Hijras in sex work face discrimination in the Indian health-care system

Venkatesan Chakrapani, Priya Babu, Timothy Ebenezer

The Hijras in India are born as biological males who reject their 'masculine' identity in due course to become identified either as women, or not-men, or in-between men and women, or neither men nor women. In current terminology, they could be considered to be male-to-female transgenders/transsexuals. In India, Hijras have existed as communities for centuries. They are given different names in different languages. In the Tamil language which is spoken in South India they are called *Aravanis* or *Alis*.[1] Though they are 'tolerated' by Indian society they are not 'accepted' and are discriminated against in various settings. In this article the authors discuss the discrimination faced by Aravanis involved in sex work by the public health system in the state of Tamil Nadu, India.

Those males who identify themselves closely with women often leave their birth families at a very young age and join the Hijra communities. They are doubly stigmatised and looked down upon by society. First, because of their transgender status – their cross-dressing or feminine appearance – which is often ridiculed. Second, because of their presumed occupation (sex work). It is true that lack of education, lack of other job opportunities and lack of economic/emotional support from their families compel many Hijras to enter into sex work for survival, or sometimes, to pay for sex change operations.
Because of this, the Indian public considers all Hijras as sex workers even though not all of them are. As a result of this misconception, Hijras have to face discrimination, and physical and sexual violence. Since the arrival of HIV/AIDS in India, they have also been blamed for spreading the disease. Being known to be HIV positive further increases the discrimination faced by Hijra communities; HIV-positive Hijras then have to face a triple stigma.

Facing discrimination

Hijras face discrimination in various ways in the Indian health-care system. Discrimination could be due to their transgender status, presumed/real occupation (sex work) or HIV status. In most instances, it may not be possible to point out the reason for discrimination. Much of the following discussion is based on the focus group discussions and in-depth interviews done by the authors and also documentation of experiences shared by Aravanis in South India.
Many Aravanis have a low socio-economic status and if they fall ill they attend public hospitals since free medical care is available there. Discrimination starts there right from the beginning: at the registration desk in the outpatient department. The staff at the reception counter enquire about the complaints of patients and refer them to the appropriate specialty outpatient department after registering their details for the hospital records. Most Aravanis are dressed as women. They can choose to have their male sexual organs left intact, or to have them completely removed in an emasculation operation, which is called castration.
If Aravani sex workers have a non-urogenital complaint and if they look like 'real women', they may be registered as females and sent to see physicians in the medical department. However, if they have come for urogenital complaints, even cross-dressed Aravanis are often registered as males and referred to the STI department. This happens regardless of whether they have been castrated or not. The reasons often cited by the STI physicians are that Aravanis are 'basically males' and women physicians might be too embarrassed to examine non-castrated Aravanis. Many Aravanis find this unacceptable since they want to be registered as females. However, some just accept this practice and convince themselves that at least they are being given some kind of medical care in the government hospitals.

Photo: Sadashivan

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Medical staff's attitudes

Many Aravanis have mentioned that the physicians do not know anything about them and do not treat them like other patients. They are often addressed in a disrespectful manner and staff frequently use male pronouns which they find very offensive. Non-castrated Aravanis often do not want to show their male genitalia even in an STI clinical examination. Similarly, many Aravanis might be reluctant to show their ano-rectal area. In both cases, they might have to endure abusive language from the examining physician or assisting paramedical staff. One Aravani sex worker told us that she was told: *"If you can widely open your 'back' during sex, why you pretend to be a shy person?"*
Another problem is that doctors sometimes force Aravanis to show their anal and genital STI lesions to medical students so they can learn about certain STIs. This happens without consent.
Aravani sex workers also face discrimination and derogatory remarks from the nursing

Aravani sex workers in Tamil Nadu

In Tamil Nadu, most Aravanis wear women's clothes, and they may or may not have undergone sex change surgery. They have a low social status in society and usually end up in low-paid jobs, such as domestic work, selling vegetables or flowers, prostitution etc.

A research study conducted by Chakrapani et al in 1999 among Aravani sex workers in Chennai, the capital of Tamil Nadu, revealed the following:

Living situation – *Many Aravanis enter into sex work at a very young age. They had run away from their biological family, joined other Aravanis and, as they had no financial support, they resorted to part-time or full-time sex work. Those who are more feminine and younger usually earn more money through sex work than middle-aged Aravanis, who have difficulties in attracting clients. Some Aravanis stay single, others live with their male partners, but most live in groups together with other Aravanis or their 'mother'. A 'mother' is a senior Aravani who has adopted another Aravani as 'daughter' through a ritual called* madi-kattuthal. *If they have boyfriends, called* Panthi *(meaning 'real man') their relationships may be unstable, as many Panthis will be married or will get married in the near future. Very few Aravanis manage to live as a couple, as most Panthis will not be able to resist societal pressure to marry a woman.*

Work situation – *Aravani sex workers usually pick up their clients near wooded areas, and sex takes place on the spot. Unlike in Calcutta and Mumbai, brothels employing Aravanis are very rare in Chennai. Most of their clients have a low socio-economic status and consequently, earnings of sex workers are relatively low.*

Sexual behaviour – *Because sex change operations in India are not available in the government hospitals and do not include vagina construction, sex between Aravanis and their male partners includes 'thigh sex', oral sex, masturbation and anal sex. Condoms are mainly used for anal sex and rarely for oral sex. Condoms also seem to be less used with regular clients or Panthis. Some Aravanis reported having unprotected anal sex with their clients if they were offered more money. Others acknowledged that they did not use condoms if their client looked clean or if they liked the person. Water-based lubricants were almost never used, increasing the risk of STI infection through anal sex. The sex workers either did not know about lubricants or said these were not affordable. HIV and STI prevalence among Aravani sex workers in Tamil Nadu is not known, as no specific studies have been conducted among them. However, it is clear that they are especially vulnerable to HIV and STI infection.*

Violence – *The level of violence towards Aravani sex workers is high. Most often this concerns violence by the police or local gangsters; however, clients may also force sex workers to have unprotected sex and might beat them after the sex act. A few incidents of gang rape and domestic violence have been reported.*

The interviewed Aravanis stressed that they have a need for assistance with regards to their planned emasculation surgery and complications following that procedure. They also expressed the need for non-judgemental sexual health services, information about hormonal therapy and sex change operations, and assistance from the government and NGOs in finding other jobs.

Source: V. Chakrapani, T. Ebenezer, S.D. Fernandes & M. Johnson. High-risk sexual practices among hijras in commercial sex work in Chennai, Tamil Nadu: Implications in prevention and control of HIV. II international conference on AIDS, AIDS India 2000, Chennai, December 1999.

staff. One said: *"That nurse was preparing to give me two shots of penicillin injection on my 'back' and I was very afraid of the pain and asked her to inject smoothly. She immediately replied that since I have experienced pleasure through my back now I have to experience pain from the injections in the back. This was in front of other patients and I felt very bad about myself at that time."*

Aravanis are admitted to the male ward of the STI inpatient department irrespective of their castration status or cross-dressing. Many of them are forced to wear male or ambiguous dress when they are in the male ward. They are also mocked and verbally abused by their co-patients in the ward. Some patients even sexually harass them and usually other patients and ward staff do not defend them in such situations.

Hijras often leave their birth families at a very young age and join the Hijra communities

Emasculation

As sex change surgery is not provided in government hospitals and the majority of Aravanis cannot afford to pay the fees of private plastic surgeons, they resort to unqualified medical practitioners for this operation. Some are operated on by older Hijras (called *Thai Amma* in Tamil Nadu), which is in fact an old custom. Rarely, some Aravanis even resort to doing the castration themselves. Consequently, due to bad surgical procedures adopted by unqualified persons, many Hijras develop post-operative complications, especially urological problems.

These complications would have been avoided if free or affordable sex reassignment surgery had been offered in the government hospitals. Those Aravanis who approach urologists for treatment of these complications often have bad experiences. They might not receive proper and prompt treatment even for post-operative (post-emasculation) wound infections. There may also be an unusual delay in getting a second opinion from plastic or general surgeons. Often the urologists will try to get rid of 'that case' by saying that plastic and general surgery colleagues should take over the patient.

Living with HIV/AIDS

HIV-positive Aravanis face severe discrimination. One HIV-positive person, aged 35 years, had a block in the urinary tract following self-emasculation. Through a hole made in the lower part of the abdomen and using a special catheter, urine was drained in a government hospital in Chennai. Even though she was eligible for reconstruction of the urethra, the urologists said that she could not undergo that procedure because of her HIV status. She was thus forced to remain with the catheter for almost three years, changing the catheter

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by herself periodically. After pressure from community organisations and after providing protective materials (through an NGO), the urologists finally agreed to do the reconstruction.
Thus, we have seen that Aravanis in sex work face discrimination in the Indian health-care system in various ways: from general physicians and nurses, from co-patients and from medical specialists.

Recommendations
Anti-discrimination laws to prevent discrimination against Hijras and other marginalised groups need to be seriously considered. Currently, the Indian legal system is silent on the issue of sex change operations. But emasculation is considered a criminal offence – whether done by oneself or another person and irrespective of consent having been given. The legal status of sex change surgery should be clarified and this surgery should be offered in government hospitals so that Hijras would not need to go to unqualified medical practitioners for having their sexual organs removed. This can prevent complications resulting from bad surgical procedures by quacks.

Furthermore, HIV status of Aravani sex workers (or any person) alone should not prevent the health-care providers from providing necessary medical or surgical treatment. Finally, it is crucial to provide training on transgender/transsexual health issues to the health-care providers so the quality of medical care given to the Aravani community can be improved.

Notes
1. Since the Tamil term Ali is considered derogatory, the term Aravani was coined by Ali activists to refer to them. However, most Aravanis identify themselves as Kothi. The Kothi identity is shared by both Aravanis and feminine homosexual males in India.
2. V. Chakrapani, T. Ebinezer, A. Fernandes, Dhanam B. Access to and use of health care services for Ali/Hijra/Aravani (male-to-female transgender/transsexual) community in Chennai, South India. Poster number: ThPeE7849, XIV International AIDS Conference 2002, Barcelona, Spain, July 2002.

About the authors
Venkatesan Chakrapani is a physician specialised in STIs and an HIV behavioural researcher. He initiated an STI clinic for men who have sex with men and transgendered persons within a community organisation called Social Welfare Association for Men (SWAM), in Chennai, India. Priya Babu is an Aravani activist who has been involved in advocating for the rights of the Aravani community in Tamil Nadu. She has been open about her transgender status and, by appearing in popular media, has gained public support for the issues pertaining to Aravanis. Timothy Ebenezer is a social work graduate who advocates for the rights of men who have sex with men and Aravanis. He currently serves as the advocacy officer in SWAM.

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PROJECT EXPERIENCES

Argentinean sex workers taking care from themselves:

The experience of AMMAR

Gabriela Irrazabal

"We are tired to go to the doctor's and see how they put two pairs of gloves to check us up." This is the way a poor female sex worker describes her regular visits to the gynaecologist's in a public hospital in Argentina. Discrimination and unethical behaviour of health-care personnel towards sex workers in this Latin American country is very common. The Argentinean sex workers union AMMAR has fought this type of behaviour by identifying and contacting 'friendly hospitals' in the framework of a comprehensive health promotion strategy.

Receiving public medical assistance in this Latin American country is not an easy task. If you want to make an appointment with a doctor you have to get up in the early hours. The procedure is very simple: you arrive at the hospital at dawn, stand in the long queue and wait, if you are lucky, for three hours. Then, you will receive a 'number' so that the receptionist can call you and make an appointment for you for the next month.
On the one hand, this chaotic situation can be explained by the fact that the public health sector is not getting enough money from the national budget, and, on the other hand, by increasing unemployment rates. Nowadays, at least 16% of the Argentinean population is unemployed. That is why many people have recently started using the public health system instead of the private sector. So, as a result of the high unemployment, hospitals are flooded with patients and do not have much input or materials available to provide good-quality health services.
The situation might be worse if you are a sex worker. Not only because of the mechanism described above, but also because of the alleged likelihood of spreading diseases, which leads many doctors and nurses to treat sex workers differently than other patients.

Unionising against unethical behaviour
The Argentinean sex workers union AMMAR (*Asociación de Mujeres Meretrices de la República Argentina:* Argentinean Female Sex Workers Association) was founded ten years ago when some sex workers from Buenos