rights, she may be moving backward in her personal life.

Relate the exercise to the questions of accessibility of quality treatment and care for transgender and hijra communities. Discuss self-stereotyping and self-stigmatisation which prevent some people from reaching out to facilities available.

**Special Note: Community-Specific Barriers Faced by Hijras in Access to Health**

A hijra does not seek medical advice/help unless permitted to do so by her guru. The hijra reaction to herpes, a common problem in the community known as *Nagin*, provides a ready example of the power dynamics in health matters. When herpes lesions appear on a hijra’s body she discusses the matter with her guru, who may advise her to visit a quack. As herpes is self-limiting (and has no cure) this approach may look harmless. However, it is important to remember that early treatment can prevent or minimise the complications of herpes, such as recurrence and secondary infections.

Hijras rarely go to a qualified medical practitioner for genital problems. Doctors often only listen to their symptoms and prescribe medicines without physical examination. Sometimes, they consciously avoid making physical contact with a transgender/hijra.

Transgender and hijras also find sharing their health problems with the doctor difficult, because of overbearing or condescending attitudes of medical practitioners.

Large numbers of transgenders and hijras frequent non-qualified medical practitioners who have a long history of treating members of the community. They perceive these healthcare providers as more caring than their qualified counterparts. They are more approving of these providers because they believe these providers understand their needs better and have no qualms in examining them.
Another factor that determines the uptake of health services is the medical fees. Given their poor economic status and lack of skill in managing finances, members from this community end up visiting facilities/providers who charge less for their services.

For most transgenders/hijras, seeking healthcare ranks low in their list of priorities. For example, many members spend their money on personal grooming, such as laser treatment for hair removal.

Living on the fringes of society, they often encounter criminals and end up getting raped and/or molested. As their complaints are not treated seriously by law enforcement officers, they are exposed to these acts often. They cannot go to clinics and claim they were raped and/or molested due to apathy and fear of being treated as a male.

**Changing Scenarios for Medical Care**

Two factors have made a change in recent years: NGO interventions and efforts of some hijra CBO office bearers.

A few private doctors have started examining them but a large number of medical professionals are still apathetic/lethargic to their issues. Most of the doctors who have started examining them are still on a learning curve, as they are yet to develop a sound understanding of typical hijra health problems.

At this stage, the change in doctors’ attitude appears to be taking place more on a personal rather than structural level.
Activity 8: Social Exclusion, Rights and Entitlements

<table>
<thead>
<tr>
<th>Time</th>
<th>55 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, the participants will be able to:</td>
</tr>
<tr>
<td></td>
<td>• Define the term ‘social exclusion’ and understand its impact on transgender and Hijra communities; and</td>
</tr>
<tr>
<td></td>
<td>• Identify ways and means of addressing social exclusion.</td>
</tr>
<tr>
<td>Materials</td>
<td>N/A</td>
</tr>
<tr>
<td>Audio-visual Support</td>
<td>Audio-video clip from the movie ‘From the Third Eye’.</td>
</tr>
<tr>
<td>Take-home Material</td>
<td>Annexure 4 on ‘Journey towards Social Inclusion’.</td>
</tr>
</tbody>
</table>

Methodology

The purpose of this session is to explain the term “social exclusion,” to summarise the various issues faced by these communities that result in their exclusion, and to highlight the relation between social exclusion and vulnerability to HIV and other health risks.

The facilitator should screen the movie ‘From the Third Eye’. After the screening of the film, she/he leads a discussion which includes the following questions:

- What do we mean by social exclusion?
- How are people socially excluded?
- What could be the possible impact of social exclusion?
- What are the possible solutions to dealing with social exclusion?

Distribute copies of Annexure 4 on ‘Journey towards Social Inclusion’ to each participant, and end the day’s activities on a positive note by discussing the social and legal events that are taking place in India that positively impact the status of the transgender and hijra community in the country.

During the debriefing of the film, point out that participants and their CBOs need to do two things:

- Identify existing community-friendly services (medical, legal, etc.) to deal with all the challenges discussed during the day; and
- Strategise on how to convert unfriendly ones into friendly ones through sensitisation/advocacy with key stakeholders. (Tell them that this will be dealt in greater detail in Module D4 on Community Friendly Services).

Wrap up the day’s activities by pointing out that for transforming lives, physical transformation is not enough. Transformation of personal attitude along with transforming surrounding social structures is also needed. It can be achieved through awareness-generation, sensitisation, and advocacy with doctors, lawyers, community leaders, policy-makers, family members, and other stakeholders.

Note to Facilitator

‘From the Third Eye’ explores the basic needs of male-to-female TGs in eight states in India, and looks at the steps taken by them in dealing with the barriers to inclusion. The film not only helps in visualising their struggles and sufferings but also reflects their skills and tenacity to survive against all odds.
Background Information
(UNDP, 2010)

Social Exclusion and the Transgender/Hijra Communities

Exclusion from social and cultural participation:
- Exclusion from family and society
- Lack of protection from violence
- Restricted access to education, health services; and public spaces

Exclusion from economy, employment and livelihood opportunities

Exclusion from Politics and Citizen Participation
- Restricted access to collectivisation
- Restricted rights of citizenship
- Restricted participation in decision-making processes

Exclusion from Social and Cultural Participation

Exclusion from Family and Society
Despite what is perceived as Indian society’s general climate of acceptance and tolerance, there appears to be limited public knowledge and understanding of same-sex sexual orientation and of people whose gender identity and expression are incongruent with their biological sex. Human rights violations against sexual minorities, including the transgender communities in India, have been widely documented.

Discrimination in Healthcare Settings
Hijras face discrimination in the healthcare settings where providers are less equipped with knowledge about sexual diversities and not sensitive to the needs of various sexual minorities.

Social and Economic Discrimination and Deprivation
Due to exclusion from economic participation and lack of social security, hijras and transgender communities face a variety of social security issues. They lack specific social welfare schemes and face barriers in the usage of existing schemes.

Here the facilitator must explain how, despite social welfare departments providing a variety of social welfare schemes for socially and economically disadvantaged groups, there are none or very few schemes for hijras.

They lack access to life and health insurance schemes. Most hijras are not covered because of lack of knowledge, inability to pay premiums, or not being able to get enrolled in the schemes. Thus, most rely on government hospitals in spite of pervasive discrimination.

They also face loss or lack of income and the lack of livelihood options. Most employers deny employment even to qualified and skilled TGs. The lack of livelihood options is a key
reason for a significant proportion of TGs choosing or continuing to remain in sex-work, with its associated HIV and other health-related risks.

**Exclusion from Access to Legal, Civil and Political Rights**

Legal issues can be complex for people who change their sex, as well as for those who are gender-variant.

Legal issues include legal recognition of their gender identity, same-sex marriage, child adoption, inheritance, wills and trusts, immigration status, employment discrimination, and access to public and private health benefits. Getting legal recognition of gender identity as a woman or a transgender is a complicated process.

Lack of legal recognition has important consequences in getting a government ration (food-price subsidy) card, a passport, or in opening a bank account.

**Difficult to Vote**

Although transgenders have the option to vote as a woman or ‘other’, the legal validity of the voter’s identity card in relation to confirming one’s gender identity is not clear.

**Difficult to Register an Association**

Some legal provisions (e.g., Indian Trust Act, Societies Registration Act) that enable a group of individuals to form a legal association pose challenges for these communities. For example, the need for address proof and identity proof of all members of the group is the basic requirement to register an association. However, most transgenders and hijras do not have identity and/or address proof or even if they do, they have documents only with their male identity. Similarly, opening a joint bank account to carry out financial transactions of their association can be difficult due to stigma and discrimination.

They face challenges in collectivisation and strengthening their community organisations. There are more than 100 organisations and networks (including agencies providing services for MSMs) who work with transgenders in India. Many have faced challenges in legally registering their organisations. In spite of the above challenges, a few hijra CBOs across India were able to meet the legal requirements for registration.

**Difficult to Buy or Rent Space**

Buying or hiring office space for their legally valid associations is very difficult. Even if they get one, the landlords quote unfair rent prices.

**Difficult to Get Funding**

Transgender and hijra associations rarely get external financial support, even from those funders who might want to primarily fund HIV prevention activities. Through NACP III, for instance, only a few TG and hijra CBOs have been granted TI projects. [Editor’s note: Increased investment in TG and hijra CBOs is expected in NACP IV.]

Many of the existing TG and hijra organisations lack basic systems that are essential for effectively running an organisation. It is crucial that the capacity of these organisations be enhanced for effective community mobilisation and providing quality services.

**Difficult to Get Sex-change Operation**

The Indian legal system is also silent on the issue of a sex change operation or sex reassignment surgery (SRS, as mentioned above). According to Section 320 of the Indian Penal Code (IPC), ‘emasculating’ (castrating) is punishable by law. Technically, even if one voluntarily (with consent) chooses to be emasculated, the doctor is liable for punishment and the person undergoing emasculation could also be punished for ‘abetting’ this offence. (However, under Section 88 of the IPC, an exception is made in case an action is undertaken in good faith and the person gives consent to suffer that harm).
Difficult to Get Police Help
Hijras who cross-dress and who are in traditional occupations of begging and dancing are often harassed by police under the Section 268 IPC for public nuisance or under obscenity covered in Section 292 IPC. They can also be potentially harassed by police under Section 377 IPC and the Immoral Trafficking Prevention Act (ITPA) can be used on those in sex work. Also Section 375 IPC which deals with rape is not gender neutral, and thus does not address transgender/hijra sexual violence and rape. Also as discussed earlier, they are perceived as men and therefore not really accepted as weak victims of rape by the police.

Begging or mangti which is a traditional form of livelihood for these communities is punishable under the Bombay Prevention of Begging Act, 1959. They can be arrested and the individual is sent to a detention centre for a year which is under the Social Welfare Department. The detention centre has separate cells only for men and women and the transgender live with men. Often, they are required to strip in front of the officials.

Journey Towards Social Inclusion
- Reading down of Section 377 IPC.
- The setting up of the Tamil Nadu Aravanigal Welfare Board offers free SRS for hijras and transgenders in select government hospitals.
- Transgenders and hijras are counted in the national census.
- Transgenders and hijras can apply for passport as ‘O’ or ‘T’ sex.

Most of them have voter/election commission issued ID card as ‘Others’.
- Support for some hijra and transgender CBOs from the Global Fund (GFATM) Round-9 through the Principal Recipient India HIV/AIDS Alliance – both for organisational development and service provision.
- National Legal Services Authority (NLSA) providing free legal aid to transgenders. Also legal literacy classes on the rights of transgendered people has been initiated since January 2011. NLSA’s state and districts counterparts are active in this regard and can be approached for support.
- Pension scheme for transgender and hijras in Delhi/NCR.
- Free Legal aid service for TGs and hijras in Haryana.
- Reservation in government jobs for transgender and hijras in Punjab.
- Reservation under OBC 2A Category for receiving state benefits in Karnataka.
Tamil Nadu: A Move Towards Inclusion

Establishment of the Tamil Nadu Aravanigal (Transgender Women) Welfare Board

In a pioneering effort to address the issues faced by transgenders, the government of Tamil Nadu established a Transgender Welfare Board in April 2008, the first of its kind by any state government in India, in fact in the Indo-Pacific region.

The Board addresses a variety of concerns including education, income-generation and other social security measures.

The Board has already conducted an enumeration of the transgender populations in all 32 districts of Tamil Nadu. In some places identity cards, with gender identity mentioned as ‘Aravani, have been issued.

The government has also started issuing transgender with ration cards to buy food and other items from government-run fair-price shops. In May 2008, a Tamil Nadu government order directed that transgenders to be enrolled in government educational institutions and included as ‘other’ or ‘third gender’ category in admission forms.

Free sex-reassignment surgery is also performed for hijras/transgenders at selected government hospitals.
Annexure 1: Working Definitions of the Terms ‘Transgender’ and ‘Hijra’

Source: (NACP IV working groups, May 2011)

Hijras
Hijras are individuals who voluntarily seek initiation into the hijra community, whose ethnic profession is Badhai (ritual of clapping hands and asking for alms when blessing new-born babies, or dancing at auspicious ceremonies such as weddings). Due to the prevailing socio-economic and cultural conditions, a significant proportion of them have been forced to enter into begging and sex work for survival. These individuals live in accordance to the hijra community’s norms, customs and rituals which may vary from region to region.

Transgender

- TG is a gender identity.
- TGs usually live or prefer to live in the gender role different from that which they are born into.
- This has no relation to an individual’s sexual preferences.
- TG is an umbrella word which includes transsexuals, cross-dressers, intersexed persons, and gender-variant persons.
- TG includes people who have not undergone any surgery or physiological changes.

Note: The above definitions are adopted under the Pehchan programme.
Annexure 2: The Transgender Umbrella

Annexure 3: Aspects of Transformation and Feminisation

(Brown and Rounsley, 1996)

Transitioning is a complicated process that involves any or all of the gendered aspects of a person’s life. People will choose elements based on their own gender identity, body image, personality, finances, and sometimes on the attitudes of others. A degree of experimentation is used to know what changes best fit them. Transitioning also varies between cultures and sub-cultures, according to differences in the societies’ views of gender. Given below are some of the key elements of transitioning:

• Legally and/or socially changing their name to something consistent with their gender identity.
• Asking others to use ‘she’ and ‘her’ while addressing them, instead of ‘he’ or ‘him’.
• Having one’s legal gender changed on the driver’s license, ID cards, etc.
• Personal relationships take on different dynamics in accordance with gender.
• Changing the type and style of clothing, jewellery, accessories, and make-up.
• Adopting the mannerisms or gender role.
• Surgery and/or hormone therapy.
• Changing their pitch.

When a person undergoes changes (some or all) as stated above, and the person believes that his transition to the opposite gender is complete, that stage is referred to as ‘transformed’. Transitioning is sometimes confused with sex-reassignment surgery (SRS), which is just one element of transitioning. Many people who transition choose not to have SRS. Whereas SRS is only a physical change, transitioning is a physical, social, and emotional change. Some gender-queer and some intersex people have little or no desire to change their body but will transition in other ways.

Medical and surgical procedures exist for transsexual and transgender people. Treatments include hormone replacement therapy for fat distribution and breasts; laser hair removal or electrolysis to remove excess hair; surgical procedures, such as SRS, for feminising the body and its functions, such as voice, skin, face, breasts, and waist.

The choice of these procedures depends on the degree of gender dysphoria, presence or absence of gender identity disorder and standards of care. Most categories of transgenders are not known to seek these treatments.

Castration

The most commonly practiced way of transformation by hijras is through castration or removal of testicles (called nirvani in transgender and hijra community parlance). Surgeries are often carried out under septic conditions by dai’s (a local community member or self-taught nurse) who plays the surgeon based on her experience of operating on other hijras. Hijras sometimes call this operation nirbaan or nirvana (also called mukti in Hindi, which means ‘release’, suggesting ‘transition’ of a person from one ‘life’ to another).
Indian legal statutes do not permit the forced castration of males; therefore, there is secrecy around nirvani. The operation is always conducted in the early hours of the day and the whole process is seen as a religious ritual, although it is often viewed as a barbaric and brutal custom.

Most hijras in India are forcibly castrated, but a few submit themselves to the process. In almost all the cases, breasts develop after castration because the source of male hormones—the testicles—are removed and the female hormones, which are normally suppressed, will take over, ensuring emergence of secondary sexual characteristics (sparse growth of facial hair, change in voice, etc).

**Hormone Replacement Therapy (Male-to-Female)**

Taking hormones causes changes such as growth of breasts and smoothing of skin. It does not usually stop facial hair growth or cause the voice to change. Irreversible changes caused include breast development, enlarged nipples and stretch marks.

Reversible changes include decreased libido, redistribution of body fat, and reduced muscle development. The psychological changes with hormone replacement therapy are hard to define, because the therapy usually causes physical changes first. If not taken in appropriate dosages, hormone replacement therapy can cause various side effects, including death.

Estrogens used in hormone replacement therapy typically have side-effects that include mood swings, headache, nausea, dizziness, acne, skin darkening, high blood pressure, fatigue, depression, obesity, blood clotting, heart disease, diabetes, gallstones, liver disease, weakening of bones, advanced age, brain damage, and infertility. Excessive estrogens can cause blood clots and strokes. This is especially important to consider and monitor if the person is living with HIV.

**Sex-reassignment Surgery (SRS)**

SRS refers to the surgical and medical procedures undertaken to align the physical appearance and genital anatomy of intersex and transsexual individuals with their gender identity. SRS encompasses surgical procedures that reshape a male body into a body with a female appearance (or vice versa) and refers to the procedures used to make male genitals into female genitals and vice versa.

Most transgenders and hijras receive no professional counselling before surgery, and they sometimes have surgeries without understanding the consequences. A transgender should take hormones before any sex-related surgery. Someone who is unhappy with the effects of hormones may decide not to have surgery or even stop taking hormones.

SRS can be completed in one or two surgeries, depending on the surgeon’s technique. Possible complications due to this surgery, regardless of the type of surgery performed, include:

- Post-operative infections (as with any surgical procedure);
- Blood loss;
- Deep-vein thrombosis (clot in the leg veins, which is preventable with compression stockings and/or drugs);
- Vaginal stricture (the narrowing of the opening of the vagina) and urethral stricture (urethra is the tube through which urine is conveyed out of the male body from the bladder; urethral stricture is the narrowing of that opening);
- Pubic hair in undesirable places;
- Numbing of the external genitals (vulva, clitoris) due to severing and lack of healing of nerve tissue during surgery;
• Excess erectile tissue, resulting in sexual side effects;
• Rectovaginal fistula (a hole between the ‘new’ vagina and the colon, this is rare);
  and
• Urethral fistula (a hole in the urethra, again this is rare).

Post-operative care is important for better healing and results.

Note: Other related procedures for transformation and feminisation include facial feminisation surgery, breast augmentation (in cases where hormones fail to work), voice feminisation surgery (to alter the pitch of the voice), and buttock augmentation.

Participants should also know:

• Taking more hormones does not mean the hormones will work faster.
• Taking too many hormones pills can damage the liver, which means that hormones will not work in future because body will not be able to process them.
• Hormones will not change the body immediately and the effects may take more than a year to show.
• Use of hormones should not be treated lightly. Dosage may depend on factors such as age, body size, smoking habits, alcohol use and whether the testicles are present or have been removed surgically.
• For better effect, hormones should be taken in a combination of estrogens and anti-androgens. Estrogens help people become more feminine and help in developing breasts and large nipples, and anti-androgens block the male hormones produced in the body, even if the testicles have been removed. They also reduce facial and body hair.
• Birth control pills such as Mala D, Sukhi, etc., are NOT the same as female hormones or hormone therapy.
• Hormones should only be taken with a prescription and under the supervision of a physician.
Annexure 4: Journey towards Social Inclusion

- Reading down of Section 377 IPC.
- The setting up of the Tamil Nadu Aravanigal Welfare Board offers free SRS for hijras and transgenders in select government hospitals.
- Transgenders and hijras are counted in the national census.
- Transgenders and hijras can apply for passport as ‘O’ or ‘T’ sex.
- Most of them have voter/election commission issued ID card as ‘Others’.
- Support for some hijra and transgender CBOs from the Global Fund (GFATM) Round-9 through the Principal Recipient India HIV/AIDS Alliance—both for organisational development and service provision.
- National Legal Services Authority (NLSA) providing free legal aid to transgenders. Also legal literacy classes on the rights of transgendered people has been initiated since January 2011. NLSA’s state and districts counterparts are active in this regard and can be approached for support.
- Pension scheme for transgender and hijras in Delhi/NCR.
- Free Legal aid service for TGs and hijras in Haryana.
- Reservation in government jobs for transgender and hijras in Punjab.
- Reservation under OBC 2A Category for receiving state benefits in Karnataka.

Tamil Nadu: A Move Towards Inclusion

Establishment of the Tamil Nadu Aravanigal (Transgender Women) Welfare Board

In a pioneering effort to address the issues faced by transgenders, the government of Tamil Nadu established a Transgender Welfare Board in April 2008, the first of its kind by any state government in India, in fact in the Indo-Pacific region.

The Board addresses a variety of concerns including education, income-generation and other social security measures.

The Board has already conducted an enumeration of the transgender populations in all 32 districts of Tamil Nadu. In some places identity cards, with gender identity mentioned as ‘Aravani, have been issued.

The government has also started issuing transgender with ration cards to buy food and other items from government-run fair-price shops. In May 2008, a Tamil Nadu government order directed that transgenders to be enrolled in government educational institutions and included as ‘other’ or ‘third gender’ category in admission forms.

Free sex-reassignment surgery is also performed for hijras/transgenders at selected government hospitals.
Annexure 5: PowerPoint Presentation – Transgender and Hijra Communities

Training on
Transgender and Hijra Communities

Transgender and Hijra Issues
Working Definitions
Who are Hijras?

- Individuals who voluntarily seek initiation into the hijra community;
- Whose ethnic profession is badhai, but due to the prevailing socio-economic cultural conditions, a significant proportion of them are into begging and sex work for survival; and
- Who live in accordance to the community norms, customs and rituals which may vary from region to region.

What Does the Term Transgender Mean?

- Transgender is a gender identity.
- Transgender persons usually live or prefer to live in the gender role different to the one which they are assigned at birth.
- This has got no relation with anyone’s sexual preferences.
- Transgender is an umbrella term which includes transsexuals, cross-dressers, intersexed persons, gender variant persons and many more.
- Transgender is a term that includes people who have not undergone any surgery or physiological changes.

Transgender and Hijra Issues

The Transgender Umbrella
The Transgender Umbrella

Transgender and Hijra Issues
Vulnerability to HIV and Risk Factors: Some Findings

Respondents Age at First Sexual Encounter

Male Commercial Partner

Male Commercial Partner (last month)


Occupation

Occupation and Sources of Earning


Reaction of Respondents Family

TG/Hijras: Acceptance by Family and Society

**Education Levels**


**Violence**


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**Transgender and Hijra Issues**

**Sexual Health, STI and Transgender and Hijras**
1: Question

Why are transgender and hijras at high-risk of contracting HIV?

2: Case Scenario

A transgender sex worker complains:

“Whenever I ask my clients to use condoms they all run away, they think I have AIDS! I am losing my business because of this.”

3: Question

What can a transgender or a hijra sex-worker do when she does not have a condom but is already at a sex-solicitation site?
4: Case Scenario

I don’t want to go for HIV testing. At hospitals – both public and private – they always laugh at me.

4: Case Scenario

“Also if my guru comes to know that I have AIDS, I will no longer be able to stay with her.”

“My friends will ignore me so it is better not to know my HIV status.”

– a hijra

Transgender and Hijra Issues

Case Studies in Transformation and Feminisation
Case Study 1

I met X, a performer in a local dance group. She was the most beautiful transgender woman I had ever met. Wanting to look like her, I asked her about the hormones she took and the amount she took. I also started using the same hormones that she did. But I started getting terrible headaches and felt sick. What is happening to me?

Case Study 2

In our dera, all my sisters are taking sukhi (a birth control pill) for breast enlargement. Some of them have also started taking injections. I am not sure which one of these is effective? Do they have any side-effects?

Case Study 3

I am going for nirvani (emasculaton) next month. I know a doctor who can perform the procedure. However, my friends suggest that I go to a hijra dai as they are better and less expensive. They tell me that undergoing dai nirvani will make me more beautiful as the process is more traditional. Which option I should choose?
Case Study 4

I am a transgender sex-worker. I am looking for silicon implants for my breasts. Unfortunately, in the cities it is too expensive. Someone suggested injecting silicon into the breasts directly. What should I do?

Case Study 5

I am told that instead of shaving, plucking facial hair helps reduce hair growth. The process is painful but all my sisters are going for that procedure. Does plucking really reduce hair growth? What should I do?

Case Study 6

After SRS, can I become a 'real woman'? Can I marry and have proper sex with my partner? Can I conceive?
References


From the Third Eye, (2010), Film-based research project, SAATHII and United Nations Development Programme, India.
Notes
Pehchan Training Curriculum
MSM, Trangender and Hijra
Community Systems Strengthening

CG Curriculum Guide

module A
A1 Organisational Development
A2 Leadership and Governance
A3 Resource Mobilisation and Financial Management

module B
B Basics of HIV Prevention and Outreach Planning (Pre-TI)

module C
C1 Identity, Gender and Sexuality
C2 Family Support
C3 Mental Health
C4 MSM with Female Partners
C5 Transgender and Hijra Communities

module D
D1 Human and Legal Rights
D2 Trauma and Violence
D3 Positive Living
D4 Community Friendly Services
D5 Community Preparedness for Sustainability
D6 Life Skills Education