

**FEMINISATION AND SUBSTANCE
USE IN THE MALE-TO-FEMALE
TRANSGENDER/*HIJRA*
POPULATION IN INDIA:
A NEEDS ASSESSMENT**

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DRAFT

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LIST OF ACRONYMS/ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
FGD	Focus Group Discussions
HCP	Health Care Provider
HIV	Human Immunodeficiency Virus
IDI	In-depth Interviews
KII	Key Informant Interviews
SOC	Standards of Care
SRS	Sex Reassignment Surgery
TGs	(Male-to-female) Transgendered people
WPATH	World Professional Association for Transgender Health

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EXECUTIVE SUMMARY

India has about 23.9 lakh cases of HIV/AIDS in which male-to-female (TGs)/*Hijra* form a marginalized sub population with inexplicably high HIV prevalence, of the order of 55%. Transgender persons when on one hand seem to challenge the gender norms by cross-dressing and performing the gender role differently than expected, they also end up embracing the polarity of gender by conforming to the expectation of the opposite gender. Some of the *Hijras* may be emasculated or *niroana*; this procedure is often performed in a traditional ritual. Nonetheless, it is quite possible that some of these may also use other feminisation methods such as hormones or breast implants.

It is thus important to understand the knowledge and practices of TG/*Hijras* with regards to feminisation procedures. Furthermore, though sexual risk activities are an important factor in their HIV risk, further attention needs to be placed on their injection practices related to hormone and other substance use. Thus, we conducted the present needs assessment to: 1) Understand the current knowledge and practices related to biological feminisation in the TG/*Hijra* communities in India; 2) Understand the hormone and other substance use among TGs/*Hijras*, and 3) Assess the needs of the TG/*Hijra* communities with respect to Aim 1 and 2

The assessment consisted to two components: a desk review and qualitative data collected from community members, community leaders and health care providers. For the desk review, we reviewed the existing Indian and global literature on biological feminisation; these included research papers, organisational reports, and guidelines. In addition, we conducted three different types of qualitative interviews across five cities of India - Thane, Kolkatta, Bengaluru, Gurdaspur, and Hoshangabad. The qualitative interviews were: 1) six focus group discussions (FGDs); 2) 15 in-depth interviews (IDIs); and 3) nine key informant interviews (KIIs).

We found that though there are international guidelines and manuals for feminisation procedures (such as surgery, hormone therapy to name some), no such standard guidelines exist in India. Indeed, although the procedure is being done in the country there is a lack of clarity about the legal status of the procedure. Though, apparently the community members have a variety of options of feminisation procedures (traditional as well as surgical), in reality the options are limited by available finances, social beliefs, or peer-pressure. Many of the individuals undergo these procedures in high-risk conditions; this often results in multiple complications including death in some cases. Substance abuse appears to be very common among

TG/*Hijra* community members. Substances are used both for recreational and medical purposes; the latter are often purchased over the counter and taken without proper medical supervision. The community members feel that they should just not be treated as subjects for HIV interventions, and the health interventions should move beyond HIV prevention and condom distribution.

Thus, some of the key recommendations include: clarity of legal status of the procedures; developing standardised guidelines for surgical and non-surgical procedures; documenting the traditional procedures and their complications; understanding the association between substance use, high risk behaviours, and infections; and developing counselling guidelines and integrating them in the interventions for TG/*Hijra* community members.

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BACKGROUND

India has about 23.9 lakh cases of HIV/AIDS [1] in which male-to-female (TGs)/*Hijra* form a marginalized sub population with inexplicably high HIV prevalence, of the order of 55% (95% confidence interval: 40% to 71%). [2] A very high HIV prevalence of 68% was reported by a study conducted in Mumbai. [3] Though initially, they were grouped with the men-who-have sex with men (MSM) in research and public health interventions, there has been an increased emphasis to separate these populations in surveillance and public health interventions. It has been argued that TG/*Hijras* are a separate socio-group and should not be grouped with MSM.

Conventionally performed and accepted gender and sexual roles do not give space to any form of alternative performance of gender or sexuality. This form of regulation and limitations posed on one's body and behaviour results in restricting and stigmatizing all forms of non-hetero-normative roles and behaviour. In social spaces it is one's gender performance rather than sexuality that is played out, hence a lot of the discrimination and violence faced by sexual minority is on their gender non-conformity. TG persons who do not conform to their expected gender roles face the brunt of societal stigma and discrimination, which puts them at the margins.

Transgender persons when on one hand seem to challenge the gender norms by cross-dressing and performing the gender role differently than expected, they also end up embracing the polarity of gender by conforming to the expectation of the opposite gender. There are only two scripts of gender performance that are available in the hetero-normative society. Transgender persons also in the process of challenging one form of gender also conform to the expected roles of the opposite gender. This initiates the process of imitating the opposite gender roles and also playing out their bodies in a way that is suited for such a gender performance. Artificial or permanent changes made to one's body is just a step towards realizing self as of opposite gender. There is a need to explore the ways and strategies used by male-to-female transgender persons to feminize their bodies and possible reasons for doing so. *Hijras* are associated with specific socio-cultural households called *gharanas*. Some of the *Hijras* may be emasculated or *nirvana*; this procedure is often performed in a traditional ritual. Nonetheless, it is quite possible that some of these may also use other feminisation methods such as hormones or breast implants.

It is thus important to understand the knowledge and practices of TG/*Hijras* with regards to feminisation procedures. Furthermore, though sexual risk activities are an

important factor in their HIV risk, further attention needs to be placed on their injection practices related to hormone and other substance use. Though these are important issues that need to be understood through systemic research, it is equally important to understand the research needs of the community with respect to these issues. Such information will help us design research programmes and public health interventions that are relevant to the needs of the community.

Thus, we propose the present needs assessment to

- 1) Understand the current knowledge and practices related to biological feminisation in the TG/*Hijra* communities in India
- 2) Understand the hormone and other substance use among TGs/*Hijras*
- 3) Assess the needs of the TG/*Hijra* communities with respect to Aim 1 and 2

METHODS

The assessment consisted to two components: a desk review and qualitative data collected from community members, community leaders and health care providers.

a) Desk review: We reviewed the existing Indian and global literature on biological feminisation; these included research papers, organisational reports, and guidelines. We performed an electronic search of Pubmed and Google Scholar, using the key words: feminization, guidelines, sex reassignment surgery, male-to-female transgender, and India. We identified additional abstracts using the 'related citations' section in Pubmed. During this search, we found a webpage for World Professional Association for Transgender Health (WPATH). [4] This site was a useful resource for additional articles and guidelines related to transgender health.

b) Qualitative interviews: We conducted three different types of qualitative interviews across five cities of India - Thane, Kolkatta, Bengaluru, Gurdaspur, and Hoshangabad. The qualitative interviews were: 1) Focus group discussions (FGDs); 2) In-depth interviews (IDIs); and 3) Key informant interviews (KIIs). The participants for these were consenting self-identified TGs/*Hijras* above the age of 18. The participant TGs/*Hijras* were as follows: 1) those who have undergone the feminisation procedure (either surgically or traditionally); or 2) those who are considering it; or 3) those who have not undergone the procedure in any form. The key informant interviews were conducted with a community leader and/or a health care provider. The qualitative interviews were led by a TG/*Hijra* community member or a nominated member from the organisation working with the community. They were trained in qualitative method data collection procedures by the project co-ordinators. They were also assisted by the Department of Research at the Humsafar Trust for data collection, transcription, and translation.

We will have three main categories of questions in the qualitative interviews: 1) Questions about the knowledge and practices of procedures and complications in biological feminisation; 2) Questions on use medications for feminisation and other substance use; and 3) Questions about the research and intervention priorities as understood by the community members.

All the interviews were audio taped. The files were transcribed and further translated into English for analysis. Analysis was done using QSR NVivo 8 (© QSR International Pvt Ltd) by coding the qualitative data.

The data collection from the five cities were as follows:

Table 1: Table showing details of the qualitative interviews conducted in five cities of India for the Needs Assessment, 2012.

City	Name of the organisation	Focus group discussions	In-depth interviews	Key informant interviews*
Thane	Kinnar Asmita	1	3	2 (CL and Dai)
Kolkatta	Amitie Trust	1	3	2 (CL and HCP)
Bengaluru	Payana	1	3	2 (CL and HCP)
Gurdaspur	Navjeevan Foundation	2	3	1 (CL)
Hoshangabad	Mitra Aabha	1	3	2 (CL and HCP)
Total		6	15	9

* CL= Community leader, HCP =Health care provider

RESULTS

We have divided the results section into two groups: 1) Desk Review, and 2) Qualitative data analysis

A) Desk review

We scanned 4693 asbstracts/ documents for the desk review; of these were reviewed 20 articles and seven reports in detail. Within the Indian context, the manuscript, by Harish and Sharma, [5] discussed medical advances for SRS and the legal implications after undergoing SRS. The author stated that there is no direct law that criminalizes castration in India but it is covered under various sections of the Indian Penal Code (IPC). For instance, Section 320 of the IPC mentions that emasculation is an offense. As castration/*nirvaan* is not legal, many surgeons do not perform the surgery or conduct these surgeries in seclusion. Many a times TGs go to 'quacks' or *dai maas* who 'specialize' in castration; this may result into grievous injuries, infection, almost no post operative care, and sometimes even death. The standard procedure or medical guidelines for SRS in India is ambiguous. The study highlights the legal issues around SRS procedures. Apart from articles discussing HIV and STIs among male-to-female TGs, we did not find any studies related to SRS in India.

We found that the WPATH [4] publishes Standards of Care (SOC) guidelines for treatment of gender dysphoria. The first SOC was published in the year 1979, and had undergone 7 revisions with the most recent version published in July 2012. The SOC is not exclusively but widely based on the North American and Western European research and knowledge, and thus needs to be adapted to the other countries. The WPATH SOC was cited in majority of the state/country guidelines and research papers referred during the desk review. [4, 6-8] The SOC has also described the role of Mental Health Professionals in treatment of Gender Dysphoria. The tasks mentioned involve assessment of gender dysphoria followed by providing information about it and the possible interventions. The mental health professional will also have to diagnose co-morbid mental health problems. If the client is eligible and prepared for sex reassignment, then s/he should be referred to hormone therapy.

The SOC gives separate criteria for Hormone therapy, breast augmentation and genital surgery. The 4 basic criteria for all feminisation processes are:

"1. Persistent, well document gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be reasonably well controlled."

The guidelines state that, to attain best results after breast augmentation one should have feminizing hormone therapy for a minimum 12 months before surgery. It also mentioned that for genital surgery, referrals of two mental health professionals are required. However, the criteria differed with the type of surgery. Thus, while for orchidectomy, the patient has to undergo 12 months of continuous hormone regime based on the patient's gender aspiration; for vaginoplasty, the patient along with the 12 months of continuous hormone regime has to undergo an additional 12 months of real life experience in the desired gender identity. Such criteria have also been discussed by other authors. For instance, Sohn [9] has suggested that a patient undergoing SRS must complete 12 months of 'real-life experience' and should be on a hormone regime for minimum 6 months. Following this, he/she should be assessed by a qualified mental health professional to ascertain if he/she fulfils the criteria of a permanent gender change and if he/she will benefit from SRS.

Majority of the articles reviewed discussed post surgical follow up and satisfaction.

Very little scientific literature on sex reassignment surgical procedures (traditional and non-traditional) in India

No short term or long term studies on the effects of these procedures on the health of TGs/Hijras

No studies on substance use among TG/Hijras with/without these procedures

*Important global sources:
<http://www.wpath.org/>
<http://transhealth.nch.ca/>*

For instance, quality of life (QOL) survey, conducted in the USA, among 247 MTF Trans-genders found that MTF TGs had a lowered mental health-related quality of life compared with the female population. However, this improved after surgical treatments like facial feminisation surgery, gender reassignment surgery or both. [10] Another report found that at some point in their life before undergoing the surgery about 50% of the patients had considered committing suicide while 4% had actually attempted it. However, after SRS about 75% of these clients experienced higher sexual satisfaction and almost none of the participants expressed any regrets about undergoing SRS. [11]

We also found three systematic/literature reviews [12-14] that discussed problems and failure after sex reassignment surgery. One systematic review

evaluated five surgical procedures for SRS (clitoroplasty, labiaplasty, orchidectomy, penectomy and vaginoplasty) and reported that the evidence for SRS required more controlled studies, proper evidence based data collection, higher follow up rates, and need for validated assessment measures. [14]

There is also a significant use of alcohol and drugs among the TG/*Hijra* population in India which remains unexplored. Though there is not a known percentage of alcohol indulgence and substance use; mostly they are consumed to reduce pain, stress & depression and/or for sex work (UNDP, 2010). A study conducted to assess the socio-sexual behavior of *Hijras* in Lahore, 2009 found that in the past 12 months 3% had injected drugs and more than 50% of *Hijras* had taken a hard drug like Cocaine, Heroin, Morphine and Amphetamine. [15] The results among TGs in India would be similar given the similar *Hijra* culture in Pakistan and India. There is a need to explore this issue in depth and plan an intervention as TGs/*Hijra* are not identified by law nor recognized by society which often adds to their miseries and pushes them further into desolation.

B) Qualitative interviews

We have presented the results from a total of six FGDs, 15 IDIs, and nine KIIs. The key themes presented in the results are as follows: 1) Knowledge and practices about feminisation and nirvana; 2) Beliefs and complications.

1. Knowledge and Practices about Feminisation

There is an urge among TG/*Hijra* community members to undergo feminisation procedures. Though, in some cases the need to undergo feminisation is their personal desire, in other cases it is the unarticulated code of accepted (gender) norms within their community or the society in general.

“There is always a social pressure. I will say about both of SRS and Castration. Social pressure is quite reduced after surgery” (Participant, KII)

“Yes I have seen changes in their lives. Before undergoing the process they live under fear. They want to be seen as a woman by the society but because of the male organs they are scared about people realizing that she has male organs. They feel bad about this and remain scared. I have seen this. After undergoing the feminization process they seem freer and open about themselves” (Participant, KII)

1.1 Types of feminization and Cost

The most traditional practice to undergo gender reassignment is the traditional castration - *Nirvaani*. This procedure has been practiced and passed on from generations. Some emerging practices that have come into practice are: surgical castration/emasculatation; complete Sex Reassignment Surgery (SRS) procedures; breast augmentation; laser treatment for hair removal; hormone treatments and voice therapy. The levels of knowledge and awareness of these procedures varied across the regions. For instance, it was observed that TGs/*Hijras* in Thane, Kolkatta, and Chennai provided procedural details while some of them in the other regions could only name the procedures and not provide further details. Castration/emasculatation is often chosen above other scientific procedures as it easily available, cheaper, and faster.

The cost for undergoing castration/emasculatation is lesser than the traditional SRS. Further, the cost for traditional *nirvani* by a *dai* is less expensive compared with that from a health care provider. As castration/emasculatation is illegal in India, castration by doctors is carried out in secrecy. Participants reported that the cost of undergoing castration/emasculatation by a doctor would be approximately ₹ 70000 to 80000, whereas, it would cost almost less than half for the traditional *Nirvaani* from *Dai*. There would be additional costs for medicines, travel, and post-procedural care. An additional cost is the cost incurred for '*jalsa*' or celebration after the procedure; the cost for this may be about ₹ 45000 to 100000. Furthermore, it was also reported that if an HIV positive were to undergo any of the procedures, they will be charged more due to the status. Besides the cost for castration/emasculatation procedure, cost will involve laser treatment for hair removal, hormonal therapy, and breast augmentation. There is another procedure employed for breast enlargement - the *katori*. In this, a *vati* or a *katora* is attached the breast and then pulled; the participants reported that electricity is used for this procedure. This, is one technique which needs to be well understood and documented.

"We who are related with Hijra profession for them SRS is very difficult. As it is very time consuming matter, rather than it castration takes less time. As our earning is totally from Hijra profession so time is very valuable to us. Only for this reason we choose the way castration" (Participant, FGD)

As TG/*Hijras* may not be accepted in their families or the society in general, they often lived in their own separate communities. Furthermore, in spite of them being qualified, they are not included in the labour market. Thus, they have limited resources of income generation such as dancing, *badhai*, begging, and sex work to name a few. The income generated from these sources is used for living as well as

the feminisation procedures. They may take loans from money lenders, other community members, or their *Gurus* for the procedure. Furthermore, some reported that their *panthis* or partners may fund for the procedure if the partners wanted them to be like biological women. However, a majority of them said that they do not get any financial support from the family for feminisation procedures.

1.2 Beliefs and complications

Nirvaani is believed to be the 'best practice' for feminisation; it is considered better than undergoing castration/emasculatation in the hospital. *Nirvaani* is believed to give the best results as it is traditional; the belief is that this procedure drains out all the 'male' blood and the blood turns into 'female' blood. The *Hijras* undergoing *Nirvaani* are also asked to rub the blood on his face and body as it is believed to reduce the hair growth. Another belief among the community is that after *Nirvaani* the infected blood in an HIV infected TG/*Hijra* flows out and the person becomes HIV negative again.

"So when they are Akwa (Hijras without castration), those who are HIV positive think that if I will get Nirvaan so my entire infected blood will go and I'll develop fresh blood. Because of which they will think I'll (they will) become negative. But still after this when we take them for testing they don't believe. They think that I have become nirvana so how come I am still positive. They think that my (their) infected blood has gone" (Participant, IDI)

One issue, however, are the complications while performing the *Dai Nirvaani*. These complications include excessive bleeding and sometimes death. However, often *Dai Nirvaani* is combined with post treatment by the health care professional. Though, the nirvana process is done at a remote place, once they return back to the city, any complications are treated by the local doctor. However, often the doctors refuse to handle these concerns. Indeed, it was reported by the participants that it is difficult to find a doctor to even open the sutures post-castration/emasculatation or treat any infection. The common complaint after undergoing castration/emasculatation was blockage of passage of urine. It was further reported that TGs/*Hijras* themselves open the passage using a stick dipped in Dettol.

As feminisation is an important goal for most TG/*Hijra*, they try to fast track the process by consuming excess hormone without consulting doctors; consequently they have the side effects of these hormones. Participants reported that hormones were used either orally or thorough injections for: increase breasts; increase hair growth on the scalp; decrease facial hair growth; and make their voice more

feminine. They mostly consumed pills such Mala-D, Sunday Monday tablets, and blueton pills. These tablets are easily available over the counter and most were used without doctor's prescription. Though, hormone injections were also used, but were administered only by a doctor. Many reported increase in body weight after consuming the hormone tablets and injection.

One important complication of feminisation procedure is 'regret' after the procedure. Some of the participants said that those who have undergone castration/emasculatation may not realise the complete implication until after they have lived with it for some time. They may repent for it later; thus, one has to be sure, well-informed about it and the lifestyle changes associated with it. Though, this was cited as one of the complication by some, others had a completely contradictory view. Indeed, they reported that there is mental peace after the procedure.

"The main benefit is peace of mind and satisfaction. We come out of home to change our sex and become a woman. We want show to the world that we are now women. Peace of mind is the greatest benefit" (Participant, KII)

"Life of kinnar gets spoiled after feminization. I don't give advice to anyone to get feminized." (Participant, IDI)

2. Substance use among TGs/Hijras

Substance use was commonly reported by our participants. The most common substance used was alcohol and cigarettes. The participants highlighted that they face hardships in life and this is one of the primary reasons for substance use. For instance, one of the participants said that they have to beg on the streets. At the end of the day, the money gets divided in the whole group with an adequate share to the *Guru*. In sex work, they may have to face rough elements such as the *goondas* and clients who may physically and/or sexually abuse them. Furthermore, they may be harassed by police on site.

The *Hijra* community faces a lot of hardships, but they always unite in times of crisis and face it like one big family. However, some of them have said that this family does not completely substitute the biological family. They often wish that their biological families would accept them the way they are and allow them to undergo feminization, but most often rejected. This social isolation combined with the pressure to survive and make a living often drives them towards alcohol and drugs. Almost all participants reported alcohol use and also drug use. This was a common finding across India.

"In between I smoke a cigarette I feel good. I drink when I am depressed. Many people take gutka. They take drugs ganja etc. The reason for this is the situation in what we all live, they make this a habit to get relief from their own state of mind. They want to forget the violence and experiences they have had, they want to get some sleep. So they take all this." (Participant, KII)

"When there is any function or party of kinnars, they take beer or alcohol. Some take it for enjoying, some take it to get rid from tension and some have become habitual of it, they don't get sleep without it." (Participant, IDI)

"Our dera forbids use of any intoxicants. However, cheli capat follow certain behaviours. When someone has an argument with their partner, they substitute tobacco in cigarettes with marijuana (charas) and smoke them. They achieve tremendous peace of mind when they drink alcohol." (Participant, KII)

"It is different that, to forget our pain and to reduce depression and if we didn't reach to the place like others then only we try to forget everything by drinking alcohol." (Participant, FGD)

Participants also reported consumption of alcohol before castration. Indeed, one of them referred it to as *prasad* (offering made to god). Some also reported that the *Dai maa* consumes alcohol before castration.

"But castration is not any scientific process so before castration alcohol or drugs are given to the patient so that they can't feel the pain." (Participant, FGD)

"Before castration intoxicating substance like brahma, khelva, alcohol and cigarette they use it. Because of this their sex power increases and they feel easy." (Participant FGD)

Other substances consumed were different forms of tobacco (*tambaku*), *charas*, *ganja*, *hafeem*, cocaine, nitrogen pills, cough syrup, and some unknown tablets. The latter were mostly used for physical strength. Though, the *TG/Hijras* used injections for breast augmentation, they were prescribed by professionals. The participants also reported use of oral contraceptive pills. They were mostly used for developing feminine features and were used even without prescription or proper supervision. Interestingly, participants reported consumption of these substances before some of the feminizing procedures. They usually get the substances from peddlers who sell them, chemist stores, or small shops. One of the participant also reported that they

get the drugs through their *panthis* or *giriya*s.

"Many among us take Ganja, Cocaine" (Participant, IDI)

"When I got Nirvaan and when I went to take laser treatment that time I used to smoke Charas (marijuana) so before I went for laser treatment I smoked Ganja and went." (Participant, FGD)

"I want to say this that when I went for the laser treatment, one of the kinnar sisters informed me that when she had done laser treatment she had consumed Banta Goli, it is an intoxicating pill. After which you don't understand, even if there is pain you don't feel it. So I also took that pill and when I went to take laser treatment I didn't feel anything. I didn't even realise that my hair was burning and that I was feeling any discomfort." (Participant, FGD)

"During 'nirvani' performed by the doctor or Dai we take a pill named as Nitrogen to get relieved from the pain. In common language we call this pill as 'anda'. Its use reduces pain. For intoxication we consume alcohol and take pills. Some people also take injections for intoxication. Some people snack oral drugs for intoxication. All these intoxicants reduce pain." (Participant, IDI)

In addition, there was a belief among the participants that consuming Hashish was beneficial for a person living with HIV. They said that Hashish consumption induced hunger and thus increased food intake resulting into better health among people living with HIV.

"Look, according to my point of view, I believe that if a sister is HIV positive and takes charas, charas is that kind of intoxicant which makes you hungry often. And if you are hungry, you eat more food. The more food you eat, CD4 growth will also increase more. So this kind of intoxication is used like a medicine. When she eats more food, the CD4 growth will be more. So this intoxicant acts on a medicinal level" (Participant, FGD)

Though, the reasons may be varied, there is a lot of substance use among TG/*Hijras*. There not only is consumption of alcohols and hard drugs, but also medical products that are often available over the counter.

3. Needs of the community

We have presented the needs as follows: 1) Monetary, social, and legal needs; 2)

Health related needs; and 3) Research needs.

3.1 Monetary, social, and legal needs

The immediate need for the community was money. Though, it may be difficult to provide money directly, it may important to develop systems so that TG/*Hijras* are a part of the formal economy, The participants communicated they should be identified as the third gender and given legal recognition, or at least bring about a social change where people accept them as they are. They felt that once the stigma from the society is overcome, their parents will also be more willing to accept them. Thus, they will not have the need to move away from their homes and earn an independent living. There may be able to complete their education and get jobs. They also wanted social entitlements such as ration cards and other identity cards.

"If we do get nirvana by the doctors, then why does the government not legalise it?"
(Participant, FGD)

"Nobody gives us a govt job or any other job, so we have to do sex work. We have to beg or do sex work." (Participant, IDI)

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"For the parent's acceptance, the government firstly needs to accept us, society will then accept us and after that naturally parents will take us" (Participant, KII)

"They just give us condoms so that we can suck cocks?"
(Participant, FGD)

"Public health interventions, there are hundreds of public health interventions and they talk only about HIV/AIDS and nothing else. But interventions should be there like (people should on the) NGOs (on the funders) should talk about hormones, should talk about the social part, should talk about the health part, should talk about the legal part at the same

3.2 Health related needs

The participants wanted sensitised team of doctors for feminisation procedures. They highlighted the fact that even though, the procedures are available in many hospitals, the staff may not necessarily be sensitive and they feel discriminated in health care settings. They also wanted specialised hospitals and centres to handle all the SRS procedures. They suggested that this should be considered seriously and they need these facilities in the hospitals. Many of them cited the Tamil Nadu experience where the government has made all the facilities available free of cost.

Interestingly, many of them also suggested that the government should provide money for feminisation procedures.

“They have to give some fund towards our nirvana. We are unable to fully depend on our gurus. If there is such support then we can get nirvana done, get dhawani (breasts) done etc. That’s what we need mainly, govt should support, and monthly ration needs to be done.” (Participant, FGD)

“Look, like how it is, we should make big sensitization programs available along with a doctor. Because there should also be a counselling process with them as it is not at all a reversible process. So according to that we will do counselling. Doctors will be sensitized.” (Participant, FGD)

“Doctor don’t have good knowledge to perform the nirvani procedure. They just do nirvani to earn money. There should be sensitization programs for the so that they can perform good nirvani procedures. These all things should be there keeping legal issues of Hijras into consideration” (Participant, IDI)

“They just give us condoms, so that we can suck cocks?” (Participant, FGD)

Besides sensitization programs for health care providers and arranging for separate hospitals for TG/Hijras and providing services for minimal or free of cost, some participants should provide counselling by developing counselling centres for TG/Hijras who wish to undergo the procedure. They wanted it to be done on the lines of HIV interventions. A few participants suggested that NGOs should be formed which would guide them in feminization process. The NGO would make the TG/Hijra understand the options available for feminisation, the changes, side effects, cost involve, and also suggest sites where the desired procedures could be accessed. Indeed, they wanted to move beyond just being subjects for HIV interventions. They emphasised the need for social and economic interventions.

“As there are NGO’s for HIV/AIDS, in the same way there should be an NGO for feminisation as there are lots of people who wants to do SRS & castration so they think that if we’ll do that then we’ll have to become a chela, we’ll have to go in Hijras. There are some people who don’t wants to come in Hijra but still want to do SRS. So if there will be an NGO, such people will get a lot of support so that they won’t come in Hijras & they can live like a girl & officially work somewhere.” (Fem_IICM2_Thane)

“Public health interventions, there are hundreds of public health interventions and they talk only about HIV/AIDS and nothing else. But interventions should be there like (people should on the) NGO’s (on the funders) should talk about hormones, should talk about the social part, should talk about the health part, should talk about the legal part at the same time.” (Participant, IDI)

3.3 Research needs

Though, most of the participants did not talk about research needs, one important suggestion for further research was to understand the use of medications used for feminization along with antiretroviral therapy in HIV infected individuals. One of the health care provider also suggested to make a G-spot for male-to-female TG by retaining a small part of the penis which can help achieve an orgasm (according to him, he has observed this to be useful). Another important suggestion was the need to develop standardised procedures for counselling, hormonal treatment, surgical procedures, and other related procedures for SRS for the Indian population.

DISCUSSION AND RECOMMENDATIONS

The desk review and the qualitative interviews have provided useful information about the health and other needs for biological feminisation procedures of the TG/*Hijra* community in India.

We found that though there are international guidelines and manuals for feminisation procedures (such as surgery, hormone therapy to name some), no such standard guidelines exist in India. Indeed, although the procedure is being done in the country there is a lack of clarity about the legal status of the procedure. Furthermore, there are no research papers on the short term or long term follow-up of individuals who have undergone this procedure.

Though, apparently the community members have a variety of options of feminisation procedures (traditional as well as surgical), in reality the options are limited by available finances, social beliefs, or peer-pressure. Many of the individuals undergo these procedures in high-risk conditions; this often results in multiple complications including death in some cases. Though, the surgical procedures have been well documented in literature, the traditional *nirvana* and other new procedures (such as *katori*) need to be well understood and documented for care and follow-up of these individuals.

Substance abuse appears to be very common among TG/*Hijra* community members. Substances are used both for recreational and medical purposes; the latter are often purchased over the counter and taken without proper medical supervision. Though, the reasons for use are varied (personal, peer-pressure, partner related, or beliefs about medical properties), the end result is ingestion of products without adequate knowledge of actions or side-effects. Interestingly, there is not much in the Indian literature on issues of substance use among the TG/*Hijra* population.

HIV-infected TG/*Hijras* are particularly more vulnerable. They undergo feminisation procedures due to the belief that they will become negative after the procedure. Furthermore, due to their seropositivity, they are often required to pay more money for the same procedure compared with the HIV negative individual. In addition, they may face discrimination in health care settings because of their infection. These factors make them more vulnerable to complications (physical, social, mental, and emotional) of the feminisation procedures. Furthermore, there is limited literature on the use of hormones and antiretroviral therapy in India among

TG/*Hijras* in India, thus further necessitating public health and clinical research on these issues in the country.

The community members feel that they should just not be treated as subjects for HIV interventions, and the health interventions should move beyond HIV prevention and condom distribution. Feminisation is a reality in the community and they would like to have standardised guidelines for counselling and surgical procedures for the Indian population.

Key recommendations

- Clarification of the legal status of feminisation procedures in India
- Development of standardised guidelines for various surgical and non-surgical procedures for the Indian population
- A thorough documentation of all the traditional procedures in the country
- Public health studies to understand the pattern of substance use among TG/*Hijras* community members
- Developing standardised counselling guidelines for TG/*Hijras* who wish to undergo feminisation procedures and using them through various NGOs to reach the intended population
- Documentation and research on the long term effects of surgical and non-surgical feminisation procedures among HIV-infected individuals. This is necessary to clarify the false beliefs, and allay fear about HIV status and feminisation among HCPs and community members
- Studies to understand the long term effects of surgical and non-surgical feminisation procedures on the health of TG/*Hijra* community members

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