

Original Research Article

## Sexual Network, Sexual Practices and Sexual Health of Hijras and Other Trans-Women Populations in 17 States of India: A Qualitative Study

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### ABSTRACT

**Background:** Hijras and other trans-women (TW) communities face several stressors in their lives, including sexual health issues. The main aim of this study was to explore and describe sexual network, sexual health and different ways of practicing sex among TW in 17 states of India.

**Methodology:** We conducted 50 focus group discussions (FGDs) with TW and 75 in-depth interviews (IDIs) with community key informants. FGDs and IDIs were audio-recorded, transcribed and translated into English. The data were analyzed using a framework approach and major categories and themes related to sexual health and sexual networks were identified.

**Results:** Sexual debut for majority of TW was reported to be between 8 and 15 years and many had it resulting from sexual abuse or exploitation by the close family members, relatives or persons at school. Their sexual network was with both genders (mainly males but sometimes females), different age groups of males, men in different occupations, males at school or at college, partners, family members, relatives, local, national or international clients. Types of their sexual partners varied by their age, looks, liking and money. In many states the TW's main occupation was sex work, in addition to badhai (giving blessings) and dancing. Regular partners played a very important role in their sexual life who would be either their husbands or boyfriends. In case of such partners, condom use was not practiced. In spite of having regular partners many TW were engaged in commercial sex also. The frequency of sexual practice was more than 3 times per day in many cases. There was high level of awareness on condom usage among the TW community. There was a range of condom usage by the TW from not using to "no sex without a condom". The NGOs and CBOs provided periodic STI and HIV testing in number of states, supplied condom and training for livelihood activities and placement. The interventions by CBOs played a major role in promoting safer sexual health practices.

**Conclusions:** Early sexual exposure and not using condom at least with regular partners in almost all states need to be addressed with appropriate prevention and control strategies in this key high risk population in the context of HIV/AIDS and STIs.

**Key words:** Sexual network, sexual health, trans-women, India.

### INTRODUCTION

Hijras and Trans-women (TW) communities face multiple and overlapping stigma and discrimination related to their gender identity, sex work status and HIV status. [1,2] Lack of education, lack of other job opportunities and lack of psychosocial

support from their families [3] force many TW and Hijra people to enter into sex work, either for survival [4] or some times, to pay for sex change operation. [5] Most Hijras and TW are from lower socio-economic status and have low literacy levels that pose barrier to seek health care. Consequently,

Hijras and TW also face some unique barriers in accessing treatment services for STIs. <sup>[4]</sup> Research with trans-women and youth have primarily focused on risks associated with commercial sex partners because of the high prevalence of sex work within this community, estimated to range from 24% to 75%. <sup>[6,7]</sup> Partnership characteristics have been found to be important predictors of unprotected intercourse. <sup>[8,9]</sup> Hijra and TW also face several sexual health issues including STIs and HIV infection. Both personal- and contextual- level factors influence sexual health as well as access to and use of sexual health services. <sup>[4]</sup>

We conducted this study to understand TW's sexual network, sexual practices and sexual health.

## **METHODOLOGY**

This analysis is an off-shoot of a study on mapping and size estimation of Hijras and other TW populations in 17 states of India. Detailed methodology of the original study has been published. <sup>[10]</sup>

We conducted the study in seventeen states of India namely, Andhra Pradesh, Assam, Bihar, Chhattisgarh, Jharkhand, Karnataka, Kerala, Gujarat, Maharashtra, Manipur, Nagaland, Orissa, Punjab, Rajasthan, Tamil Nadu, Uttar Pradesh and West Bengal covering all regions of India. The study states were selected on the basis of urban/semi urban/rural nature, availability of data on the density of Hijra and TW population, availability of HIV prevalence data and presence of NGOs/CBOs working with MSM and/or Hijra and TW community. To collect the qualitative data, we used focus group discussions (FGDs) with TW community representatives, and in-depth interviews (IDIs) with community key informants, primarily their gurus and community leaders, covering details on sexual network, sexual practices and sexual health. Qualitative data was collected through 50 FGDs (50x10; n=500) and 75 IDIs.

Before proceeding with FGDs and IDIs, written informed consent was obtained from the respondents. The IDIs and FGDs were recorded in the local language in addition to digital recording (wherever consent was given for audio recording); and also detailed notes were taken (with verbatim quotes that illustrate the key concepts). The FGDs and IDIs were conducted by experienced moderators/interviewers across all the states that were given specific training on ethical considerations involved in the study along with training in data collection. There was a recorder (note-taker) in each FGD who recorded notes of the entire discussion, including non-verbal communications. Each FGD/IDI took about 60 to 90 minutes.

Themes were identified by looking for similarities, differences and relationships between categories. Major categories and themes related to the sexual network, sexual practices and sexual health of the TW community were identified and inferences were drawn from both FGDs and IDIs.

**Ethics statement:** The study protocol was approved by the Institutional Human Ethics committee of National Institute of Epidemiology, Indian Council of Medical Research, and Chennai, India.

## **Findings**

### **Sexual initiation**

All trans-women across each state reported that their sexual partners were males, whereas very few reported to have females also as their sexual partners. Majority of the trans-women mentioned during the discussion that they started having sex from the age of 8-15 years. For many, the first encounter happened with their close relatives and family members and mostly it was forced sex.

There was lot of variation as far as age of the sexual partner was concerned. Their age ranged from 10 years to 50 years. Though most of them expressed that they prefer to engage in sexual activity with young people aged between 20 and 30 years, when it comes to economic benefits, they compromise with their choice.

*“First time it happens with relative because they know you very well. ....There are... many houses where real brothers had done this first time. They understood that we had feelings of girls and get attracted towards males and that’s why they had sex with us” (Bihar).*

*“.....my first sexual experience was at 13 years. Most of us have our first sexual experience at 10-15 years (Andhra Pradesh)*

*“.....so, I had first sexual enjoyment at the age of 10 - 12 years. I was around 12 years old at that time.” (Assam)*

*“...My cousin brother used to have sex with me. I didn’t know that time what is sex.....He told me not to tell my family members..... So I didn’t tell. At that young age we didn’t know anything..... Actually we didn’t get to know each other. Because of that age (less than 10 years) for thrill we started and it was a great fun in mind.....” (Andhra Pradesh).*

In Bihar, the TW mentioned in the FGD that initially it was not necessary that they need to disclose their sexual orientation and identity to family members and relatives, but adult family members and relatives discovered it anyway and had sexual relationship with them.

Like other states, in Chhattisgarh also TW mentioned that their involvement in sexual practices started at an earlier age, generally less than 10 years. In majority of the cases they shared that their first sexual experience had been with people whom they come in contact on daily basis such as their brothers, cousins, school teachers, neighbors, close relatives and uncles. Mostly the first sexual experience was reported in the form of sexual abuse and exploitation by the close family members and relatives.

In Gujarat, majority of the TW mentioned that they were involved in commercial sexual practices. Few of them expressed that they had been raped by groups of males when they were 17 or 18 years old. The TW community in Gujarat felt that sexual practices were unsafe

because the partners were not for using condoms.

Most of the TW who belonged to Gharana system of Jharkhand State mentioned that sex work was their primary source of income and a few informed that ‘Badhai’ (giving blessings) was their major source of income. Majority of them clarified that during the initial days it was for enjoyment; however relatives like uncles and cousins had forced them to have sex.

*“Some had sex by wish and some had forcefully. I did according to my wish. In case of some of them, their uncles forcefully had sex with them at the age of 13-14. I was 10 years old when I had sex” (Jharkhand).*

In west Bengal, TW reported first sexual experience at the age of 15 years and their first sexual partners were people living in close proximity with them such as school teachers, friends of their brothers and fathers.

In many states selection of partners for sex was reported to be dependent on their looks, age, nature and amount of love and affection they showed for TW, which differed in different cases. Majority of TW mentioned that their first sexual experience was in school and they had different partners. Few of them reported of their school teachers who did not pay them any money but did favours in some other forms such as promotion to next class, promoting participation in competition, etc. They had both new and old customers.

*“We generally have new customers and also we would have both new and old”. (Karnataka)*

*“There are people (TW) who have husbands; there are people with whom they regularly have sex (boy-friends or [male] keeps) and there are lovers (whom they think of marrying later); nowadays, most of them have lovers and I prefer lovers...” (Kerala)*

Male partners were, by and large from lower socio-economic background who were drivers (car, auto, truck or cycle rickshaw), waiters in hotels or restaurants,

daily wage earners, coolies etc. However, some of them mentioned that people from upper and middle class strata also visited them for sex. They commented that people in executive jobs like engineers, police officers, political and influential people and their sons were also part of their clients. Some of the TW indicated that they had customers from Canada, Dubai, Malaysia and Bangkok.

*“..The partners are general public, taxi drivers, rickshaw drivers, truck drivers and so on. There are lot of truck drivers...they are all non-community...there are men who visit many women..but still they come to us for sex.... (Maharashtra)*

In Manipur and Nagaland, though majority TW was living with their biological families and going for work from there, they had regular partners who were their husbands or boyfriends. They engaged in sexual practices with their regular male partners on a regular basis.

### Sexual network

Usually TW’s sexual partners would be males, sometimes females. They reported various male partners like casual partners (e.g. clients of various categories), regular partners (husband, boy friend, male-keep); family members/relatives; school/college teachers, school/college mates, class mates, friends, friends of family members.

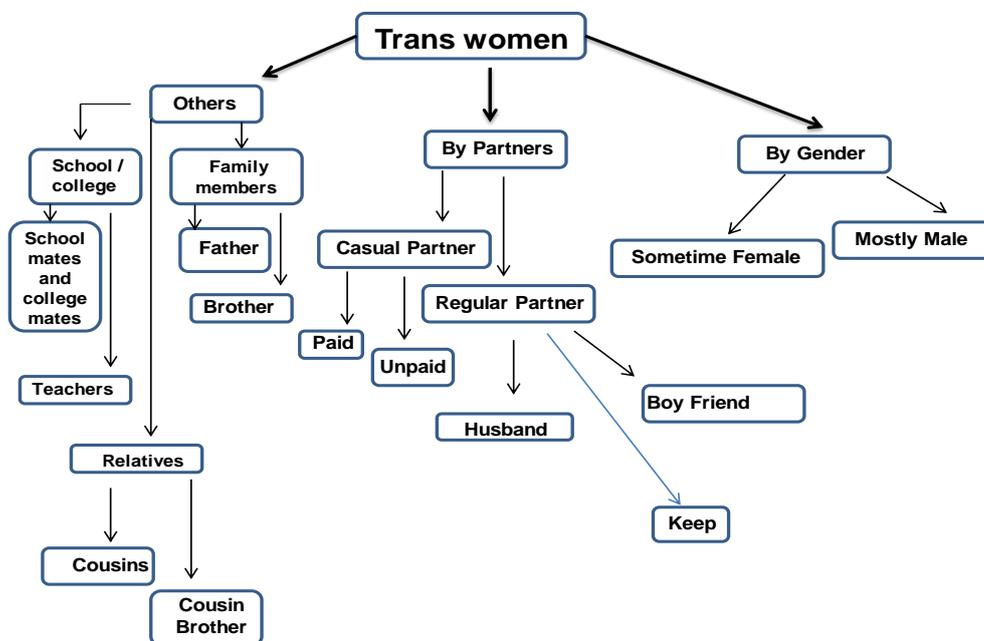


Figure1.Sexualnetwork

### Sexual practices

The frequency of sexual practices was reported to be more than 3 times a day in majority of the cases, in Karnataka.

*“Will have sex every day. That’s our main earning and also..... if we don’t do sex for even a single day, we will be craving for sex. I have sex for money and also for my own pleasure..... every day; and for money....twice, thrice or more times a day.” (Karnataka)*

In states like Maharashtra, sex work was the main occupation of the community.

Though the TW community members had their regular partners living with them as husbands or boyfriends, they also went for commercial sex for money. They would even have more than 3 clients a day.

In Odisha, about half the TW were engaged in commercial sexual practice as that was the main source of income for many. Community felt that they had very limited options for other means of income generation and involvement in commercial sexual practices which started at a very young age.

Though a number TW were engaged in commercial sexual practices, badhai and dancing were also their major occupations as they were the primary source of income in Punjab. Majority of them mentioned that they engage in sexual activities with their regular partners on daily basis but do not engage in commercial sex, which needed to be outside their households. Those who were engaged in commercial sexual practices mainly came from the non-Gharana background because they did not have any additional economic support.

In Rajasthan, most of the TW were engaged in sex work, badhai and performing dance programs. Majority, informed that they had their sexual practice with their regular partners and few mentioned that they would have sex with either regular or casual partners, that would have been paid or unpaid. Many informed that they had their first sex at 10 -12 years of age with relatives, neighbors or school friends.

*"...I started sex at the age of 12 .....He was my relative...aged 23 years.. Was a male...he used to admire me and whenever I used to go near him he would enjoy.....with me (Rajasthan)*

In Tamil Nadu, though a considerable amount of TW had their regular partners who lived with them as their husband, they also engaged in sexual practices on commercial basis as they did not get proper financial support from them to meet their livelihood. In addition they were involved in sexual activities with multiple partners at one time. They use the social networking sites and dating sites for accessing the partners for sex. Frequency of sexual activities was very high and majority of them informed that they had more than 3 clients per day for meeting their financial need. They would access their clients mostly by cell phone or sometimes through face book.

*"...they invite them to the home over cell phone..... Some would be regular customer to TW..... We access face book also and receive messages too..." (Tamil Nadu)*

In Uttar Pradesh, majority of the community members engage in commercial sexual practices in the state due to fair prevalence of Gharana system and culture in addition to be engaged with regular partners. Though the proportion of TW was by and large equally distributed among them (involved in badhai, dancing or doing sex work), Gharana system had a strong control in the state, not allowing them to go out of the identified geographical boundaries to engage in any of the livelihood activities. This restriction to operate within a certain geographical area left them with less scope of earning an amount which could adequately support their financial needs. So they engaged in some income generation activities during day time as well as night.

In Manipur and Nagaland, the TW community earns livelihood by working in beauty parlors and other small scale income generation activities in addition to engagement in sexual practices. Sex work was reported as one of the major sources of earning among TW of Nagaland. Though majority of TW were living with their biological families and working from there, they had their regular partners who were either their husbands or boyfriends.

### **Sexual health**

There was a high level of awareness among the TW community in Andhra Pradesh on the advantages of condom usage during sex. They all mentioned that condoms provide safety from acquisition of HIV/AIDS, STIs and RTIs.

*"...We use condoms for safety and security. It also gives pleasure while doing sex and prevents STIs. It is a must to use condom because I may not have diseases like HIV but the other person may have them, what is the guarantee that he does not have HIV; so, it is a must to use condom". (Andhra Pradesh).*

Some of the TW (Kerala) mentioned that they use protective measures even with their regular partners. With the help of voluntary organizations they were undergoing regular testing and check-ups for HIV.

*“The counsellors.....if we are going to have sex.....will recommends doing it safely..... (Kerala)*

*“.....I go every 6 months once to Pulari kendra. I go for HIV and syphilis tests...Once*

*I got syphilis, I got the treatment there.”(Kerala)*

They expressed that since they were involved in sexual activities with multiple partners, it is imperative to use condoms for their safety and for their partners' safety.

The TW community felt that the usage of condoms was less among the community members as compared to their awareness. The possible reason for the gap between the level of awareness and condom usage was the non-acceptance and unwillingness of the sexual partners to use condoms.

In Assam, though the awareness of HIV/AIDS and safe sexual health practices among TW were high, the reported usage of condoms was less because there was resistance in their usage. Additional reasons for sub-optimal use of condoms included lack of availability and accessibility.

*“Sometimes I use and sometimes I do not, when it is not available. In my group too, some use and some do not use.. .....it should be used as it is good for health in preventing diseases.”(Assam).*

In Bihar, TW reported in the group discussion that both awareness of condoms and their usage among the TW was very low. They also felt that considerable number of TW was suffering from HIV/AIDS. In Chhattisgarh and Karnataka, sex work was the main source of income for many of TW even though they lived with male partners and had economic security. They also commented that level of awareness among their community members about the safe sexual health practices was high. They shared that they would not have sex with their partners if they were not willing to use condoms.

*“I take money from everyone. I always use condom and the person who does not agree to use condom..... I don't*

*have sex with him. I always have sex for money and those who do not give money I don't have sex with them. I would have to take money for my livelihood and..... this is my compulsion.” (Chhattisgarh).*

In Gujarat, some of TW did not use condoms because they generally had sex only with their regular partners who lived with them as husbands or boyfriends. In few cases, their regular partners would not like to use condoms. Generally they had good awareness on condom usage and their benefits. They regularly went for check-ups and had access to health services.

*“We keep condoms ready with us for our clients. Condoms would protect us from HIV and STIs; but with our regular friends we will not use (condoms)” (Gujarat)*

Awareness about HIV/AIDS and other STIs was reported to be high in Jharkhand, Karnataka and Maharashtra. Most of the TW in Jharkhand and Maharashtra attributed this to emphasis on consistent condom usage and regular check-ups by Voluntary organizations.

A considerable number of TW stayed with their regular long term partners. They operated from cruising points, hammams, hotels, public toilets and railway stations. In Karnataka, the frequency of sex work was more than 3 times a day in majority of the cases.

*“.....if we do well and provide good pleasure then they will come to us only. We usually have one time sex with one partner. We have sex for money.” (Karnataka)*

The condoms were reportedly provided to TW by voluntary organizations. The TW community acknowledged contribution of the civil society organizations in promoting the safe sexual health practices. Regular checkup and safety were considered important by TW and they accessed the government health facilities for any health problems.

In Manipur and Nagaland the TW accessed the services of government and private organizations for getting regular checkups and testing. They also submitted

that awareness programs were conducted by the voluntary organizations on a regular basis.

Most of the TW from Punjab reported that they were aware of condom usage and its advantages and, were using condoms. Safe sex practices were promoted by the voluntary organizations which conducted regular awareness activities with testing and counseling for HIV/AIDS and other sexually transmitted diseases.

In Rajasthan, majority of TW were aware of condoms and their usefulness. The TW community communicated interventions and awareness program by the voluntary organizations, had created awareness in them. Most of them accessed government health facilities for HIV testing on regular basis and used condoms mostly provided by the voluntary organizations.

The usage of modern technology and networking sites such as Face book was very much prevalent and common in Tamil Nadu.

*“.....they invite the customers to home over cell phone; some would be regular also. We access face book and receive messages there also.” (Tamil Nadu)*

There is a high level of awareness as well as usage of condoms and other protection measures in Tamil Nadu state. The community had expressed that after the interventions and efforts by the Government and voluntary organizations, people in the community were well aware about the usage of condoms and protection measures. Majority of them accessed the services provided by the government health system for HIV testing, counseling and procuring condoms. In addition the voluntary organizations were providing those condoms and other facilities.

In Uttar Pradesh, there were fewer interventions compared to other states of northern part of the country and the usage of protection and access to the safe sexual health practices was also less than desirable. A huge gap between the level of awareness and usage of safe sexual health practices. Possible reasons identified by the

community members were, lack of condom use by regular partners of TW, refusal to use condoms by customers for perceived loss of pleasure and TW themselves being not convinced about the benefit of condom use.

They were not aware that their regular partners might also be having sex with someone else. Majority of TW mentioned that they did not go for regular testing at the hospitals because of discrimination and lack of privacy. They pointed out that other high risk group (HRG) community members like FSWs, IDUs, etc. were given preference over them in the health facilities. The TW community felt that there should be more interventions for health and safe sexual health practices in the state, and the interventions should be community specific.

In Bihar, some TW commented that they did not want to go to health facilities as they were concerned about judgmental comments and prejudices.

Although there is a higher level of awareness on HIV and safe sex practices among the TW in West Bengal, they reported that there was a wide gap between the level of awareness among the community members and actual usage of the safe sex practices because of failure of negotiation with the clients and acceptance by TW due to financial needs. The higher level of awareness was associated with the interventions of voluntary organizations and CBOs for promoting safe sexual health practices.

## **DISCUSSION**

The present study describes the sexual network and sexual health of Hijras and other TW in the 17 states of the country. In the current study, in Gujarat, majority of the TW mentioned that they were involved in commercial sexual practices. Few of them mentioned that they had been raped when they were 17 or 18 years old. They felt that sexual practices were unsafe because the partners were not willing to use condoms. A study by Nemoto et al. found that risk for HIV was highest for TW who

were engaged in sex work, possibly due to the higher volume of sexual partnerships by choice or by sexual assault that increased chances for exposure to HIV. [11]

Trans-women are often ostracised by their families or run away from home and, having dropped out of school and with no family support, usually survive by begging or sex work. "We face rejection from an early age," "Our siblings, friends and families reject us. There is no acceptance anywhere. Medical professionals are also part of this very society and we dwell on begging or sex work." [12] In the present study, most of the TW of different states were reported to be engaged in sex work, badhai and performing dance programs.

Majority of TW in the current study had their sexual debut between 8 and 15 years and many had it resulting from sexual abuse or exploitation by the close family members, relatives or persons at school. Abuse may begin in adolescence or childhood, when transgender individuals begin to express atypical gender characteristics. [13,14] In IBBA [15] the average age at which they entered into sex work was 16.5 years, which means many entered into transactional sex even before the legal age for consensual sex, which also highlights the need to reach hijra/TG legal minors through HIV and social protection programmes.

In the present study the TW community felt that the usage of condoms was less as compared to the level of awareness among the community due to unwillingness of the sexual partners to use condoms. In a study among [16] HIV positive hijras (Chennai and Mumbai), the prevalence of inconsistent condom use during receptive anal sex was 34% for male regular partners and 41% for male casual partners. Even though two-fifths of hijra participants in that study reported having disclosed their HIV status to their male regular partner, disclosure was not uniformly followed by practice of safe sex, and non-disclosure did not always lead to unprotected sex.

### **Limitations**

The findings from this study cannot be generalized to all the states of India. Even in the study states, the IDI or the FGD were done only with certain members and groups. Although findings are likely to be prototypic, they cannot be generalized to the respective states or the entire country.

### **CONCLUSIONS**

- In most of the states TW had their sexual debut at very young age, i.e. between 8 and 15 years, either as sexual abuse or as sexual exploitation
- In many states, the TW had their sexual network within their relations, sexual partners, known and unknown clients.
- Sexual practice was mentioned as more than three times a day by many of the TW community in most of the states
- In many states, the TW community was aware of condoms and their (condoms) providing safety from acquiring HIV/AIDS, STIs and RTIs.
- The NGOs and CBOs of majority of the states were providing education of condom and its usage. Sensitization on condom awareness was created by them. In addition, they were doing STIs and HIV testing and required counseling.
- Almost in all the states, TW reported of not using condoms with their regular partners
- In majority of the states the NGOs/CBOs were involved in safer sexual health activities

Early sexual exposure and not using condom at least with regular partners in almost all states need to be addressed with appropriate prevention and control strategies in hijras and other TW communities in the context of HIV/AIDS and STIs.

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