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Differentiating the Vulnerability of Kothis and Hijras to HIV/AIDS: A Case Study of Lucknow, Uttar Pradesh

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DIFFERENTIATING THE VULNERABILITY OF *KOTHIS* AND *HIJRAS* TO HIV/AIDS: A CASE STUDY OF LUCKNOW, UTTAR PRADESH

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
BSS	Behavioral surveillance survey
CCC	Community care centre
HIV	Human immunodeficiency virus
HRG	High-risk group
ICTC	Integrated counseling and testing centre
IPC	Indian Penal Code
MSM	Males who have sex with males
NACO	National AIDS Control Organization
NACP III	National AIDS Control Programme Phase III
NFI	Naz Foundation International
SRS	Sex reassignment surgery
STI	Sexually transmitted infection
TG	Transgender
UNGASS	United Nations General Assembly Special Session
UNDP	United Nations Development Programme
WHO	World Health Organization

ABSTRACT

The present study aims to begin the process of differentiation between the various sub-populations that fall under the agenda of interventions targeted at Males who have Sex with Males (MSM). This separation is accomplished though an investigation of the sociocultural factors and behavioral patterns impacting the vulnerability of MSM and transgender (TG)

communities to HIV/AIDS. Specifically, the situation of *kothi* and *hijra* populations are compared in order to understand how the differences in their cultural practices and lifestyles create unique sexual health needs. The study was completed in Lucknow, Uttar Pradesh under the guidance of Bharosa Trust and MAAN AIDS Foundation. Interviews were conducted with a variety of stakeholders, including *kothis, hijras*, NGO representatives, and medical professionals, in order to gain multiple perspectives on the condition of MSM and TG populations. It was found that the correspondingly dissimilar life situations of *kothis* and *hijras* make them distinctly vulnerable to HIV/AIDS and hence denote the demand for separate interventions. The public identity and regulated structure of *hijra* communities creates social inequities and needs that differ greatly from those of *kothis*. In order to effectively respond to and mitigate vulnerability to HIV, these unique needs must be addressed by interventions headed by members within the communities themselves.

INTRODUCTION

In recent years the issue of HIV/AIDS in India has been forced into the spotlight of the public sphere. With the second largest number of people living with HIV/AIDS in the world, India has striven to devise and implement a comprehensive and effective response strategy. The current response, as outlined by the National AIDS Control Programme phase III (NACP III), focuses much of its attention on a number of high-risk groups (HRG) that have been identified as driving the epidemic. Individuals at greatest risk of contracting the disease are those who, even without the ramifications of HIV/AIDS, are already vulnerable members of society. Once such marginalized group has been formally termed Men who have Sex with Men (MSM), an umbrella label encompassing almost any male with non-hetero gender variance. NACP III recognizes the

demand to accelerate efforts aimed at HRGs, especially in light of estimates that claim HIV prevalence amongst these sectors of society to be ten to twenty times higher than that of the general population (WHO MSM Report, 49). The disproportionately high number of incidences in HRGs points to the fact that the disease is concentrated in marginalized pockets of society, essentially resulting in the manifestation of many different AIDS epidemics in India. Because the experience of HIV/AIDS differs substantially between communities, targeted interventions have claimed to cater to and focus on meeting the specific needs of the groups they seek to represent.

However, evidence indicates that interventions intended for MSM are not achieving these standards. The 2010 Country Progress Report by the United Nations General Assembly Special Session (UNGASS) shows an overall declining trend in the HIV epidemic. The HIV prevalence among adult populations decreased from 0.34% in 2007 to 0.29% in 2008, and the number of people living with HIV (PLHIV) in the country dropped from 2.31 million in 2007 to 2.27 million in 2008. The discrepancy becomes apparent when comparing these statistics to those for the MSM population, where this decline is not mirrored. According to the same report, HIV prevalence amongst MSM in India is mostly stable at around 7.3%, and there has been an increasing trend among south Indian states and Delhi (UNGASS Country Progress Report, 19). Thus, though a glace at the country as a whole suggests that substantial strides have been made in combating HIV/AIDS, it is apparent that there "remains a real and ever-expanding gap between the rhetoric of focused responses and the reality of the increasing HIV prevalence" among MSM in India (*Pukaar,* NFI). Despite the fact that interventions targeted at this population have surfaced throughout the country, the number of HIV infected MSM individuals

in India is growing as interventions have not yet succeeded in making accessible the care and support required by this community.

The reason for this deficiency lies in the fact that MSM in an Indian context are not a united or organized group. Within the label of 'MSM,' there is not only a great diversity of terms and sub-categories, but of lifestyles, situations, behaviors, identities, and cultural practices as well. Each of these sub-populations of MSM differently experiences their sexual sense of self. However, for years now, India's approach to sexual behavior has been based on a borrowed Western construction of hetero/homosexuality. Adoption of such a constrained binary has resulted in a complete overlook of the diversity of MSM behavior in India. Even within the broad categories outlined in following sections, there are several sub-divisions, as well as individuals with multiple identities whose lifestyles and situations defy designation into socially constructed stratifications. In a study conducted by Naz Foundation International (NFI) in 2000, it was found that many interventions targeted at MSM ultimately failed due to a lack of understanding and knowledge regarding the wide range of male-to-male sexual behaviors. Shaping India's complex MSM dynamic in a culturally inapt and unfitting framework actually led to "an increase in the invisibility of the behaviors" (NFI Bangalore Assessment, 4). Thus, by adapting to the Western homo/hetero paradigm, India actually homogenized homosexuality and erased crucial distinctions between the various populations.

Field Study Objectives

The term MSM has generally embodied any male exhibiting non-hetero gender behaviors. Hence, for organizations that identify as MSM-agencies, their programs have conventionally been molded to include everyone from *kothis*, to *giryas*, to TG women such as *hijra*s. The problem with this blanket approach is that it conflates multiple interests and needs to the detriment of each population involved. As described in Guidelines for Policy-Making and

Interventions in the Time of AIDS, "the different types face differential risks, because their life situations vary considerably. They have different negotiation powers, differential access to information and varied resources for practicing safer sex" (Ramakrishna et al., 386). In clumping together anyone with a gender variance under the designation of 'MSM,' the HIV/AIDS response has failed to understand the unique behavior patterns and specific needs of individual communities. Simple condom promotion and HIV education is not adequate in reducing the vulnerabilities of these groups. Without addressing the social inequities distinct to a population that produce their HIV risk, that risk will never be effectively dissipated. The objective of the present study is then to begin the process of differentiation, particularly between the *kothi* and *hijra* populations of Lucknow, though an examination of the lifestyle factors and social determinants that render them differently vulnerable to HIV/AIDS. Because health issues interface at multiple levels with a range of social forces, this study intends to demonstrate how the differing sociocultural situations of *kothis* and *hijra*s create the need for separate HIV interventions.

Field Study Methods

The present study was conducted in Lucknow, the capital city of Uttar Pradesh in India over the course of four weeks in November 2011. The site was chosen for various reasons. Firstly, while there are decreasing trends of the HIV/AIDS epidemic in southern states, rising trends are visible in the North East (WHO MSM Report, 3). Uttar Pradesh has overall poor health indicators as compared to the rest of the country and is considered to be one of the six high-prevalence states for HIV/AIDS (UNGASS Country Progress Report, 4). This study was carried out in collaboration with MAAN AIDS Foundation and Bharosa Trust. The populations and issues confronted by MAAN and Bharosa directly deal with strengthening the response to HIV services for MSM networks. MAAN is international development agency that provides

technical assistance and support to evolve local programs to address the needs of MSM made

vulnerable to HIV/AIDS transmission. MAAN strongly focuses on the relationship between

male-male sexuality and HIV epidemiology, and Bharosa is one of the community-based

organizations that they have partnered with to develop. The NFI journal, *Pukaar,* describes

Bharosa as the "lead MSM and sexual health agency in Uttar Pradesh" (5). Both organizations

are heavily involved in global and local dissuasions of MSM and HIV/AIDS and thus were able

to provide both the resources and connections to MSM and TG communities needed to guide this

field study.

A total of seventeen interviews were conducted during the duration of this field study.

This study attempts to examine the lived experiences of specifically the *kothi* and *hijra*

populations of Lucknow because they are two largest and most prominent groups. Of the

respondents, seven are self-identified *kothi*, two are *hijra*s, four are representatives from the

medical community, and the remaining four are administrators and authorities within MAAN

and Bharosa. Six out of the seven *kothis* serve as either outreach workers or peer educators for

Bharosa, and one of them is also a HIV positive individual. Interviews with *kothis* and *hijra*s

were arranged by Bharosa, while government medical officials were contacted directly by the

student interviewer. Owing to concerns about confidentiality, a number of informants who

agreed to be interviewed did not want to be recorded, though a recording device was utilized

when permitted. Hand-written notes were taken during the interview itself, and each interview

was transcribed immediately following its completion. Except for a few interviews collected at

medical facilities and in the *hijra* community, the majority took place at the Bharosa center in a

private room. With the exception of one, the interviews were carried out in Hindi. In most

cases, a representative from Bharosa was available to help facilitate communication, though in

circumstances when such aid was not present, the student interviewer served as the primary

interpreter. While structured sets of questions tailored to specific participants were developed,

they generally functioned as guidelines to direct the flow of the conversation. Hence, the

interviews followed a primarily semi-structured format, which provided room for adaption and

modifications depending on the progression of the discussion. Interviews ranged anywhere from

thirty minutes to two hours. For protection and privacy purposes, the names of the respondents

have been changed, including those of officials from organizations, as per requests by Bharosa.

All quotations are drawn from the interviews.

DEFINITIONS

In considering the terminology pertinent to discussions of sexual identity and behavior, it

is important to note that the definitions of such words stem from the manner in which the terms

are employed in a given framework. Thus, the following descriptions are neither stiff nor finite;

rather they represent interpretations reached through an understanding of local context and

usage. Many of these terms overlap in meaning, highlighting the complexity of categorizing

sexuality given the fluid and dynamic nature of labels in an Indian context. While there exists

endless variations of classifications, the terms explored here are restricted to those groups

relevant to this study and the situation in Lucknow. Though distinctions between the various

constructs are both vague and flexible, the general identifying features of each category are

outlined below.

Males who have Sex with Males (MSM): In most contexts, including the global field of

HIV/AIDS, the acronym 'MSM' denotes 'men who have sex with men.' However, as realized

by NFI, this designation becomes problematized when considering the sociocultural associations

and connotations of 'man.' The implied masculinity imbedded in the word 'man' immediately places the term 'men who have sex with men' in a hegemonic mentality that has vivid expectations of manly behavior, responsibility, and identity. Though constructions of masculinity and manhood vary across cultures, the association of the purely behavioral term 'MSM' with an expected gender expression delineates the need for an alternate perspective. Thus, in an attempt to dissociate 'MSM' from such social definitions of 'man,' in the context of this study the term 'MSM' will be used to mean 'males who have sex with males.' The substitution of 'man' with 'male' shifts the lens to a biological focus that is not intended to suggest a self-identity. In an Indian discourse, one's sexual desire, sexual behavior, and sexual identity are not always congruent, lending to a very well defined line of separation between the psychological and behavioral components of sexual activity. In this sense, the phrase 'males who have sex with males' does not designate any individual or personal identity, such as gay or homosexual; rather, it refers only to MSM type interactions and physical activity. A pertinent issue then becomes how to define what classifies as MSM behavior. There are no set guidelines dictating the frequency or type of male-to-male action that qualifies a person as MSM (NFI Situational Analysis, 5). Because of the generic nature of this perspective, MSM has become an umbrella term encompassing a diverse array of sub-populations that operate within a variety of networks. For the purposes of their work, NFI applies the term to "gay men, *kothi* -identified males, *metis, zenanas, bakla, waria*, and other marginalized male sexualities, along with *hijra* - identified males, *panthis/giryas*, and all those men who identify as men and also have sex with other males, occasionally, frequently, or all the time." Due to the considerable diffusion between various identities and practices, NFI recognizes that the phrase 'MSM' intersects with TG categories on several levels.

Transgender (TG): Generally, TG is used to signify people whose gender expression differs from their biological sex and who "present a breaking and/or blurring of culturally prevalent stereotypical gender roles" (UNDP India 2010, 3). Through transgressing gender norms, TG individuals challenge rigid social constructs of sexuality. As in the case with MSM, the term 'transgender' can function as an identity marker, but in many cases it is also used to describe any individual whose behaviors are gender deviant or unconventional, regardless of personal sexual orientation. In present-day usage, the term covers a wide spectrum of behaviors and identities, from "pre-operative, post-operative and non-operative transsexual people" to *hijra*s and, in some cases, *kothis* as well (UNDP India 2010, 3). This broad understanding of the term 'TG' has led to its inadequacy in describing any particular gender experience. For instance, a castrated *hijra* who has fully adopted that lifestyle and a feminized *kothi* who occupies a TG space only on a part-time basis have radically separate identities, though they are both considered under the TG tag and agenda.

Kothi: Whereas any individual engaging in male-to-male sexual relations falls within range of the MSM classification, the term '*kothi*' typically aligns with an a sense of self or identity. As the most visible and predominant subpopulation of MSM, *kothis* are a "heterogeneous group that includes same-sex-attracted males of all ages whose gender behavioral traits are primarily feminine; MSWs who may adopt feminine mannerisms to attract male clients; and TG or trans-sexual women" (WHO MSM Report, 50). Characterized mainly as males exhibiting varying degrees of femininity, *kothis* play a highly performative role in society, exploiting feminine conduct and mannerisms in certain social spaces to attract 'real men,' also known as *giryas,* and to communicate their own gender expression. While the actions of *kothis* are modeled after those of *hijra*s, their exhibition of effeminate behaviors is generally situation specific, with many

adapting to heteronormative standards when in the workplace or mainstream society (Interview with Salman Ji). Along this same vein, many *kothis* are married to women and thus perform double-roles within their lives. In sexual activity, *kothis* normally assume only the passive positive and claim to prefer being penetrated both anally and orally. While there are circumstances where this boundary is crossed, it is usually kept hidden from the larger *kothi* and MSM community. A *kothi* is not regarded by himself or society to be a man, thereby setting the foundation for the gendered dynamic in which most Indian MSM relations take place. In the case of Lucknow, most self-identifying *kothis* are from lower socioeconomic backgrounds with high rates of illiteracy and poverty.

Girya: Also known in many regions as *panthi, girya* is the term utilized by *kothis* to describe their penetrating counterparts. Thought of as 'real men,' *girya*s are any partner who assumes the insertive position. However, this term has been entirely fabricated by *kothis*, as *girya*s will never self-identify with the label. Because they are penetrating feminized males (*kothis*), *girya*s retain their manliness and thus do not recognize their actions as MSM or perceive themselves as engaging in homosexual behavior. Consequently, the *girya* community is largely invisible and inaccessible, complicating outreach efforts and posing a hurdle to effective interventions. For most *girya*s, the act is purely behavioral and based on semen discharge as opposed to psychological inclination or attraction.

Hijra: Rooted in the India's long historicity, *hijra*s (more respectfully referred to as *kinnar)* function within a cultural space outlined by traditional rules and structures. Unlike other sub-categories of MSM, the *hijra* identity is very much linked to a distinct lifestyle and public figure, making them easily recognizable. Furthermore, *hijra*s have negotiated an established (albeit neglected and ostracized) standing for themselves within Indian society through their fulfillment

of specific cultural roles (such as *badai* and *basti*) as well as their residence in organized communities under a *Guru-chela* system. '*Hijra*' is generally a self-identifying term for individuals who perceive themselves to be neither male nor female, but rather a third gender. While a number of *hijra*s are born with ambiguous genitalia, many undergo ritual castration procedures. The intersection of *kothis* and *hijra*s remains quite blurred, as many pre-operation *hijra*s consider themselves *kothi* and many *kothis* consider themselves TG (WHO MSM Report, 50). Because of this fluidity, *hijra*s have conventionally been incorporated into interventions tailored to MSM, though the process of separation is now being stressed.

CURRENT STATISTICAL INFORMATION

Depending on the male population surveyed, same-sex behavior in India has a prevalence of 6%-13% (WHO MSM Report, 49). For the state of Uttar Pradesh, the Behavioral Surveillance Survey (BSS) 2006 reports that 51.5% of MSM have had a female partner within the last month, with 37.5% being married to women. (WHO MSM Report, 53). This high percentage of bisexual behaviors among MSM points to the risk of HIV infection generated for the female partners of MSM. The BSS 2006 found use of a condom with commercial (13.1%) and non-commercial (13.8%) male partners to be lowest between MSM in Uttar Pradesh, suggesting that greater attention needs to be paid to this area (WHO MSM Report, 54). The 2010 UNGASS Country Progress Report shows the dominant route of HIV transmission to be heterosexual intercourse (87.1%), with homosexual activity accounting for only 1.5% of all reported cases. However, because many MSM are married and others simply conceal their MSM activity, numerous cases of HIV among them are likely to be categorized as heterosexually transmitted**.** The gravity of their situation has thus yet to be realized, as numbers do not

accurately reflect the magnitude of the impact this population has on the entire country's HIV/AIDS status.

TG individuals are usually subsumed in statistics as well as interventions for MSM. The complete neglect of *hijra*s in current interventions tailored to MSM is evident in the dearth of information available on the population. Considering the historical presence of TG individuals in Indian society, there are surprisingly few statistics in current literature that specifically monitor trends in their behavior. The 2010 World Health Organization (WHO) MSM Report estimated the MSM population in 2006 to be 2,352,133, but then further stated that no reliable estimates of the number or size of the *hijra* population is available. While HIV prevalence amongst MSM is reported to be 7.3% against an overall prevalence of 0.29%, recent studies conducted amongst *hijra*s and TG have found their rate of prevalence to be much higher, anywhere from 17.5% to 41% (UNDP India 2010, 4). Such a drastic difference largely indicates that the sociocultural situations of MSM and *hijra*s are distinct and that the social inequities of *hijra*s are being entirely overlooked by the present HIV response for their rates to be this disproportionately high.

GENDERED FRAMEWORK

In South Asia, the dominant framework of male-to-male sexualities is derived from the prevalence of gendered identities. This factor serves as the primary divider between perceptions of homosexuality in India and her western counterparts, where MSM behaviors are rooted in a binary based on either homo or hetero sexual orientation. Recognition of this divergence is crucial to understanding and addressing the needs specific to India's MSM population. In a Western context, the gender and biological expression of a MSM individual are usually

congruent, suggesting that one's physical behavior and sexual sense of identity are in agreement. Hence, in MSM encounters where both partners consider themselves male, the term 'gay' comes to imply "a mutuality, friendship and exchangeable sexual acts- they are companionate relationships formed within a same sex/same gender dynamic" (NFI Situational Assessment, 6). However, the state of equality associated with this notion of 'gay' is very much embedded in an Anglo-Saxon history that is does not translate into South Asian workings. In India, the label 'gay' is limited to "primarily English speaking, middle and upper class, with extensive contacts with Western gay culture and/or emergent gay groups across India through the internet" (NFI Situational Assessment, 6). Consequently, the concept of 'gay' remains a relatively foreign phenomenon contained within an esoteric group of urban elite that has access to such terminology and thinking. The newly emerging population of self-identified gays is not an accurate reflection of the majority of MSM experiences, which are constructed around an unyielding gendered perspective. Thus, the remainder of MSM relations must be interpreted and examined from a rationale conscious of South Asian culture and functioning.

Public spaces in Indian society are dominated and controlled by male figures and authorities. Most visible domains of society either severely exclude or objectify the female body, while strict, socially policed boundaries restrain female voice and agency. There are detailed expectations and standards linked to the male and female gender, and it is compliance to these molds that has encouraged the development of an openly homosocial and homoaffectionist culture (NFI Website). Traditional and orthodox regulations, especially in a conservative city such as Lucknow, limit access to females and condemn pre-marital male-female interactions. As a result, men relate socially with other men and close male relationships are both customary and accepted. In an interview with Salman Ji, the director of Bharosa, he explained that no one

questions or suspects two men living in the same room, though an unmarried man and woman staying together would never culturally be tolerated. He further stated that the pervasiveness of this homosocial attitude leads to many opportunities for MSM behavior, for the close proximity of men and the unavailability of women facilitate an easy transition to homosexual actions. Others have commented on this tendency; in *Living with the AIDS Virus,* it is written that while "homosocial and homosexual should not be mixed up, the divide between social and sexual in male-male relations is fluid and not very sharp" (Panda et al., 113). Such are the social circumstances in which most MSM behaviors occur. For many, the premise of MSM interactions is friendship ties, physical convenience, and semen discharge- not orientation or identity.

Multiple interviews with a range of authorities and MSM individuals has confirmed that the most visible demographic of MSM in Lucknow is disadvantaged *kothis* of generally lower socioeconomic status. This is representative of the entire nation's standing, with male-to-male sex occurring mainly "among low-income populations, where poverty, low levels of literacy, and economic disempowerment" are prevailing and common elements (NFI Situational Analysis, 2). Of the respondents, only two had pursued formal education past the 12th standard, with the majority dropping out much before reaching even that stage. As all of the *kothis* interviewed began realizing their same-sex interests at a very young age, one the prevailing reasons for this trend of illiteracy is the absence of a safe and comfortable learning environment for children struggling with understanding their sexuality (Interview with Rahul Ji). Accordingly, it is unsurprising that none of the MSM respondents self-identified as gay, substantiating the notion that such classification is reserved for a distant and educated select. It is with this understanding of the sociocultural forces at play that the needs of MSM can effectively be discerned and

discussed.

Examination of Kothi and Girya Roles

The phrase 'gendered framework' denotes a state of affairs in which the dynamic of MSM behavior mimics that of a heteronormative relationship, in the sense that each male partner assumes a socially prescribed gender role (NFI). The framework is generally manifested and contextualized within the *kothi*/*girya* relationship, where the feminized *kothi* personifies the role of a penetrated woman while the *girya* adheres to the standards of a penetrating, normative male. MSM behaviors taking place within this gendered dynamic extend much beyond mere designation of passive and insertive positions. As described in an interview with Samir Ji, Country Director of MAAN AIDS Foundation, the *kothi* in a sexual relationship adapts to not only the penetrated role of a female, but the socially constructed behaviors and status attached to a female in that position as well. Along with exhibiting the physical appearance of women, *kothis* subsume womanly mannerisms, demeanor, and sense of self. *Kothis* consider other *kothis* to be their sisters, and this feeling of kinship keeps them from crossing boundaries and becoming sexually involved with one another. In the case of almost every *kothi* interviewed, their feminized gender expression was found to be much more sincere than an exaggerated display to entice sexual partners; in actuality, their performance is a meaningful declaration of their own self-identities in which they view themselves as mentally 'not-male.' A number of the *kothis* interviewed asked to be addressed by feminine names and pronouns, evidencing the connection of their behaviors to an established personal identity. Due to this intrinsic link, their MSM interactions are not driven solely by the act of discharge; on the contrary, they are both attracted and attached to their relationships with *girya* partners on a psychological and emotional level. This becomes the point of divergence between *kothis* and *girya*s, who do not manifest this same level or degree of investment in the MSM relationship.

With the *kothi* serving as a surrogate woman, the *girya* is able to preserve the attitude and status of a heterosexual male. Although he is engaging in MSM-type behaviors, the fact that he is penetrating a perceived female allows him to "easily merge into the general normative male society, their sense of masculinity maintained because they are the penetrators, not of other men, but of 'not-men'" (NFI Situational Assessment, 8). Because of the cultural implications of the gendered framework, a *girya*'s behaviors are not discerned by himself or society as digressing from standards of masculinity. For *girya*s, their encounters with *kothis* are generally motivated simply by the gender segregation that hinders their access to females. *Kothis* also appeal to *girya*s because the relation has no financial strings, unlike with sex workers, and they do not have to fear impregnating their partner. In contrast to most *kothis*, the actions of *girya*s must be viewed solely in the context of "'need', 'discharge', 'play', 'a man's right', and so on, where the act is just an act and not an identity" (NFI Bangalore Assessment, 82). In an interview at Bharosa, Salman Ji shared that while *kothis* treat their *girya* partners as husbands, valuing their bond as that between a married couple, *girya*s are involved on a very temporary basis. For younger *girya*s, their interest in the *kothi* is limited to the time until they are married and can receive sexual satisfaction from their wives. For those who continue involvement after marriage, it is generally on a physical basis and not reflective of same-sex attraction or identity. Because they do not recognize their behavior as MSM, *girya*s will never identify with the label (it has been constructed and employed only by *kothis*) or respond to interventions openly targeted at MSM. During the duration of this fieldwork, not a single self-identifying '*girya*' could be obtained for interview. The population is hidden and inaccessible; believing themselves to be neither homosexual nor engaged in MSM behavior, they are veiled by the conventions to which they conform and hence become invisible to outreach and awareness efforts.

Sources of Kothi Stigmatization

In a society where heteronormative relationships are neither companionate nor egalitarian, a framework imitating that structure finds itself similarly deficient and inequitable. In almost any given male-female interaction within the context of Lucknow, women are disenfranchised and devalued, reduced to shadows or property of the male figure. Consequently, the reconstruction of a *kothi* as a female automatically relegates the individual to a subordinate and disempowered status, while the *girya*'s maintenance of a masculine image grants him access to the same power afforded a male in a heteronormative relationship. In contrast to Western conceptions of sexuality, which are identity and orientation driven, this gendered perspective produces a "hierarchal and oppositional" relationship in which male and female roles are perceived as unequal and conflicting (NFI). It is this state of inequality that characterizes most MSM relationships and ultimately renders both parties exceptionally vulnerable to HIV/AIDS infection. A Situational Analysis conducted by NFI in 2004 reports that "the male being anally penetrated by another male is highly stigmatized, both by the penetrator, as well as general society" (8). Thus, both the masculine *girya* and society view the *kothi* as inferior and serve as agents of degradation and marginalization.

Kothis spend their lives craving a love and acceptance that they are constantly denied. From their youngest childhood memories to present day, they are emotionally cheated and abused. When a reprehensible culture of silence surrounds all discussions of sexuality, those with non-hetero orientations become further relegated to the margins of society. Schools provide no credible information on sexual behaviors, and the subject is blatantly ignored within families. Without an outlet to discuss or cope with their unfamiliar and changing emotions, many of the *kothis* interviewed grew up feeling confused, ashamed, and abnormal.

"I was 13 years old when I first came in contact with Bharosa. Before Bharosa, I

have never heard of the '*kothi*' term. I just knew that I liked men, but I thought

that I was alone, that I was the only one, and that something was just wrong with

me." (Interview with Raj Ji, *Kothi*)

"From as young as I can remember, I liked to play with girls more than boys. I

liked badminton, dolls, dressing up. In school plays I was always the queen and I

did the lady's part in dance functions. I could not openly discuss this all with my

family because I myself did not understand it, all I knew was that I was attracted

to males." (Interview with Zeba Ji, *Kothi*)

"I studied up until 12th and then I learnt dance. I could never focus on my

education with all the teasing and harassment from other kids at school."

(Interview with Priya Ji, *Kothi*)

Only one of the participants reported confiding in their family about their *kothi* identity and

finding understanding and sensitivity thanks to education provided by Bharosa. The rest

expressed considerable distress and angst at the prospect of their families uncovering the truth

about their orientation. Outreach programs such as Bharosa are constricted in their capacity to

intervene with families because encouraging acceptance through awareness is misunderstood as

promoting the spread of homosexuality, a falsity that has led to legal complications in the past

(Interview with Salman Ji). The cultural traditions of Lucknow, a city that reproduces the

patriarchal tendencies of the greater Indian mentality, prize male offspring and resist

relationships that transgress social norms. In a society that sustains such a conservative attitude,

marriage and reproduction become mandatory, in a manner that has now been termed

"compulsory heterosexuality" by writers of gender issues (NFI Bangalore Assessment, 78).

Employment opportunities for *kothis* in Lucknow are mostly limited to meager, odd end jobs,

rendering many financially dependent on their families and making the severing of ties

impractical (Interview with Sanjay Ji). A widespread belief amongst parents is that marriage

will 'cure' the feminine inclinations of their child. Societal scrutiny and condemnation of a

family with an unmarried child exacerbates pressures to comply with demands of

heteronormalcy. Since public approval is given paramount importance, as long as the son is

outwardly fulfilling societal standards of manliness, no one will concern themselves with his

private pursuits. Of the seven *kothis* interviewed, four are married and one will be in coming

years. None of their wives are aware of their MSM behaviors, placing them and their children at

great risk of unknowingly contracting HIV. Such an involuntary marriage leads to substantial

psychological and emotional strain for the *kothi*, as one is forced to perform and satisfy in a

heteronormative space that conflicts with internal desires and instincts. Managing such a duality

involves "keeping secrets, denying opportunities for emotional fulfillment, balancing needs, and

fears of discovery" (NFI Bangalore Assessment, 82). These feelings of pressure, guilt, and

tension pervaded many of the interviews.

> "Being married and leading this dual life used to be a cause of great stress for me.
> Before I received counseling from Bharosa, I thought I was a bad person."
> (Interview with Dhru Ji, *Kothi*)
> "My family knew that I work for Bharosa, but after rumors started spreading that
> the organization advocates homosexuality, they began to be suspicious of me.
> They had a hunch, though they never openly accused me of being a *kothi*. I did
> not want my father to have to deal with taunts and teasing from society for having
> a *kothi* son- I could not burden him with this shame. Also, if I did not get
> married, then who would take care of my father in old age? To prove to them that

I am normal, I got married this past February." (Interview with Raj Ji, *Kothi*)

In addition to familial pressures, there are no legal structures in place in India to support homosexual interactions. In fact, Section 377 of the Indian Penal Code (IPC) criminalized consensual same-sex relations. An impediment to public health interventions, Section 377 was an invitation for extortion as well as physical and sexual abuse from police and government officials. When asked what daily struggles they felt they faced due to their identity, almost all of the *kothi* respondents cited police harassment as the major impediment. They reported being regularly troubled by police who threaten to reveal their identities to their families, beat and arrest them without cause, and extort them for money, sex, and alcohol (Interview with Priya Ji, Dhru Ji, Raj Ji, Zeba Ji). Many of the *kothis* described cases of police violence while on duty in the field as an outreach worker or peer educator attempting to extend support to MSM individuals. In 2009, after years of pressure from litigations instigated by the Naz Foundation Trust, Delhi High Court finally decriminalized consensual same-sex conduct (WHO MSM Report, 56). However, objections to the ruling were immediately filed, and the dissolution of Section 377 has not yet translated into attitudinal change. Bharosa has established alliances with police superintendents in Lucknow to discuss incidents of police coercion and devise strategies for change, but the gap remains that it is the constables, not higher ranking officials, who engage in this form of discrimination.

With limited means of disclosing their identity and revealing their genuine selves, *kothis* turn to *girya*s for acceptance and belonging. They seek companionship and longevity in their relationships- a desire that is not echoed by *girya*s. Since most never found validation within their families and society, *kothis* are in a "constant search for a 'real man' who will affirm their being," and *girya*s are entirely conscious of this power they exercise over the feminized, and

hence weakened, *kothi* (NFI Bangalore Assessment, 82). As described previously, most *girya*s

are involved with *kothis* provisionally, until they are married, or solely to indulge in sexual acts

not performed by their wives. Because they do not harbor same-sex attractions in the way *kothis*

do, many are simply exploiting *kothis* for gifts, alcohol, money, and sex (Interview with Salman

Ji). This is in stark contrast to *kothis*, whose level of attachment to their partners varies from

participating in marital rituals, such as *karva chowd,* to self-destructive declarations of love such

as cutting oneself and attempting suicide (Interview with Rahul Ji). None of the *kothis*

interviewed referred to a *girya* as their 'partner,' which carries only sexual significance, but

rather 'boyfriend,' 'husband,' or '*dost'* (friend), each of which conveys an intimate bond. Great

hopes are invested by *kothis* in each relation, though they are aware of and acknowledge the

transitory nature of their love.

> "I dream of finding a life partner, but I also know from experience that this is not
>
> reality and will probably never happen." (Interview with Priya Ji, *Kothi*)
>
> "When my father caught me with my boyfriend, he kicked him out and forbade
>
> me from seeing him again. I cut myself, refused to eat, was hospitalized and
>
> would not take my medicines until my father let me meet him. My boyfriend
>
> came to see me, but by this time he had already gotten married and never met me
>
> after that time." (Interview with Raj Ji, *Kothi*)
>
> "My first boyfriend told me that the reason I got raped was because I attract too
>
> much attention to myself. He asked me to change, to cut off my long hair, to stop
>
> wearing make-up and acting like a girl. My boyfriend now wants me to get a sex
>
> change so we can get married. He told me to stop working and be a housewife
>
> that serves his family as their daughter-in-law. I am happy with my body and the

way I am, but I don't know how to tell my boyfriend to accept me like this. I

don't want a sex change or to get married and lose my independence, but I am

afraid he will leave me if I tell him this." (Interview with Zeba Ji, *Kothi*)

Kothi Internalization of Negative Self-imagery

In a homosocial culture where men publicly holding hands and interacting on an intimate

level is a daily, unconcerning sight, it becomes obvious that the stigmatization of *kothis* is not

necessarily due to their male-to-male sexual behaviors, but rather the effeminacy they exhibit. It

is because of this reason that *girya*s escape such alienation and intolerance; they fulfill societal

expectations of manly behavior and responsibilities. The social estrangement and discrimination

of *kothis* specifically "results from the fact that many *kothis* do not live up to the expected

normative standards of masculine behaviour. It is this belief that leads to the notion that those

who are feminised can be exploited and abused and that being feminised somehow weakens the

person, a notion often harboured by the *kothis* themselves" (NFI Situational Analysis, 9). Over

time, *kothis* internalize the negative images reflected onto them by both their partners and

community. As they incorporate the feminine consciousness and beliefs about women projected

on to them by their surroundings, they develop precariously low levels of self-esteem. Every

MSM counselor and expert interviewed (Samir Ji, Salman Ji, Rahul Ji, and Sanjay Ji) cited the

kothis' lack of self-worth and confidence as the greatest challenge they face in reducing the

health risks of this population. In the words of Rahul Ji, "*kothis* don't care that their behaviors

are putting them at risk of HIV. They have no reason to live without love. For them, their

greatest disease is being *kothi*, and nothing, not even HIV, seems worse than that." *Kothis*

become irresponsive and negligent to health education in their desperate search for any form of

acceptance.

As evidenced by this, the psychological component of a *kothi*'s female performance has a

significant influence on the way they perceive their health and interact with medical services. Inferior to the manly *girya*, *kothis* are stripped of their negotiating power in terms of condom and lubricant usage, sexual rights, and authority over their personal body. In their desire and need to please the *girya*, they must heed to his demands, or else face the possibility of being physically abused and/or losing the partner altogether. Decisions relating to sexual practices and preventative measures in this sense are not in control of the *kothi*, regardless of their awareness and education concerning safer sex (Interview with Salman Ji). Furthermore, continual abandonment by *girya*s heightens participation in high-risk behaviors, such as multiple partners, a lack of monogamous relationships, and alcohol abuse. The emotional and mental damage caused by some of these relationships drives many *kothis* to drink excessively, and alcohol impairment is associated with a decrease in the ability to use (or insist the use of) a condom and an increase in number of overall partners (Interview with Salman Ji). Bharosa has compiled a list of *kothis* who they know suffer from alcoholism and counsel them regularly on the dangerous implications of their actions. They advise *kothis* to always carry a condom on themselves, and in cases where they are inebriated without a readily available condom, they promote oral sex as a safer alternative to anal intercourse. In the case of Lucknow, the deprival of authority and self-assertion (rather than the unavailability of information) seems to be the fundamental cause of statistics that report the use of a condom by MSM with both commercial (13.1%) and non-commercial (13.8%) male partners to be lowest in the state of Uttar Pradesh (WHO MSM Report, 54). The types of sexual acts practiced by MSM, such as anal intercourse, carry a much greater rate of HIV transmission than vaginal intercourse (Interview with Salman Ji). In addition, the penetrated partner (in this case, the *kothi*) is always at higher risk of HIV contraction than the inserting male. Due to their practices and helplessness in demanding

change, *kothis* become "a 'bridging population' to both the female population through marriage and sexual encounters with other females, but also to the general male population where most of their partners come from" (NFI MSM and HIV/AIDS in India, 11). According to Rahul Ji, the wives of kothis who are aware of their husband's relations at times also engage in extramarital affairs, which further widens the impact of MSM behaviors. Thus, the voiceless state of *kothis* heightens their vulnerability to acquiring HIV as well as spreading it to the multitude of sectors with which they interface.

Challenging the Gendered Framework

The situation outlined above highlights the risky behaviors developed and perpetuated in the local context of Lucknow, which is where they must be framed for effective change to be implemented. As explained by Sanjay Ji, the counselor at Bharosa's sister project Ibtada-e-anese, the sociocultural setting and circumstances of *kothis* in Lucknow differ greatly from those in a larger metropolitan city, such as Delhi. In more urbanized areas, there is much less emphasis on the preservation of the orthodox family structure and rigid gender dynamic, creating room for greater mobility and flexibility. Such versatility is still deficient in Lucknow; hence interventions must consider ways to carve a secure and encouraging environment for *kothis*. The first, and most obvious, change necessitated is equality for *kothis* within their relationships. Nishant Ji, a research specialist at MAAN AIDS Foundation, conceded that one of the major flaws in the current national program aimed at MSM is the disregard and underestimation of the role of *girya*s in generating risk. *Kothis*, subjugated to a compromised and enfeebled position, are defenseless against the desires of *girya*s, irrespective of their level of awareness or risk perception. *Girya*s hold the leverage, thus interventions should aim to educate them about safer sex, HIV/AIDS, and respect for their sexual partners. The issue, however, is that giyras are largely inaccessible and unreceptive to interventions. In an effort to overcome this issue,

Bharosa tracks networks of *girya*s through the sexual partners of *kothis*, for while *girya*s can publicly disown their behaviors, they cannot deny their actions to the person with whom they are physically engaged (Interview with Samir Ji).

Nonetheless, even if a portion of *girya*s is reached through this method, the underlying root of the problem still remains with *kothis*. Their lack of morale and self-worth, caused by unending belittlement from every facet of life, is the core determinant of their poor sexual health. For this reason, the main route towards attaining equality lies with the empowerment of *kothis*, which is contingently related to the empowerment of women. Bharosa regards the populations as intrinsically linked; accordingly, they extend support to organizations that fight for women's rights, such as AALI and Hum Safar (Interview with Salman Ji). If the status and esteem of women are raised in society, the situation of *kothis* will inevitably improve, for *girya*s and the public markedly equate the two. The oppression of women and stigma surrounding effeminacy are "the major factors that lead to disempowerment of and opens *kothis* to abuse and assault and refusal of service provision," and hence these detriments need to be dissipated if *kothis* are to secure acceptance and equity (NFI Situational Analysis: MSM in South Asia, 9). To counter the internalization of such disapproval and generate a demand for change from the *kothis* themselves, counseling and mental health services should strive to "empower them [*kothis*] to start valuing their lives and enhancing their self respect so as to reduce their risks for HIV infection" (NFI Situational Analysis: MSM in South Asia, 9). For instance, in the counseling provided by Bharosa, *kothis* are told to seek and imbibe the positive qualities of women- their distinctive strengths and enriching virtues, not traits that lead to their subordination. It is only through instilling self-confidence that *kothis* will be able to assert themselves, vocalize their needs and desires, and reclaim negotiating power in their relationships.

While a wide spectrum of TG women exists in India, this section concerns itself exclusively with the experiences of *hijra*s in Lucknow, as they are the predominant and most easily distinguished community. The situation of *hijra*s must be examined from a historical perspective that recognizes their long-standing existence in Indian tradition. *Hijra*s have been documented and immortalized in many of India's ancient texts, from the timeless *Kama Sutra* to epics such as the *Mahabharata*. Analysis of this historicity, however, unveils the gradual degradation of their status over the eras. From serving as the esteemed personal advisors of kings, *hijra*s now reside amongst the socially neglected and marginalized. Although there is considerable fluidity in the practices of *kothis* and *hijra*s, the culture and socioeconomic forces impacting *hijra*s are markedly different from those of *kothis*. Their distinctive lifestyles confer on them differential access to social services, information, and resources for maintaining their health. These divergences place *hijra*s in their own unique forum that requires special attention if their health needs are to be realized.

Though the literal translation of the Urdu word '*hijra*' is hermaphrodite, which refers to a person who is naturally born with ambiguous genitalia, the label is now being claimed by any individual who self-relates to the *hijra* identity. In actuality, only a small segment of *hijra*s in India are true hermaphrodites, with the rest being castrated and even physiologically male individuals (Nag, 83). Many who are born with intersex variations are rejected by their parents at birth and given to the *hijra* community to be raised, while others voluntarily find their way to the identity later in life (Interview with Sony Ji, *Hijra*). For most *hijra*s who join the community by free will, their early childhood impulses and experiences closely align with those of *kothis*. Studies have found that "teenage homosexual activity often figures significantly in the lives of

many men who join the *hijra* community" (Nag, 86). As young boys, *hijra*s display the same innate disposition to womanly behaviors and effeminate activities as *kothis*. Due to their female gender identity, they too struggle with comparable issues of stigma and discrimination. Their families generally lack an understanding of atypical sexualities, and hence they battle with compromising their sense of self and complying with socially stratified gender roles. The parallels are such that before formal induction into the *hijra* community, many describe themselves as *kothi*, this being the case with both of the *hijra*s interviewed for this study.

     *Hijra*s function within a cultural sphere defined by custom and ritualism. Unlike *kothi* and other TG populations, the *hijra* community has negotiated a space in society through an established *Guru-chela* (teacher- disciple) system. This form of social organization serves as the core principle around which the *hijra* community is arranged. Every *hijra* is subordinate to a *guru* to whom they are expected to show unconditional respect and obedience. As informed by Rhea Ji, a *hijra* interviewed for this study, "without our *guru* we do not exist. They decide how we live. If your *guru* dies, then you have to live like a widow. We cannot move without their permission." Typically five to fifteen *hijra*s are organized in such a *gharana* (familial house), and initiation of a *chela* is entirely contingent on approval from the *guru*. The *gharana* operates as both a domestic as well as economic unit, for *hijra*s fulfill a recognized "cultural role as performers for means of livelihood" (Nag, 86). Known as *badai,* the tradition involves singing, dancing, and bestowing blessings of prosperity and health during occasions such as childbirth and marriage. At present, society holds very little esteem for this ritual performance; most people pay *hijra*s only out of fear or resignation "because we come uninvited and start clapping and yelling and even taking off our cloths if they do not give us enough money" (Interview with Rhea Ji). Another means of income is referred to as *basti*, which is akin to begging. Daily

earnings are submitted to the *guru*, who apportions them appropriately. Upon admittance to the *gharana*, a *hijra* is "expected to adopt the values and organizational principles of the community" (Nag, 85). In this sense, asserting oneself as a *hijra* entails not only the preference for a third-gender identity, but also the acceptance of an institutionalized role and distinct, regulated lifestyle. Thus, understanding the motives behind the decision to transition from a *kothi* or unlabeled TG to a *hijra* is fundamental because the change marks their departure from the MSM framework.

The reasons inspiring individuals to enter the *hijra* community structure are various. The principal force is the desire for acceptance that was wanting at home or in their community (Interview with Samir Ji). Like *kothis*, *hijra*s come from highly stigmatized backgrounds, where they contend with constant heterosexism and exclusion from their families, partners, and society. Ostracized on their own, they are drawn to the prospects of solidarity and support that a *hijra* community assures. The *gharana* is intended to replicate a familial environment, with fellow *chela*s acting as sisters and the *guru* embodying the role of a guiding, parental figure. Such a surrogate family presents the security and inclusion needed by many to validate their own notions of self-worth. The second compelling incentive is the economical and financial appeal of being a part of the community. As the case with *kothis*, most *hijra*s are from a lower socio-economic class with little, if any, education. Beyond the lack of schooling or training, their employment opportunities are further constricted by their effeminate appearance and conduct. *Hijra*s, through their fulfillment of customary rituals, earn a consistent and sizable income of approximately 500 rupees a day, which accumulates to anywhere from 10,000-15,000 rupees a month (Interview with Salman Ji). Due to the potential for acceptance and financial gain, many who do not truly identity with the *hijra* ideology elect to become members.

Implications of Castration in Hijra Communities

Though emasculation is no longer an enforced requirement for initiation into the community, numerous *hijra*s choose to undergo the procedure. For many *hijra*s, the possession of the organs of male sexuality is very psychologically disturbing. To someone who internally, emotionally, and mentally feels like a woman, the presence of male genitalia is both bewildering and upsetting. When asked why she chose to undergo the castration procedure, Sony Ji replied that "I have the soul of a woman, so what was a penis doing on my body? It had no use. I was allergic to it." Such *hijra*s believe that removal of the organs will advance their conversion from man to woman, though as will be discussed, this satisfaction is not usually attained. The other major reason for undergoing the procedure is that "the evidence of castration is culturally defined 'proof' of a *hijra*s' renunciation of sex which legitimizes their ritual functions in Indian society…if their genitals have not been removed they may be reviled and driven away as imposters" (Nag, 88). The cause of *hijra*s' power to both bless and curse is their sexual abstinence, which can only be substantiated through emasculation and impotence. As explained in an interview with Salman Ji, castration legitimizes the *hijra*'s capabilities in public view; otherwise, people have no reason to pay *hijra*s for their services. With this being the reality of the situation, many *hijra*s feel obligated to endure the operation.

One of the greatest medical hurdles presented to *hijra*s is the silence surrounding sex reassignment surgeries (SRS) in the Indian legal system. Under Section-320 of the IPC, emasculation can be considered a procedure that causes grievous hurt and can hence be punished under Section 325 of the IPC. This provision renders both the doctor liable to penalization as well as the consenting patient for supporting the misdemeanor. However, in contradiction to this clause, Section-88 of the IPC makes an exception to cases in which a harmful action is done in good faith to an individual "who has given a consent…to suffer that harm, or to take the risk of

that harm" (UNDP India 2010, 6). Besides these vague provisions, which can be interpreted subjectively, no explicit legislation addressing SRS exists in India. Thus, while SRS is not listed as a cognizable offence, the ambiguity and inconsistency of current laws makes it near impossible for *hijra*s to find a certified professional who is willing to conduct the procedure. Most emasculation procedures are performed by either a *dai-ma* within the *hijra* community who has no formal medical training or by an unqualified quack doctor (Interview with Salman Ji). As would be expected, the conditions are unsanitary and hazardous; in fact, Salman Ji recalled two males who died in the process of being emasculated just last year. When the *hijra*s interviewed for this study were questioned about information regarding the conditions of their castrations, the responses received were indistinct and uncertain. After several moments of hesitation, one answered that a doctor had performed the operation, though when probed about the doctor's credentials, the reply given by Rhea Ji was that he was "experienced." They related the forty days of recovery, in which they were tended to and cared for by other *hijra*s. Neither indicated receiving any form of pre or post-operation counseling. The uncertainty and inconsistencies in their account point to the culture of secrecy that surrounds such procedures, as they are forced underground. While neither of the *hijra*s interviewed mentioned any personal difficulties, there are endless reports of those who develop "post-operative complications- especially urological problems" that go untreated or mistreated (UNDP India 2010, 6). Without clarity in the legality of gender transition services, castrations will continue to be performed by unauthorized practitioners, thereby endangering the health of the *hijra* in question.

The repercussions of castration extend beyond the parameters of the actual operation, as evidenced by the *hijra*s interviewed. After a while, the realities of being emasculated begin to settle, and some are not left with the feelings of satisfaction and fulfillment they had imagined.

In the case of the respondents, the permanence of the procedure was unsettling. Both had renounced all relations with their biological family and had discontinued contact after joining the *hijra* community. Their families had refused to accept their decision to become *hijra*s; hence, they were left with no other alternative but to sever ties. Rhea Ji confessed, "Even after castration I am not happy. I feel the absence of my family everyday and know that after being castrated I can never go back. This saddens me greatly." When asked if their *gharana* provided the same comforts as a family, their answers were less than affirmative. Sony Ji admitted, "We do not get the same love that you receive from a family. The love that you can only get from a mother and father you do not get from a *guru*. Your parents forgive you and love you unconditionally; your *guru* does not. If we make a mistake, our *guru* will punish us or take our earnings. But there is no point being sad or worrying. Whether or not we like it, there is no going back." Zeba Ji, a *kothi* outreach worker at Bharosa who was present to facilitate the interview, interjected by asserting that the relationship between a *guru* and *chela* is equivalent to that of a mother and daughter. Sony Ji was quick to correct her, countering the statement with, "no, not at all. Our relationship is that of a *saas-bahu* [mother and daughter-in-law]," suggesting inequity and stringent boundaries. Rather than appearing gratified with their lives within the *hijra* community, they seemed resigned, as if no choice existed but to reconcile themselves to their circumstances. As *kothis*, they were afforded the freedom to elect when, where, and to what degree they would express their sexuality. Many *kothis* merge into heteronormative spaces as they please and sustain relations with their families, but *hijra*s are not provided that liberty. They must cross-dress and perform both publicly and privately, as their lifestyle and *gharana* demand permanent occupation of the *hijra* identity.

Castration for many *hijra*s is symbolic of an endeavor to align their biological self with their gender identity, yet this attempt to shed their masculine distinctions and progress towards womanhood in the end proves insufficient and unfruitful. They find themselves suspended in a limbo between male and female, for while they possess the mindset of a woman and are unburdened of male physiology, they are ultimately unable to replicate the most significant measure of womanhood- the female reproductive organs. This deficiency is the basis for their self-perception as a 'third gender,' for their impotence translates into their inability to wholly incarnate a female identity and fulfill the functions of a woman. *Hijra*s, similar to *kothis*, are in a continual search for a sustainable relationship. Because society defines women as vessels of reproduction and child rearing, "a family life with a *hijra* perceived as neither male nor female and unable to procreate is prohibited under sociocultural, religious, and political rules and customs. At some point, such love relationships disappear…*hijra* are aware of this uncertainty…and risk HIV infections but keep looking for men to love for sexual acts, mostly unprotected" (Khan et al., 2009). Their relationship struggles parallel those of *kothis*, in the sense that they experience regular abandonment by their *girya* partners who are not equally attached or devoted. The center of Sony Ji's small room boasts a framed picture of her and her husband, who she remorsefully states visits her much less now that he is married. Rhea Ji currently has a boyfriend who claims to love her immensely, but she expresses skepticism at his words. Their stories and sentiments betray their underlying grief.

> "My husband loves me less now that he is married and has a child. He used to
> spend all his time with me, and now he only comes to see me some evenings. It
> hurts a lot when the person you love gets married and forgets about you, but we
> must convince ourselves not to be upset. We know that we can never be the

wives that our boyfriends need. Our lives are punishments." (Interview with Sony

Ji, *Hijra*)

"My boyfriend says he loves me today, but who knows about tomorrow? I may

be castrated, but I will never be a woman. I cannot reproduce and provide kids

for my boyfriend. How is he supposed to take me back to his family? Kinnar can

never get the happiness that a woman gets or be loved in the same way. Because

of this, for every five days of happiness, we have 25 days of pain and sadness."

(Interview with Rhea Ji, *Hijra*)

Challenges to Reducing HIV Risk of Hijras

The HIV high-risk behaviors engaged in by *hijra*s in efforts to appease their partners

correspond to those of *kothis*. Being the perceived inferior partner, they lose the ability to assert

their sexual rights, such as condom and lubricant usage, while the absence of commitment from

*girya*s results in a multi-partner network of activity. In addition, "the declining demand for their

ritual performances and the consequent lowering of their economic status" has resulted in their

increasing reliance on prostitution and sex work as a means of income (Nag, 88). Of the *hijra*s

interviewed, Rhea Ji had previously worked in close association with Bharosa and hence

displayed thorough knowledge concerning HIV acquisition and transmission. She reported

seeking HIV testing regularly for her own safety and assurance because she previously engaged

in unsafe sex. In contrast, Sony Ji, who has had less exposure to Bharosa outreach, did not

demonstrate the same level of awareness or risk perception. She disclosed never having been

tested for HIV, and when asked why, she stated that the thought had simply never occurred to

her that she should be tested. She identified only one route of transmission (unsafe sex) and

responded with "being safe" as the means to preventing the spread of HIV. Such a dearth of

understanding reveals the current gap in education and awareness efforts in reaching this community.

Although *hijra*s are more publicly visible than any other TG population due to their distinctive lifestyle and historical presence, they are amongst the most inaccessible groups in terms of providing outreach and education services. Consistent throughout every interview with NGO authorities as well as medical professionals was the assertion that the *hijra* communities of Lucknow reject and strongly resist any attempt to extend sexual health resources. The receptiveness of a *hijra* community to outside health interventions is determined by the *guru*, who controls how and when *chela*s interact with such services. In the case of the communities in Lucknow, head *guru*s have largely prohibited *hijra*s from accepting HIV/AIDS resources. Salman Ji offered elucidation for the grounds of this behavior, explaining that "*hijra*s refuse and oppose our services because receiving them would mean acknowledging that they are engaging in sexual relations- and this they are restricted from doing. When we try to go teach *hijra*s about HIV/AIDS and safer sex, they say 'why do I need this information? I am not involved in these activities.'" Their own infertility allegedly results in an accumulation of sexual energy that they can harness to bestow fertility and reproductive prosperity upon others. The source of this ability is believed to be their sexual abstinence, for once castrated, they supposedly abandon all sexual and reproductive desires. Upon entering the *hijra* community, "the novice vows to abstain from sexual relation or to marry. The *hijra* call the castration operation *nirvan*- condition of calm and absence of desire which is believed to transform the ordinary impotent male to a *hijra* endowed with *Mata's* sacred powers" (Nag, 88). The continuation of *badai* and the livelihood of *hijra*s are dependent on public sanctioning, so while they and their *guru*s both know that they participate in sexual activity, they must uphold a façade of chastity. As informed by Rhea Ji,

"society already does not respect us. The only reason they give us money is because they fear us and are afraid that we will harass or curse them." Thus, revelation of their sexual behaviors would deprive them of the one meager standing they have in society and lead to their further marginalization. However, while exposure of their sexual involvements may invalidate their ritual functions, its denial has resulted in the greater predicament of jeopardizing their sexual well-being.

DISCUSSION: DIFFERENTIATING *KOTHI* AND *HIJRA* NEEDS

Through these explorations of the current situations of *kothi* and *hijra* populations in Lucknow, it becomes apparent that there is considerable overlap and similarities in their fundamental needs. Societal discrimination against gender variance has led to secrecy becoming normalcy, and this inclination towards concealment has endangered the health of MSM and TG communities. Hence, in the case of *kothis* and *hijra*s, greater social understanding through open discourse and education is needed to mitigate the stigma, violence, and silence surrounding non-hetero conforming sexualities. Both populations furthermore delineate the urgent need for improved mental health and counseling services. Years of being berated and subordinated have eroded their personal notions of self-respect and self-worth. Without regard for themselves and their lives, *kothis* and *hijra*s will perpetually lack the voice to demand their sexual rights within their communities, families, and intimate relationships. *Hijra*s and *kothis* could also benefit from the development of educational and vocational opportunities that serve to strengthen their mobility and elevate their standing in society. However, beyond these broad and basic concerns that are shared between *kothis* and *hijra*s, their respective lifestyles and modes of conduct divide

the two populations into unique frameworks that render them differently vulnerable to HIV/AIDS.

Unlike *kothis*, *hijra*s exist within a solidified cultural context with particular regulations, customs, and expectations that distinguish their situation from that of all other sexual orientations. Upon initiation into a *gharana*, *hijra*s pledge to abide by the community and *guru*'s beliefs and directives. Thus, while Bharosa's biggest obstacle in reducing the HIV risks of *kothis* is bolstering their self-confidence, with *hijra*s the challenge is gaining entrance into the community itself. *Guru*s in Lucknow defend the sexual renunciation of their communities and consequently reject attempts to provide HIV/AIDS education and services. To overcome this issue, Bharosa has tried to reason with *guru*s and make them alert to the benefits of early HIV testing and safer sex practices. They have also made efforts to steer their concentration away from HIV/AIDS specifically and instead attend to general health needs, though this tactic has achieved limited success (Interview with Salman Ji). As a leverage to achieve admittance, Bharosa is trying to gain the support of prominent *hijra* leaders, such as Lakshmi Ji. Sanjay Ji, the counselor at Bharosa's sister project Ibteda-e-anese, explained that because of the restrictions placed by *guru*s, interactions with *hijra*s are veiled as "friendly services" that involve an innocent exchange of greetings and the discreet dissemination of information in order to protect the *hijra* from punishment. Without approval from the *guru* or an inside connection to the community, reaching the lives of *hijra*s is a complicated task that meets much resistance from within.

The difficulties in approaching *hijra*s are further exacerbated by the prevailing tensions between different TG and MSM communities within Lucknow. Many interviews pointed to the strained relations between *kothis* and *hijra*s. According to Salman Ji, "*Guru*s do not want *hijra*s

to be publically connected to *kothis* because *kothis* are openly involved in sexual activities and *hijra*s are not." This sense of unease was mirrored in interviews with *kothis*. When questioned about her perceptions of *hijra*s, Zeba Ji, a self-identifying *kothi*, responded, "I fear most *hijra*s. Once, they asked me to join their community and I said no. I have some *hijra* friends but the community itself scares me." Salman Ji reiterated this concern, stating that many *kothis* feel harassed and pressured by *hijra*s to become a part of their community. Even though some were not able to articulate and put into words the differences, every *kothi* and *hijra* interviewed declared the two identities to be distinct entities and the communities to be contrasting. This mutual desire for disassociation complicates the goals of Bharosa, which is operated almost entirely by *kothis* with no *hijra* representation in the staff. Bharosa authorities openly admitted that the their work is primarily focused on addressing issues related to *kothis*, and they additionally acknowledged that their center may not always be the most inviting or secure environment to *hijra*s. The doctor interviewed at the Sexually Transmitted Infection (STI) clinic in Bharosa conceded that *hijra*s do not feel entirely comfortable visiting the clinic because it is so heavily dominated by *kothis*, who generally have no reservations in utilizing the center. In the same vein, when Sanjay Ji at Ibteda-e-anese was asked to account for the low number of *hijra* patients, he stated, "If *hijra*s are caught coming to the organization by their *guru*s, they will be get into trouble. The problem is also that if more *hijra*s start visiting this center, then *kothis* will stop coming." In the three weeks spent in contact with Bharosa and related organizations, a *hijra* was never encountered at the site. Therefore, though Bharosa displays sincere intentions to connect to the *hijra* community, the undisputable discomfort between *kothis* and *hijra*s makes one intervention targeted at both ultimately inadequate and ineffectual.

Besides the tensions that hinder a shared movement, the health risks of *hijra*s vary from those of other populations, for their health care seeking behavior is markedly different. *Guru*s regulate the *hijra*s' contact with the medical environment, many times dictating who and what services they will seek (Interview with Sanjay Ji). As has been discussed, most *hijra*s undergo ritual castration and gender transition treatments, which carry possibilities of a range of complications. Even if a certified practitioner is willing to perform the emasculation procedure, the financial costs are usually so steep that the *hijra* resorts to the traditional dai-ma and home remedies. Furthermore, Samir Ji asserted, "Many *kothis* who become *hijra*s greatly regret their decision to be emasculated and join the community." A certain degree of such remorse was felt in the reflections of the *hijra*s interviewed in this study, indicating the need for proper pre and post operation counseling and care. *Hijra*s should deliberate the gravity of this major transition and be well informed on the ramifications and irreversibility of their actions. Some join for questionable reasons (such as financial gain), and without appropriate guidance in the matter, they may find themselves repenting their decisions with no escape. In addition, many *hijra*s consume hormone supplements to facilitate the development of secondary female sex characteristics. However, because the provision of such hormonal pills is limited and often times inaccessible, the majority purchase MALA D, a high dosage contraceptive pill that is known for negative side-effects such as chest pains and dehydration (Interview with Salman Ji). Effective change requires the clarification of legal issues concerning such services as well as the sensitization of medical professionals to *hijra* issues.

Many other social issues particular to the *hijra* identity surface as barriers to reducing their vulnerability to HIV/AIDS. Due to their self-perception as a third gender identity, *hijra*s often become invisible in the male/female binary that dominates the current political, social, and

economical landscape. Without legal recognition of their gender identity, *hijra*s have yet to

realize their right to vote, marry, own and inherit property, contest elections, adopt children,

claim formal identity, procure official documents, and access welfare schemes (UNDP India

2010, 12). The denial of these basic rights was discussed in the interviews with Sony Ji and

Rhea Ji. Both *hijra*s conveyed a longing to adopt daughters and fulfill their maternal desires,

although they realized that this would realistically never be achieved because of legal obstacles

as well as the inability to provide a complete and stable family to a child. In addition, Rhea Ji

recounted the troubles she experienced trying to obtain a government card. With no 'kinnar' or

'*hijra*' option, she stated that she would prefer to mark herself as female, though officials always

delegate her to the male category. The *kothi* identity is not as rigorously defined by cultural

precedent and is under greater personal discretion than the *hijra* identity. As a result, *kothis* have

the flexibility to navigate these rights and are not as severely negated these liberties as *hijra*s.

Kothi issues that require attention are much more personal and internal than the structural forces

inhibiting the health of *hijra*s. *Hijra*s require their own "holistic and comprehensive approach"

that rallies on their behalf for these specific matters (UNDP India 2010, 5). A single intervention

targeted at the general "MSM/TG" population is spread thin in addressing all of these concerns,

which ultimately adversely affects each of the sub-groups involved because their unique needs

are lost in the breadth.

The gaps in Bharosa's intervention are reflective of the nation's current standing. As

disclosed in the 2010 WHO MSM Report, as of 2008 there were 66 sentinel sites for MSM and

only one for TG individuals (51). This scarcity is true for CBOs as well, with only a handful

existing specifically of *Hijra*/TG communities (UNDP India 2010, 5). Currently, Bharosa is

striving to institute a *hijra* on their board and to establish a union exclusively for *hijra*s, though

they are still awaiting funding and nothing concrete has yet been implemented (Interview with

Salman Ji). However, one of the problems predicted by Sanjay Ji is that even if a site was to be

instituted that concentrates solely on *hijra*s, the frictions between various *gharana*s would

prevent the center from being accessible and utilized by the entire *hijra* population. Diffusion

between *gharana*s occurs only with permission due to the hostilities and differences that prevail.

Because a site would serve only the nearest *gharana*, Sanjay Ji proposed the idea of devising a

mobile team composed solely of *hijra*s who travel and circulate services between *gharana*s.

There are several potential options, but the common thread in each is the emphases on having

*hijra*s themselves head the initiative. *Hijra* and MSM needs can no longer be conflated; they

must be differentiated and given their own voices to instigate change and alleviate the

sociocultural and structural ruptures that determine HIV risk.

DISCRIMINATION IN THE MEDICAL COMMUNITY

Interviews with *kothis*, *hijra*s, and various representatives of the medical community in

Lucknow revealed a lack of sensitivity and understanding of MSM and TG issues in health care

facilities. A visit to the one Community Care Centre (CCC) serving Lucknow unveiled many

misconceptions concerning MSM/TG behavior as well as undertones of stigma. The National

AIDS Control Society (NACO) has established CCCs throughout India in order to provide

support, counseling, and referral to outreach services for PLHIV. One of the first inadequacies

noted was that the center had no employed counselor, as the spot had been vacated almost a

month prior and not yet filled. With no certified counselor, the sole doctor at the center had to

perform both functions. According to the doctor, MSM constitute only 1-2% of the yearly

admits. When asked about the number of *hijra* patients, the doctor appeared confused, stating

that *hijra*s and MSM are interchangeable terms. Both the doctor and project coordinator reported never having received education specific to MSM and TG health needs, besides the general training provided by NACO. The counselor interviewed at the Integrated Counseling and Testing Centre (ICTC) at the Lucknow Medical University echoed the same response. This want of awareness was manifested in the doctor's comments and perceptions on matters concerning MSM and TG individuals. When asked if special services or outreach for MSM and TG populations were provided through the CCC program, the doctor replied, "No, we do not encourage homosexuality. In the West it is considered normal behavior, not here. We consider homosexuality to be abnormal behavior." He then presented inaccurate, false information on MSM prevalence. In response to a question concerning the specific health needs of MSM and TG, he asserted, "India does not have many MSM. This is a problem in your country, not this area of Lucknow. For the MSM that do exist, they are high-class individuals so they go to private facilities. MSM is not a lower class problem." In actuality, MSM behaviors are conceived primarily amongst lower socioeconomic communities, and there is a substantially sized population residing within Lucknow. The repeated usage of the word 'problem' and 'abnormal' to describe MSM behavior points to the intolerance and prejudices still pervading medical institutions. The doctor could not even distinguish between the meaning of MSM and *hijra*, let alone comprehend their unique health needs. His replies provide insight into the huge gaps in understanding amongst medical staff and professionals. With this being the current situation, it is unsurprising that most *kothi* and *hijra* respondents recounted facing discomfort and discrimination in medical settings.

Interviews with *kothis* relayed negative experiences in health care facilities. Many reported being neglected by medical professionals. Among the *kothis* interviewed, those who

appear physically feminine reported extreme cases of medical harassment and stigma, while those who maintain an outwardly heteronormative male appearance claimed to rarely face prejudices due to their identity. This trend affirms that the stigma surrounding *kothis* stems from their effeminacy, rather than their actual MSM behaviors. Although there were no accounts of directly being denied services, many encountered other forms for discriminative action. Doctors would feign excuses such as being too busy and not having available appointments; or in other cases, *kothis* were forced to stand in long queues in which they were harassed and verbally abused by other patients. Raj Ji described a personal instance in a public health facility when "the doctor began gossiping about me to the other nurses and staff. He was telling them, 'look at him, he is a *kothi*.'" Such disparaging comments have the effect of further alienating MSM and TG individuals from medical services. *Kothis* and *hijra*s encountered insensitivity such as use of male pronouns or admittance into a male ward when female was desired. Concerns about confidentiality were a reoccurring theme throughout the interviews. Many expressed fears of being spotted and discovered by a family or community member at a HIV testing center. Every *kothi* interviewed reported only visiting the Bharosa clinic for STI testing because they felt it to be a secure environment. A few had family doctors that they were comfortable approaching for general health concerns. These findings are consistent with a study conducted by the Karnataka Health Promotion Trust in 2009, which found that the main obstacles to accessing health care services and support were the homophobia and ignorance of HIV/AIDS displayed by medical professionals and staff. Due to this alarming state of affairs, utilization of even free government HIV/AIDS testing and counseling services remain low.

CONCLUSION

For NACO, the key objective of targeted interventions has been to curb the spread of HIV and reverse the epidemic. With that perspective, the similar sexual practices of MSM and TG individuals have placed them in a single high-risk category. However, for the first time since its conception, the NACP III plan articulates the need to focus on the issues of the *hijra* and TG population as separate from those of MSM (WHO MSM Report, 56). The consciousness of the needs of *hijra*s as being different from *kothis* and MSM is gradually emerging, though implementation of separate programs is still unrealized. In the case of Lucknow, this study found that the rigid and highly regulated structure of the *hijra* community serves as a barrier against effective outreach. The *hijra* community is not receptive to HIV resources, even if being provided by a MSM agency. Hence, the design and delivery of these services must originate within the *hijra* community itself from representatives who understand the complexities of sexual renunciation and the *guru-chela* dynamic. NACO has expressed that if *hijra*s are to be provided a safe space to fight HIV/AIDS, " a clear articulation of the issues specific to TG/*Hijra* persons have to come from the communities concerned" (SAATHII Report of the Regional TG/*Hijra* Consultation in Eastern India, 5). For *kothis*, the most eminent demand is for mental health services that impress feelings of self-worth and dignity. Only with self-esteem and confidence will they gain the value for their lives needed to comprehend the importance of maintaining their sexual health. One intervention trying to serve such strikingly dissimilar ends finds itself perpetually falling short of fulfilling these gaps.

From a broader perspective, the government of India needs to be actively engaged in alleviating the social inequities faced by MSM and TG populations. Thus far, all of the supportive measures that have been devised, from targeted interventions to the decriminalization

of the IPC Section 377, have been a part of the response to control the AIDS epidemic. However, structures are required to support the general needs and social factors impacting MSM and TG individuals because ultimately those conditions shape and determine their health care seeking behaviors. A NACO spokesperson was quoted saying, "prioritized issues of a particular set of people might not be their [NACO's] priority," yet what they fail to realize is that these issues that are sources generating vulnerability to HIV/AIDS (SAATHII Report of the Regional TG/*Hijra* Consultation in Eastern India, 5). Support must be extended with the intention of achieving human and sexuality rights that extend beyond narrow HIV concerns.

Fundamentally, one the major problems with the construction of *kothis* and *hijra*s is that it validates the notion that one partner must always metamorphose into a female for the relationship to be legitimized or recognized by society. Social institutions impose the idea that being penetrated is a feminizing act; consequently, a male who finds himself attracted to other males is socially conditioned to justify his divergent emotions by asserting that he must internally be a female. Such a reasoning stems from the fact that the "gender chasm is often perceived as innate, extra-ordinary, fixed and absolute. If you do not 'fit' into one gender role, then you must be the other" (NFI Bangalore Assessment, 81). With this framework, people with non-conforming bearings box themselves into a labeled identity with which they may not truly relate. As this study found, such an approach denies and compromises one's sense of self and may result in long-term dissatisfaction. Sexuality is not a topic restricted to *kothis* or *hijra*s; rather, it is a personal manifestation of a universal sensibility. India is hence on the fringe of a new discourse, one that embraces the depth of human expression and provides opportunity for people to define and claim their sexualities for themselves.

RECOMMENDATIONS FOR FURTHER STUDY

1) *Hijra*s represent only one of the many male-to-female transgendered identities unique to India. Exploration of other TG populations (such as *Jogappa* and *Shiva Shakti*) that are not as historically visible as *hijra*s could illuminate new demographic categories with distinct needs that have yet to acknowledged or addressed.

2) The present study focused on male-male sexualities. The reverse, female-female sexualities, is another neglected discourse in an Indian context. Female-female relations are not considered a high-risk category for HIV/AIDS and limited information is available on such behaviors. Future studies can begin to monitor and understand the context of female-female activities and interactions to extend the range of the forum on sexuality in India.

3) As indicated by this study, the *girya* population plays a key role in generating risk themselves as well as for *kothis*, *hijra*s, and other partners. Because they are hidden and extremely hard to access, not much focus has been placed on their position in the HIV/AIDS epidemic. Studies need to be conducted on their behaviors and ways to effect change through efforts targeted at this influential population.

4) The possibilities of a new framework can be the basis of future investigations. Examination of an approach based on differentiating between identity and behavior may be more effective than a gendered perspective that results in inequality.

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Interview Questions
A. MSM/ *Hijra*

General Personal Background
1) What is your age?
2) What do you do for a living? What are your monthly earnings?
3) What is your educational background?
4) How would you personally describe your identity? How and when did you come to realize this identity?
5) (If they use a specific label to describe their identities) When and how did you learn of this identity with which you associate yourself?
6) How do you feel that your identity differs from that of other sexual identities? (If answer is based on sexual role, explore who is more vulnerable, who is more at risk, if one sexual role has more negotiating power or is more accepted)
7) How did your family and community react? If they are not yet aware, what are your fears for if they come to know?
8) (If they are married) What factors motivated you to get married? If your wife aware or understanding of your behaviors? Do you have any children?

Sexual Practices and HIV/AIDS Awareness
1) How many partners have you engaged in sexual relations with in the past month?
2) How would you identify your partners? (ie. MSM, homosexual, normative men, etc.)
3) How would you report your level of condom use? (Very infrequently/Never, Frequently, Always) What are your reasons for using (or not using) condoms? Do you feel like you have the power to negotiate condom usage in your relationships? Who generally has control over condom usage in your relationships?
4) Do you see yourself as being at higher-risk of HIV/AIDS than the rest of the population because of your identity? Probe about if this is a personal point of view, what kind of internalization do they have, how do they self-reflect and feel about their identity, do you assume that you will be discriminated against even before you visit a medical institution? Does fear of discrimination keep you from seeking treatment and care?
5) Gauge level of self-acceptance: How comfortable are you with your identity?
6) What is HIV and how is it transmitted? Where did you get this information?
7) What are ways to prevent HIV transmission? Where did you get this information?
8) Have you ever been tested for HIV/AIDS?
9) When was the last time you visited a clinic or hospital? What was the reason for your visit? Did you go alone or were you accompanied?
10) What do you define as healthy and good sexual health?

Stigma and Discrimination
1) Do you feel that you face any daily struggles because of your identity?
2) Have you ever faced discrimination in a medical setting? From doctors as well as non-medical staff such as receptionists, clerks, nurses, lab technicians, etc.
3) Do you know of friends who have resisted visiting a medical setting even when ill because of fear of discrimination?

4) If you are sick, what is your immediate approach to getting better? (home remedies, doctors, ignore sickness, quack doctors)
5) Do you feel like your identity is keeping you from maintaining or achieving good health?
6) Do you ever experience violence (physical/sexual, mental, emotional) due to your identity? Did you require any medical assistance after this violence? If you did, where did you go for care or treatment?
7) Have laws or legal structures ever served as an obstacle to being treated equally and fairly? How do you think these can be addressed or changed?

General
1) What kinds of services have Bharosa (or any other organization) provided or connected you to that have helped you maintain a state of healthy mental, physical, emotional well-being?
2) What needs do you, or your community, have that still need to be addressed? How do your needs differ from those of other sexual minorities? How can those needs be addressed?
3) What more can be done for you as an individual or as a community that will help you feel accepted?

Hijra Specific
1) Are you castrated?
2) What prompted you to get castrated?
3) Who conducted this castration procedure? (*Dai-ma* or Doctor) Where and what were the circumstances? Was there any medical follow up? (If they did not), why did you not visit a hospital or medical professional for castration?
4) Why did you become a part of the *Hijra* community? What is the experience of being a part of this community? (greater acceptance, comfort, inclusion, economic reasons such as option of *basti* and *badai* etc.)
5) How many partners do you have? How would you describe the identity of those partners?
6) How do your needs as a TG individual differ from that of other sexual identities, such as *Kothis*?
7) If you have a common illness, such as fever or cough and cold, how to you treat this? Do you visit a medical professional (why or why not), use home remedies, or visit a member of the *hijra* community?
8) Who is the most influential person in your life?
9) What has your experience been in obtaining personal identity documents and government papers?

HIV/AIDS positive MSM/TG
1) How did you contract HIV/AIDS?
2) How did you find out about your positive status? What prompted you to seek testing?
3) Where did you get tested?
4) What was your initial reaction when you found out about your positive status? That of your family, sexual partner, and society?

5) When you found out about your positive status, were you offered pre/post counseling services? Do you feel like the counseling was effective in helping you cope and manage/deal your concerns?
6) What is your access to treatment and care?
7) Are you on ARTC? Why or why not? (strong side-effects (drowsiness, rashes) or because of discrimination in medical setting?)
8) Do you or have you visited a CCC center? What services were provided and what was your experience like?
9) How do you prevent the spread of HIV/AIDS to anyone else?
10) Are you married? Does your wife or partner know about your positive status? Ask about condom usage and negotiation with wife/ partner. Has your wife/partner been tested for HIV/AIDS? What about children?
11) Do you feel like you have ever been discriminated against because you have HIV? Describe how your treatment by society has changed after you found out you are HIV positive.
12) If you have not disclosed your HIV status, what factors are preventing you from doing so? Who have you disclosed your status to (wife, friends, family, sexual partner) and for what reasons?
13) Have you ever had trouble accessing medical attention or treatment because of a) your sexual identity b) your positive status?
14) What did you know about HIV/AIDS before you were infected?
15) What kinds of services are Bharosa (or any other NGO/program) providing or connecting you to so that you are able to lead a productive and happy life?
16) How has being HIV positive impacted you economically/ financially?
17) (If on ART treatment) Did you complete your five-day stay at the CCC center? What was your experience like?

B. NGO Representative
1) What are the major differences between the different distinctions? *Hijra* vs. *kothi*?
2) What do you see as being the main forces/ factors impacting sexual health?
3) What kind of education do you provide about HIV prevention? How to reach out to those who are illiterate?
4) Do you encourage MSM/TG or their families to seek HIV/AIDS testing? Under what circumstances do you recommend testing?
5) What kinds of counseling services are provided for HIV/AIDS positive MSM/TG?
6) How do you ensure that HIV/AIDS positive MSM/TG are receiving proper treatment and medical attention?
7) For MSM/ TG that are married, do you have any programs that reach out to the wives and their needs?
8) How do you reach out to the families of MSM/TG so that they become more accepting?
9) For *hijra* communities that are resistant to interventions because they deny sexual activity, what are your methods of outreach and raising awareness to effect change?
10) How do you address and overcome the issue of the low self-confidence and self-worth of *kothis*?
11) How do you differentiate between the needs of the MSM and TG communities? What do you feel are the differences in the way that the two communities access/seek health care?

How do you cater to their individual needs? What more needs to be done so that the two groups become unique identities?

12) With what identity do the majority of the staff and outreach workers identity? Is there a representation of both *kothi* and *hijra* staff/ peer educators/ outreach workers?

13) For *hijra*s, how do you promote safer castration or SRS procedures?

14) How does the tension between *hijra* and *kothi* communities complicate/ serve as a hurdle to an intervention trying to target both populations?

15) For those MSM/TG involved in sex work, how do you address their large number of sexual partners and the risks involved? How much on average are they paid for sex work?

16) How do you reach out those WHO MSM do not identify with the label? Or young WHO MSM do not yet identify with a label but know they have a gender expression that is different from their biological sex?

17) What do you see as being the greatest challenges for your NGO in meeting the needs of MSM/TG? From both within the community as well as government/infrastructure?

18) What opportunities do you provide for vocational training? Does the community utilize or access these services?

19) How do you reduce stigma and discrimination in a health care setting? Do you have programs or education for medical staff in government/ private hospitals about issues surrounding MSM and TG individuals?

20) What connection do you see between women's empowerment and increasing the negotiation power/access to health care of MSM/TG who take on feminized behaviors?

C. Medical Professional

1) On average, how many PLHA do you see in a month? What is the general demographic of those patients?

2) What is the main route of transmission for MSM/TG individuals who are HIV/AIDS positive?

3) What indicators do you look for before recommending an individual to get tested for HIV/AIDS?

4) What is the protocol for individuals who refuse testing? Do you think testing should be mandatory for MSM and TG? Why?

5) What is the general procedure/ protocol for pre and post-test counseling? Do you cater the counseling towards the situation/ identity of the patient? (ex. In counseling a MSM/TG individual who is positive, are there different needs that need to be addressed?)

6) What kind of training have you been provided on MSM and TG issues?

7) Do you see MSM and TG individuals as being at a greater risk of contracting HIV/AIDS than the general population? What behaviors do you believe make them more vulnerable or at greater risk? What do you do to reduce those risky behaviors?

8) Do you feel like a stigma against PLHIV exists in the medical community and amongst medical professionals? What is the difference between this stigma and that of a positive MSM/TG individual? What efforts have been made by your institution to make sure that everyone is comfortable getting STI/HIV tested? Are there any special efforts to ensure that MSM and TG are not left out?

9) How has the stigma and discrimination against PLHIV changed over time in your experience?

10) If a patient is found to be HIV/AIDS positive, do you recommend or require testing of their partners and children? If a positive MSM/TG individual is married, do you encourage them to disclose their status to their wives and partners?
11) What do you believe are the differences in the health needs of MSM and TG/*Hijra*s? What are the differences in the way each sub-population of MSM accesses or seeks health care?
12) What is the most common illness or health problem of the MSM and TG patients you see?
13) What forms of follow-up care and support are provided to HIV/AIDS positive patients?
14) For *hijra*s, do you encourage castration procedures to be conducted by a certified medical professional? How do you do this?