Transgender – Hijra strategy

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INTRODUCTION

In most parts around the world "Hijras and Transgender" continue to be included under the umbrella term "MSM", however it has been increasingly been recognized that Hijras and TG have unique needs and concerns, and it would be more useful to view them as a separate group.

As the term "trans-gender" itself is the symbolic representation of crossing the boundaries, and it has been derived from the two different languages; the Latin word 'trans' and the English word 'gender'. The term "transgender" is generally used to describe those who transgress social gender norms. Transgender is often used as an umbrella term to signify individuals who defy rigid, binary gender constructions, and who express or present a breaking or blurring of culturally prevalent stereotypical gender roles[1].

OVERVIEW OF THE HIV EPIDEMIC INDIA

The HIV estimates 2008-09 highlight an overall reduction in adult HIV prevalence and HIV incidence (new infections) in India. Adult HIV prevalence at national level has declined from 0.41% in 2000 to 0.31% in 2009, although variations exist across the states. The estimated number of new annual HIV infections has declined by more than 50% over the past decade. One of the biggest and most immediate challenges in effectively responding to HIV in India is confronting the truly startling rates of infection among Hijras and transgender persons.

Clearly sexual minorities, such as men - who - have - sex - with – men (MSM), Hijras and transgender (TG), are significantly affected by the HIV epidemic. Since the practice of male to male sexuality in India is very complex and unique, it needs to be better understood. This will also help to improve the design of interventions in the current NACP Phase and proposed interventions in NACP IV.

CURRENT SITUATION

NACP III preparation exercises reconfirmed the importance of focusing efforts on prevention amongst high risk groups (HRGs). While much work has been done in India with female sex workers, it was recognized that the national programme had not given enough attention to injection drug users and "MSM." In addition to this, NACP III - for the first time - recognizes that "MSM" is not a homogeneous population. The programme especially acknowledges the unique HIV prevention, care, and treatment needs of Hijras and transgendered (TG) persons.

Coverage

- **NACO**
- **3 TIs – Denominator 3000 – 5000 (Mumbai, Maharashtra)**
- **BMGF**

[1] HIV/AIDS among men who have sex with men and transgender populations in South – East Asia, WHO 2010

- **TG – 7,400**
- **Mumbai and Bengaluru, 2 districts in AP, 5 districts in TN**

ESTIMATES

India UNGASS 2010 report estimates that there are 3.1 million MSM for India. Currently there are no national estimates of the either the enumeration or prevalence of HIV among transgender populations due to lack of data collection on transgender populations at the national level. Anecdotal guestimates peg the transgender populace between .5 – 1 million in India. UNDP study - *166,665 –* reported by CBOs in 42 sites*

For working purposes the lower bound can be 166,665, the upper bound range will be explored through data triangulation using census, mapping and revalidation data.

ANALYSIS OF THE EPIDEMIC

HIV prevalence among MSM/Transgender populations was 5.7% as against the overall adult prevalence of 0.36%[2]. Until recently, transgender communities were not distinguished from MSM in HIV sentinel serosurveillance. As a result, limited data is available on the prevalence of HIV and STIs among transgender communities.
In 2002-03 a study was conducted in Mumbai, which indicated HIV prevalence among transgender (Hijra) sex worker were 56% (n = 163). In 2005, the prevalence rate among the same population went down to about 40%. In 2003, in Chennai city a similar study was conducted among 1200 Transgender population which revealed 45% prevalence rate.

A study conducted in Mumbai reported very high HIV prevalence of 68% and high syphilis prevalence of 57%[3]. Similarly, a study conducted among male sex workers in Mumbai that included Hijras as a major sub-group documented a very high HIV prevalence of 41%[4]. In Southern India, a study documented a high HIV prevalence (18.1%) and Syphilis prevalence (13.6%) among Hijras[5]. A study conducted in Chennai documented high HIV and STI prevalence among Aravanis: 17.5% diagnosed positive for HIV and 72% had at least one STI (48% tested seropositive for HSV-1; 29% for HSV-2; and 7.8% for HBV)[6].

Published data on sexual risk behaviours of Hijras/TG women are limited. The available information from the Integrated Biological and Behavioural Assessment (IBBA) survey 2007 conducted in select districts of

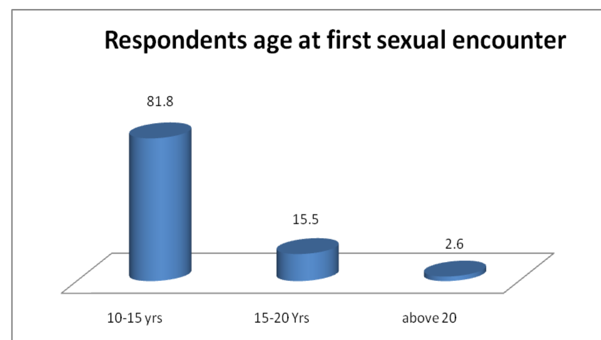
2 National AIDS Control Organisation (NACO). 2006, Annual HIV Sentinel Surveillance Country Report
3 Setia, M.S., Lindan, C., Jerajani, H.R., Kumta, S., Ekstrand, M., Mathur, M., Gogate, A., Kavi, A.R., Anand, V., & Klausner, J.D., (2006). Men who have sex with men and transgenders in Mumbai, India: An emerging risk group for STIs and HIV. Indian Journal of Dermatalogy, Venereology & Leprology, 72(6), 425-431
4 Shinde S, Setia MS, Row-Kavi A, et al. Male sex workers: are we ignoring a risk group in Mumbai, India? Indian J Dermatol Venereol Leprol 2009;75(1):41-46
5 Brahmam, G.N.V., Kodavalla, V., Rajkamur, H., et al. (2008). Sexual practices, HIV and sexually transmitted infections among self-identified men who have sex with men in four high HIV prevalence states of India. AIDS, 22(5), S45 - S57
6 Saravanamurthy, P., P. Rajendran, L. Ramakrishnan, G. Ashok, P.M. Miranda, S.S. Raghavan, V.S. Dorairaj, S. Sahu. STI and HIV prevalence in male-to-female transgender communities in Chennai, Southern India. International AIDS Conference, Mexico, 2008.

Tamil Nadu, reported that, among Hijras/TG, the condom use during last anal sex with commercial male partners and 81% with non-commercial male partners is 85% and 81% respectively. Also, the survey documented low level of consistent condom use among Hijras/TG women: 6% with commercial male partners and 20% with non-commercial male partners.

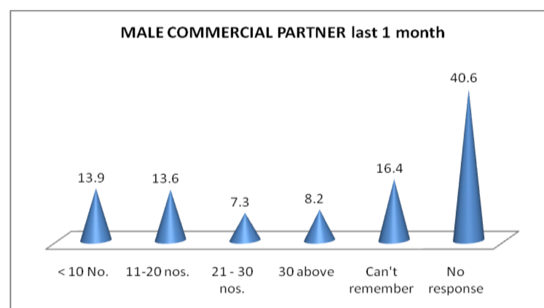
VULNERABILITY TO HIV AND RISK FACTORS

In India, Hijras and Transgenders are seen as a separate socio-religious and cultural group. Primary and Secondary data suggest that Transgender/Hijras are not a homogeneous group, they have various subgroups within them such as TGs/Hijras who earn their living as a sex worker on the street, TGs/Hijras who beg and those who are living in some *Dera* and are limited only to *Badhai-Toli* and as such have different health needs and concerns and also can be reached by varying approaches. Most of the Transgender/Hijras are still a hidden population and largely out of reach. This makes it difficult to meet the prevention needs of transgender persons which continue to go largely unaddressed. The primary sexual practice among Transgender/Hijras is unprotected anal sex where most of the time they perform the role of a receptive partner. According to secondary data, various research studies report rvery limited access to water-based lubricant and overall low levels of condom use;[7] this practice makes them more vulnerable to become infected with HIV and other STI infections.

A review of the results from the data[8] collected from 772 self-identified TGs shows that 67% of the respondents recognize that their community is at high risk towards getting infected with HIV because of unprotected sexual practices of many members of the community.



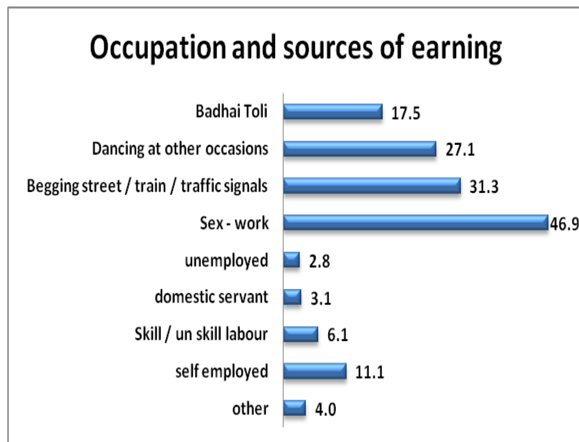
Their sexual activities start at a very young age. Over 82% respondents reported that they had the first sexual experience with a male by the age of 15. They have multiple commercial partners in a month and they have more potential to get infected and to spread the virus to many others. According to our primary data, 43.3% (n=683) respondents reported having commercial partners in a month. More than 50% do not even remember the number of male partners they had in the past one month. About 47% are earning their livelihood by doing sex work. Moreover, it is a common practice almost a phenomenon among 78.6% of the transgender that they frequently visit other places for long periods. Over



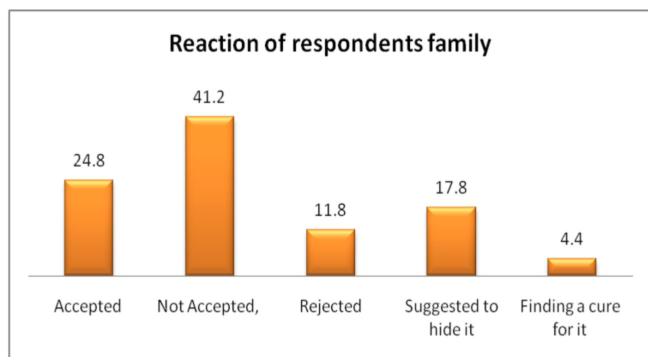
[7] Hijras in sex work face discrimination in the Indian health-care system by Venkatesan Chakrapani, Priya Babu, Timothy Ebenezer

[8] UNDP unpublished

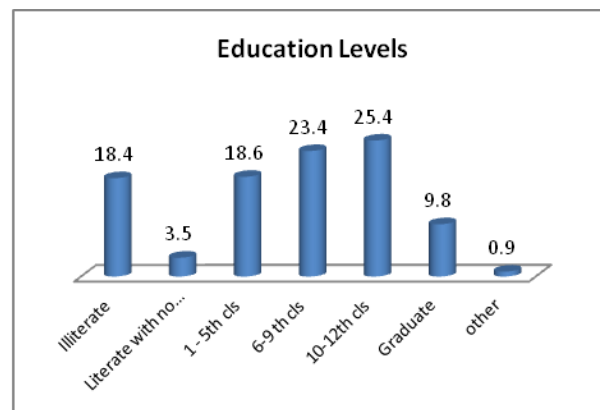
63% respondents reported the purpose behind their travel as sex work.



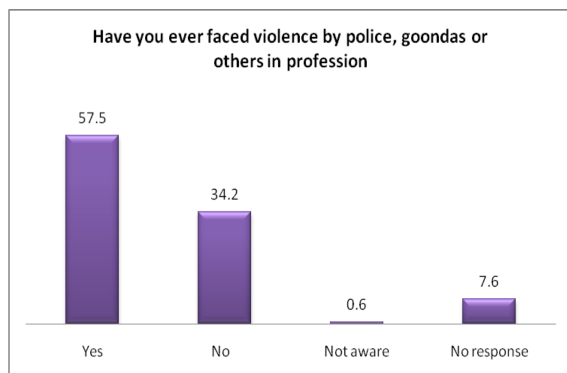
A majority also report periods of intense sex work which we understand includes ***Melas*** and festivals etc where the number of partners are many and are occasions for easy transmission to many members of the community and others. According to our data, 54% reported in indulging in "heightened or an intensive" period of sexual activity in the past 6 months. However, this also gives us a clue that this may present opportunities to reach them and their clients.*(for details please see the section-1 and annex-1 of research report).* Therefore, it's clear that TGs & Hijras are very mobile, are involved in sex work in various environments and places. Hence they are at risk to themselves and also at risk of infecting their partners.



Data also suggests that Transgender/Hijras are not accepted (75.2%) and supported by their families and society due to their gender status. Therefore, they are forced to leave their families and be on their own so that the family does not experience any discrimination and stigma. Being economically disadvantaged, semi-literate, unaccepted, away from their homes with no emotional and psychological support from their families and society, they have to face life's challenges on their own. According to our data, only 18.4% (N=772) are illiterate, 48.8% are drop-outs between 6th -12th standard. About 41.2% have indicated that they are not accepted by their families. Consequently they are pushed towards either traditional options (toli badhai) and/or unhealthy options of earning such as sex work to earn two meals a day. They sell themselves for as meager an amount as Rs. Ten or Twenty.[9]



[9] Police refuse to file our complaints, say we don't come under law- an Indian Express Newspaper report by Mohana Dam **on Saturday, Feb 28, 2009**



They are stigmatized, discriminated and vulnerable to bullying by law enforcement agencies, goondas and often teased and harassed by general community members. They are not empowered adequately which prevents them from reporting any incidents of sexual harassment and rape to police. According to our data, the police refuse to register their complaints saying that they do not come under the existing laws. [10]Over 57% respondents have reported to have faced violence from police, *goondas* or others in profession.

The social hierarchy and community norms among Hijra communities influence HIV prevention behaviours among them and have both positive and negative influences on HIV risk behaviours among Hijras. In Eastern and Northern India s**exual silence in certain *Gharana*s is the norm and this** makes the situation worst. Hijras from certain *Gharana*s are not supposed to have sex as they are dedicated to the Goddess. *Guru*s from such *Gharana* may not approve the distribution of condoms to them.[11]

All these factors add up and together make TGs extremely vulnerable to HIV. The TGs continue to feel the need for an identity as a separate group which has to be made an acknowledged partner in the fight against HIV/AIDS. According to our data, over half of the respondents (53%) reported the requirement for a separate intervention program for TGs.

DEFINING AND DESCRIBING MSM AND TRANSGENDER POPULATIONS IN NACP 3 PROGRAMMING

In the third phase of the National AIDS Control Programme (NACP-III; 2007-12), National AIDS Control Organisation (NACO[12]) separately mentioned 'transgender people' as having different HIV prevention and care needs although some commonalities between men who have sex with men (MSM) and transgender people are present. Except for a few sites (such as Mumbai and Madurai), elsewhere interventions among TG are clubbed together with that of MSM.

Considering the high HIV prevalence (17.5%[13] to 41%[14]) among TG/Hijras when compared with that of MSM, it is crucial that HIV interventions among TG/Hijras need to be scaled up. And to assist NACO/SACS in scaling up TG interventions, operational guidelines for TG interventions are needed. A recent document from UNDP noted that there could be at least three ways for scaling up HIV

[10] *"Police refuse to file our complaints, say we don't come under law"*, ***The Indian Express***, February 28, 2009

[11] Central India Regional Transgender-Hijra Consultation Report June 6-7, 2009 Bhopal, Madhya Pradesh

[12] More information on NACO at www.nacoonline.org

[13] Saravanamurthy, P.S., Rajendran, P., Miranda, P.M., Ashok, G., Raghavan, S.S., Arnsten, J.H., et al. (2010). A cross-sectional study of sexual practices, sexually transmitted infections and human immunodeficiency virus among male-to-female transgender people. American Medical Journal, 1, 87-93.

[14] Shinde S, Setia MS, Row-Kavi A, et al. (2009). Male sex workers: are we ignoring a risk group in Mumbai, India? Indian J Dermatol Venereol Leprol;75(1):41-46

interventions among TG/Hijras – by having NGO-/CBO-led intervention (similar to exclusive MSM TI intervention); Festivals/Functions-based intervention; and Gharana-based intervention. Building from these models, DFID TAST and UNDP will work with key stakeholders in preparing and testing operational guidelines.

UNDERSTANDING TG HIJRA POPULATIONS IN INDIA

The term 'transgender people' is generally used to describe those who transgress social gender norms. Transgender is often used as an umbrella term to signify individuals who defy rigid, binary gender constructions, and who express or present a breaking and/or blurring of culturally prevalent stereotypical gender roles. Transgender people may live full- or part-time in the gender role 'opposite' to their biological sex by birth. In India, people with a wide range of transgender-related identities, cultures, or experiences exist - including Hijras, Aravanis, Thirunangai, Kothis, Jogtas/Jogappas, and Shiv-Shakthis. *Glossary of transgender terms to be enclosed as annexure.*

WORKING DEFINITION

Hijra

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

Transgender

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

RISK PROFILE

- Number of partners?
- Types of partners
- Types of sexual behaviour?
- Sex work?
- Vulnerability and non ability to negotiate safer sex?

- Migration- mobility- awareness/knowledge levels
- Proportion of them exposed to violence, emasculated status, anal sex, substance abuse and risk behaviours?

Other influencers: *Structural, biological, physiological, migration and mobility, awareness and knowledge levels?, proportion of them exposed to violence, emasculated status, anal sex, substance abuse and risk taking behaviours?, consistent condom usage.*

INTERVENTION PACKAGES FOR TRANSGENDER AND HIJRAs

Hijras and TG issues are separate from MSM and cannot be addressed under common intervention model emerged as one of the critical findings in NACP III Mid Term Review. Hence there is a need to develop a customized prevention model for TGs in India which is community driven and aligned with NACP III principles. Recent national and regional consultations by UNDP in India have highlighted the need to address TG – Hijra populations, some of the community recommendations with regard to NACO and NACP 3 are as follows:

NACP-III (2007–2012) has included “MSM and transgender” people among the ‘core groups’ for whom intensified HIV prevention and care programs are implemented. Interventions for transgender women are currently subsumed under ‘MSM interventions’. Nevertheless, in some states (e.g., Tamil Nadu and Maharashtra) separate interventions for Hijras/TG are being implemented for some years. Some gaps that need to be addressed in relation to interventions among TG include the following.

1. ***Need for separate HIV sero-surveillance centers:*** In India, separate HIV sentinel sites for MSM were introduced only in 2000 and for Hijras/TG in 2005. As of 2007, there were 40 sites for MSM and 1 site for TG.

2. ***Need for interventions that provide holistic care to Hijras/TG:*** Preventing HIV and mitigating the impact of HIV epidemic is the primary focus of NACP-III. However, other health-related components which would have significance effects on HIV such as mental health counselling and counselling on sex change operation are not part of the existing MSM/TG interventions. Thus, there is a lack of holistic and comprehensive approach that includes health and social services for transgender people.

3. ***Greater involvement of Hijras/TG communities in decision-making process:*** In line with the guiding principles of NACP-III that include community involvement and greater involvement of people infected and affected by HIV/AIDS (GIPA), it is crucial to include representatives of Hijras/TG communities in HIV policy formulation and program development. Currently, national GIPA policy is being finalized, but it does not explicitly articulate the importance and ways of including Hijras/TG representatives in decision-making process.

4. ***Need for CBO formation and strengthening:*** NACP-III envisions that 50% of TIs would be transitioned from NGOs to CBOs by the end of 2012. However, so far, only a countable number

of CBOs of Hijras/TG communities, with various levels of capacity exist. The capacities of existing and emerging CBOs need to be strengthened so that they can effectively implement TI projects and other programs.

Transgender/hijras expect that the intervention packages/projects must be designed to address their overall welfare rather than just focusing on HIV/AIDS.They have often claimed that mainstream society does not understand their culture, gender, and sexuality. Dimensions of their social deprivation and harassment towards them have never received attention in development sectors. Violations of their human and sexual rights have been overlooked in the traditional Targeted Intervention Projects. The CBOs also do not provide any social or legal services to them in terms of establishing their citizenship rights. Sole promotion of condoms and lubricants ignores multidimensional ruptures and alienation that exist within any targeted population. Understanding the socio-cultural and human rights aspects of discrimination against the TG & hijra community and deprivation can help reduce STI/HIV transmission and safeguard this marginalized community.

NACP IV DESIGN AND APPROACH

Approach

- Enabling environment
- Evidence informed
- Strength-based
- Affirming sexualities and acknowledging sexual behaviours at risk
- Community driven interventions
- Involvement
- Adequate resources

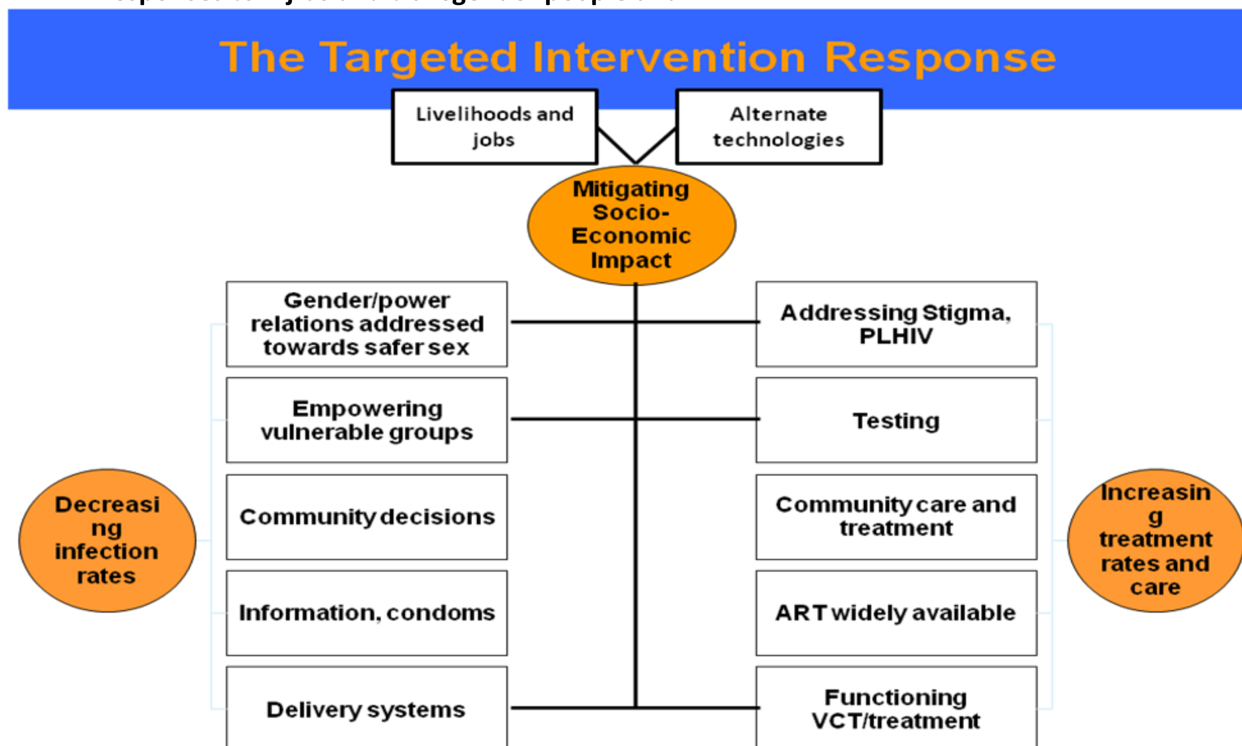
Design

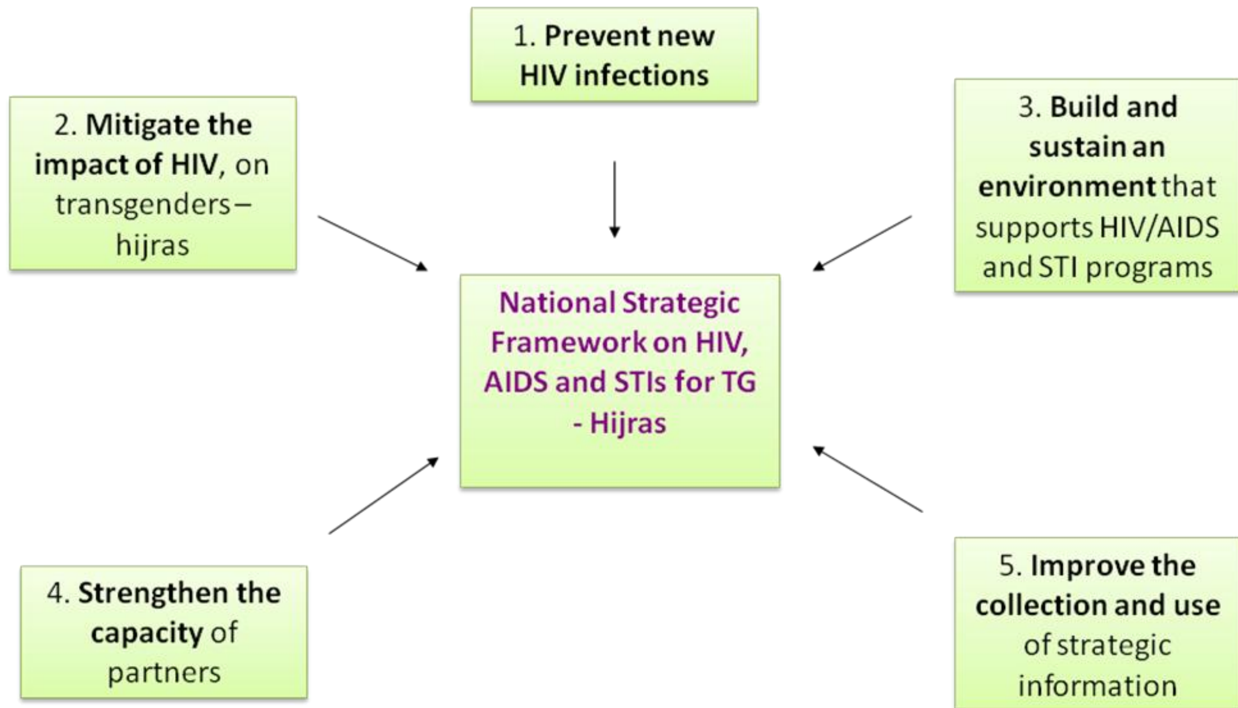
- It is clear that there is an urgent need not just for more programming, but also for new and better approaches to programming.
- Attention to their needs in broader HIV responses, and bridge-building with broader efforts to achieve gender equality, promote human rights and protect public health.
- Ensuring the full involvement of government, nongovernmental and private sector organizations, and of civil society, including CBOs working with MSM and Hijras/ TG, through a broad-based partnership approach;
- Tailoring interventions to where the burden of the disease lies, taking into account the nature of the epidemic and the context in specific settings (e.g. HIV prevalence and risk behaviour, cultural traditions, social attitudes, and political, legal and economic constraints);
- Creating a supportive enabling environment by addressing stigma and discrimination in both the health-care services and the broader society, applying human rights principles and promoting gender equity, as well as reforming laws and law enforcement to ensure support for a public health response to HIV and AIDS;
- Ensuring equitable access to health-care services for Hijras and TG; providing a comprehensive approach, with a continuum of prevention, care, support and treatment services;

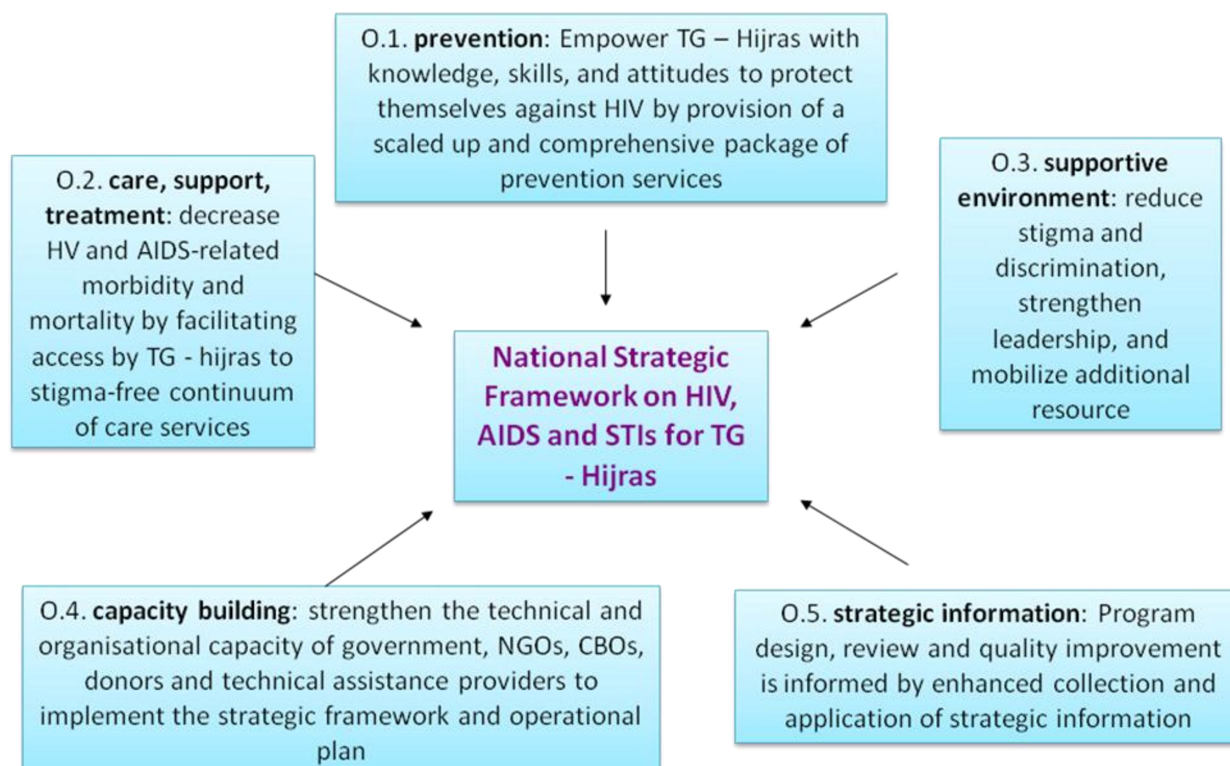
- Providing a combination of prevention interventions, delivered at scale and with intensity to maximize effectiveness; and ensuring that interventions and services are, to the largest extent possible, evidence based.

Objectives for enhanced action: Beyond 'business as usual'

- **Objective 1: Improve the human rights situation for transgender – hijras the cornerstone to an effective response to HIV**
- **Objective 2: Strengthen and promote the evidence base on hijras and transgender people and HIV**
- **Objective 3: Strengthen capacity and promote partnerships to ensure broader and better responses to hijras and transgender people and HIV**




National Strategic Framework for Transgender - Hijras: 5 strategies
1. Prevent new HIV infections
2. Mitigate the impact of HIV, on transgenders – hijras
3. Build and sustain an environment that supports HIV/AIDS and STI programs
National Strategic Framework on HIV, AIDS and STIs for TG - Hijras
4. Strengthen the capacity of partners
5. Improve the collection and use of strategic information



Key priorities (to improve the HIV response for TG - Hijras)

1. Scaling up of **comprehensive prevention package** to achieve significantly increased coverage, particularly where TG – hijras are concentrated and then scale up coverage where they are spread out/ scattered
2. Improving the **quality of prevention services**
3. Building the **technical skills and organizational capacity of CBOs and provide transition support where ever needed**
4. Strengthening the **involvement of TG - hijras in HIV/AIDS response** through community development and mobilization
5. Strengthening the **partnership** between government, CBOs, TG- hijras and technical assistance providers
6. Reducing **stigma and discrimination** against TG - hijras
7. Mobilizing **sufficient resource** for effective response

Activities proposed to be covered 1(2011 inception phase) + 5 years (April 2012- March 2017)

Expected results

- S.1: **5 Expected results**

Result 1: Scaled up delivery of strategic behaviour changes communications, community outreach and peer education programs for visible- concentrated and hidden- scattered TG – Hijras
Result 2: Increased correct and consistent condom and lubricant use by TG – hijras
Result 3: Increased availability and use of quality and stigma-free STI services appropriate for TG – hijras
Result 4: Increased use of quality and stigma-free ICTC services by TG – Hijras
Result5:Conducive environment for delivery of comprehensive prevention package through collaboration with gatekeepers and stakeholders

- S.2: **3 Expected results**

Result 1: Better understanding barriers to TG - Hijras accessing HIV/AIDS care, support and treatment services
Result 2: Increased use of stigma-free HIV/AIDS care, support and treatment services by HIV positive Hijras /TG and their partners.
Result 3: Strengthened linkages between prevention services and care, support and treatment services

- S.3: **4 Expected results**

Result 1: Reduced stigma and discrimination against TG - Hijras
Result 2: Leadership and advocacy demonstrated by all partners (government, donors, technical assistance providers, CBOs)
Result 3: Increased coordination and collaboration among partners
Result 4: Sufficient resources mobilized and allocated

- S.4: **6 Expected results**

Result 1: Strengthened leadership and advocacy capacity by all partners
Result 2: Strengthened technical and organizational capacity of CBOs to undertake quality prevention activities and referral to care, support and treatment services
Result 3: Strengthened involvement of TG- Hijras and CBOs in the HIV and AIDS response
Result 4: Increased and more coordinated technical assistance to CBOs providing Hijras/TG prevention services
Result 5: Strengthened capacity of STI services to provide quality and stigma-free STI services
Result 6: Strengthened capacity of care, support and treatment services to provide quality and stigma-free services to TG - Hijras

- S.5**: 4 Expected results**

Result 1: HIV and STI surveillance and behavioural data is collected and used to inform the response
Result 2: Agreed TG-Hijras population size estimate and networks and entry points for interventions identified
Result 3: Improved social and operations research on TG – Hijras interventions
Result 4: Improved monitoring of TG – Hijras programs and evaluation of the efficacy, effectiveness and impact of interventions

Broad Implementation plan:

Pre NACP IV phase

Objectives:

- To have Hijra TG resource pool
- To initiate exclusive TIs for Hijra TG community.
- Involve Gurus as Leaders for health initiative
  - Setting up of stand alone 12 Hijra TG TI by Aug 2011- (To know how Hijra TG TI functions – issues)
  - Synergy with Round 9 and other efforts (To build capacities of Hijra TG CBOs)
  - Validation of KP population – by Dec 2011
  - Advocacy with Gharanas this year- Task force constitution
  - Working Group – will work as TRG
  - Communication strategy/ material
  - Analysis of 12+ Hijra TG TI in this year

NACP IV (2012-2017)

Goal:

- **100% community and community leaders will be empowered to deal with all the Health issues related to Hijra TG community.**
- **Bring down HIV incidence by 50%**

1st YEAR-

- As per validation start new TIs
- Out of previous TIs – develop 3? Learning Sites

2nd YEAR

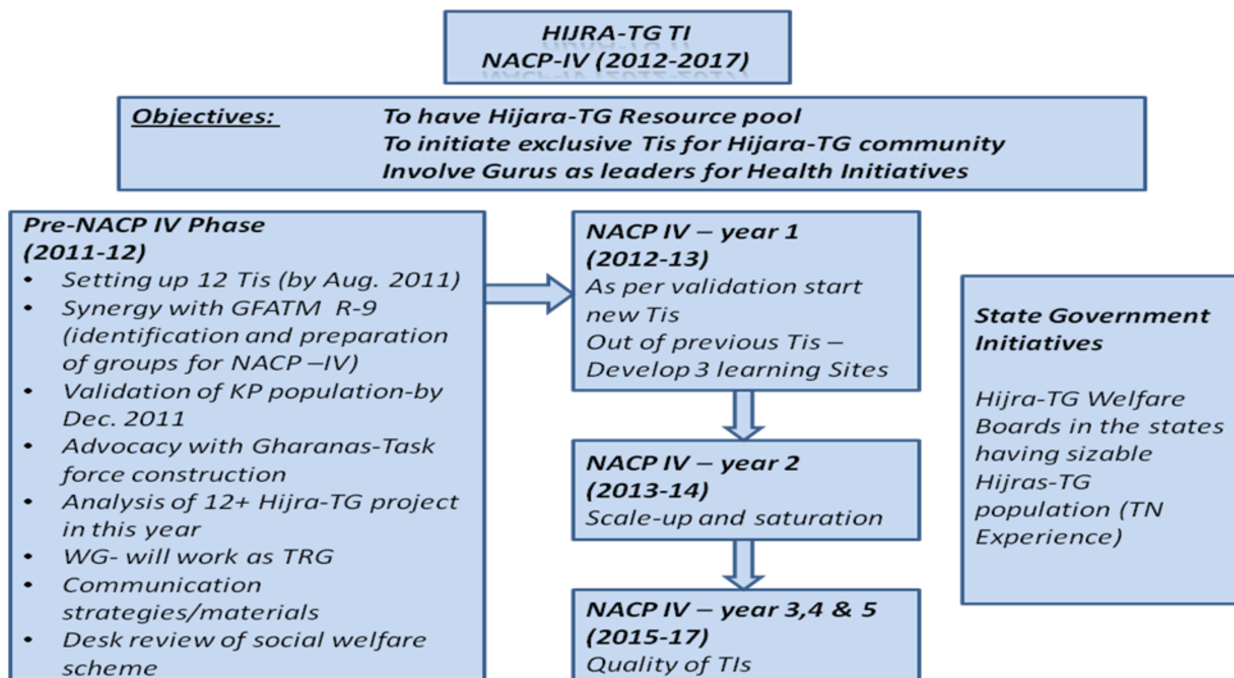
- Scale up and saturation

3rd YEAR onwards

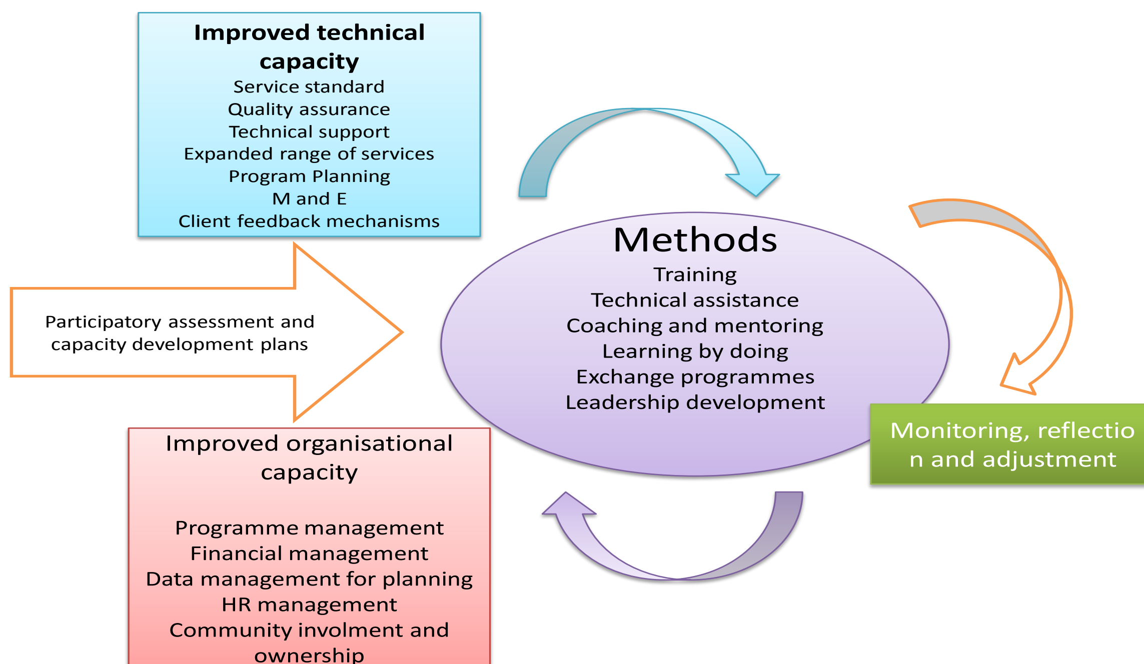
- Quality TI

Other Structures through State Government -

- Hijra TG Welfare Boards in the States having sizable Hijra TG population



Capacity building plan



Expected outcomes

1. Improved HIV/AIDS program management capacity at the national and provincial level for a scaled up and more comprehensive range of services for TG - Hijras.

2. This includes the technical and organizational capacity to deliver a comprehensive package of services for TG - Hijras in HIV prevention, care, treatment and support.
3. Improved organizational management and leadership capacity of CBOs and NGOs working to deliver HIV prevention services for TG – Hijras leading to increased absorptive capacity for scaled-up, higher quality services fully accountable to donors and the community.