Report of the Regional Transgender / Hijra Consultation in Eastern India

Waylink Guest House, Kolkata
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Organised by:
Solidarity and Action Against The HIV Infection in India (SAATHII)

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Contents

1) List of Participants

No.	Name	Organization	Day 1	Day 2
1.	Amit Kumar Dey	Dum Dum Swikriti Society, Kolkata	√	√
2.	Pinky Banerjee	Bandhan, Kolkata	√	√
3.	Uttam Mondal	People Like Us (PLUS), Kolkata	√	√
4.	Subharthi Mukherjee	Individual, Kolkata	√	√
5.	Satya Sundar Mishra	Sakha, Bhubaneswar (Orissa)	√	√
6.	Tista Das	Phoenix, Kolkata	√	√
7.	Bini Roy	Anandam, Kolkata	√	√
8.	Sanjay Ram	Koshish, Kolkata	√	√
9.	Pallab Toy	Impulse, Shillong (Meghalaya)	√	√
10.	Sonu Arjun	Manbha Foundation, Shillong (Meghalaya)	√	√
11.	Prity Sengupta	Pratyay Gender Trust, Kolkata	√	√
12.	Sudeb Sadhu	Prantik, Bongaon	√	√
13.	Ananta Jana	Santi Seva, Bhadrak (Orissa)	√	√
14.	Sanjay Mondal	Astitva Dakshin, Baruipur	√	√
15.	Sudip Chakraborty	Individual, Kolkata	√	√
16.	Ashok Biswal	Maa Manikeswari Group, Titilagarh (Orissa)	√	√
17.	Jagadish Darga	Laxminarayan Group, Balangir (Orissa)	√	√
18.	Dambarudhar Sunani	Bhawani's, Kalahandi (Orissa)	√	√
19.	Rathin Saha	Northan Black Rose, Siliguri	√	√
20.	Mithu Saha	Swapnil, Burdwan	√	√
21.	Annapurna Kinnar	Individual, Bhubaneswar (Orissa)	√	√
22.	Bipul Chakraborty	Individual, Kolkata	√	√
23.	Mery Hijra	Individual, Chandannagar	√	√
24.	Chinglen	Rural Multi Media for Public and Promotion, Guwahati (Assam)	√	√
26.	Pemba Bhutia	Miitjyu, Darjeeling	√	√
27.	Maksud Alam	Sangram, Beherampore	√	√
28.	Soniya	Kolkata Rista, Kolkata	√	-
29.	Santosh Giri	Individual, Kolkata	√	√
30.	Souvik Kumar Ghosh	SAATHII / Organizer	√	√
31.	Priyanka	Individual, Kolkata	√	-
32.	Debojit Bose	Jalpaiguri Uttarapan, Jalpaiguri	√	√
33.	Rina S. K.	Individual, Madhyamgram	√	-

No.	Name	Organization	Day 1	Day 2
34.	Shangita Biswas	Individual, Madhyamgram	√	-
35.	Dr. Smarajit Jana	Durbar Mahila Samanwaya Committee, Kolkata	√	-
36.	Arunabha Hazra	SAATHII (Volunteer)	√	-
37.	Nisha Roy	Individual, Kolkata	-	√
38.	Pawan Dhall	SAATHII / Resource Person	√	-
39.	Agniva Lahiri	PLUS / Convening Committee Member	√	√
40.	Anindya Hajra	Praytay Gender Trust / Convening Committee Member	√	√
41.	Amitava Sarkar	SAATHII / Convening Committee Member	√	√
42.	Ranjit Sinha	Bandhan / Convening Committee Member	√	√

2) Proceedings (Day 1)

1) Registration: Ranjit Sinha helped the participants in the registration process

2) Explanation of the rationale of the consultation: Souvik Ghosh started with a formal thanks giving and welcomed all the participants. Then he introduced the Convening Committee to all the participants. This was followed by Ranijit Sinha explaining the rationale for organizing this consultation. He started with a sharing of the Delhi UNDP consultation on males who have sex with males (MSM) and male-to-female transgender (TG) issues in 2008, and the GFATM meeting in Mumbai in March 2009 to plan India's Round 9 proposal on MSM and TG issues. Amitava Sarkar gave the reasons why this consultation was important for all TG / Hijra people in Eastern India. S/he explained that apart from South India, there was no or little information about these communities in other parts of India. S/he gave emphasis on the needs of these communities that go beyond narrow HIV and sexual health concerns. Agniva Lahiri explained that definitions on concepts around TG issues needed to be set out, and work happening in Tamil Nadu needed to be replicated in other parts of the country. S/he requested all the participants to utilize the space for a fruitful result. This was followed by the sharing of the consultation schedule with all the participants. Agniva Lahiri also informed the participants about the key agenda for organizing this regional consultation.

3) One line about the participants: All participants were requested to introduce themselves in a line. A wide range of gender / sexual identities and professions were mentioned by the participants. Some of them identified themselves as Hijra, some identified as TG and some also identified themselves with local identities like Rango or Maichiya in Orissa. There were participants who were working for TG / Hijra community organizations. There were also Hijra participants who were engaged in Badhai (giving blessing at social ceremonies, child birth in return for money) or Challa (asking for money in trains and other public places) work.

4) Setting of ground rules: Anindya Hajra requested all the participants to set the necessary ground rules. The following were the rules set:

- To maintain discipline, no clapping and no personal attacks
- No threats to anyone and to be patient
- Asking respectfully for meaning of new terms if needed
- Speaking one at a time
- Keeping mobile phones on silent / vibrant mode maintaining punctuality
- Taking responsibility for one's belongings
- Raising one's hand to speak

5) Session on National AIDS Control Programme – Phase III (NACP III): Dr. Smarajit Jana, formerly associated with National AIDS Control Organisation (NACO), and currently engaged with Durbar Mahila Samanwaya Committee attended the consultation and gave inputs on NACP III and what its implications were for the TG / Hijra populations of India. He started by mentioning that the UNDP consultation in Delhi in October 2008 was fruitful, but mainly with regard to MSM issues. TG / Hijra issues were also discussed, but perhaps not adequately. He said the current consultation was a good opportunity to discuss TG and Hijra issues in detail.

According to Dr. Jana, the key objective of NACO was to prevent the spread of HIV. From NACO's point of view, targeted intervention programmes focused on groups practising high-risk sexual and other behaviours were the most important aspect. Hence they had put MSM, TG and other similar identities into a single high-risk category (as each of these had similar sexual practices). But in reality, everyone had a unique and individual identity. These unique identities were related to a social position or situation for each individual and each group of people. For MSM, TG and male / TG sex workers stigma and discrimination on grounds of gender, sexuality and faith was part of their social situation, which increased their vulnerability to HIV. This fact had now been acknowledged by NACO, and they were keen to see how social inequities made each of these groups "differently vulnerable" to HIV. NACO also wanted to explore how these groups could be provided support in the form of safe spaces to fight the HIV epidemic. But a clear articulation of the issues specific to TG / Hijra persons had to come from the communities concerned. NACO would look to the TG and Hijra communities to clarify their concerns as different from those of MSM.

TG / Hijra people all over India would have to come out with an articulation of their own social identities, including perhaps the issue of a third gender. In Tamil Nadu they had already started the process. There was a need for capacity building and support which would push the TG / Hijra people to raise their voices. There was a need for some form of collectivization. Community leaders had to take the lead in this regard. Various UN agencies could help in this process. This would result in TG / Hijra issues receiving space and attention at the NACO level.

In his speech, Dr. Jana also pointed out that there were two important factors: Risk of HIV infection and vulnerability to HIV. Risk was based on personal behaviour, but vulnerability was related to the social environment in which one lived. Since NACO was keen to create an enabling environment in which targeted interventions could function effectively, it would surely assist the TG / Hijra groups to reduce their vulnerability to HIV.

Discussion: One of the participants asked whether apart from HIV NACO was interested in other issues concerning TG and Hijra people. Dr. Jana replied that NACO was focused on HIV. Prioritized issues of a particular set of people might not be their priority. But violence could be an issue through which NACO's interest could be gained. Since reduction of violence was known to help reduce vulnerability to HIV and to improve its prevention, this could be the route through which TG and Hijra communities could engage their attention.

Agniva Lahiri said that there were only two exclusive TG / Hijra targeted intervention sites identified by NACO.S/he wanted to know what action could be taken to scale up this process. Dr. Jana informed that there were 1,244 targeted interventions supported by NACO. Among these, more than 300 were focused exclusively on MSM populations, and 80% of these also worked with TG and Hijra people. Scaling up would probably have to involve these programmes.

The next speaker in this session was Pawan Dhall, Director, SAATHII, Kolkata Office, who first explained Dr. Jana's inputs in Hindi for those not conversant in English or Bengali. He continued with his inputs saying that TG and Hijra people had several concerns other than HIV. Besides, whether for HIV or other concerns, there were several government and non-government agencies with which linkages had to be developed. NACO alone would not be in a position to fulfill all their needs. However, the first requirement was for the TG and Hijra communities to understand the diversity within, to arrive at a mutually acceptable "definition" of concepts like "transgender", and

to respectfully acknowledge common as well as specific health and development concerns of the diverse TG and Hijra communities in India. Once this was done, advocacy strategies could be developed for working with different government, funding and technical assistance bodies.

Pawan Dhall also emphasized the need for thorough data to back up one's claims. So, if specific HIV programmes were needed for TG / Hijra groups rather than addressing their concerns through generic MSM targeted interventions, then data on HIV prevalence among TG / Hijra populations was needed to show that they were more vulnerable than MSM. For instance, the HIV sentinel surveillance in Mumbai in 2005 had shown a consolidated MSM-Hijra prevalence rate of 6%. But if this data was disaggregated, then the prevalence rate for MSM was far lower compared to 44% among Hijras. Another study in 2007 conducted by the Bill & Melinda Gates Foundation (Integrated Behavioral and Biological Assessment) had shown an HIV prevalence of 18% among Hijras and 6-7% among MSM. Such data clearly delineated the need for separate HIV responses for MSM and Hijras.

Discussion: Different opinions were expressed by the participants. Bini Roy said the biggest challenge was in reaching out to the Hijra populations and to work with them. Sanjay Mondal said the customs of Hijra communities needed to be understood properly before working with them. Sanjay Ram also supported this opinion, adding that nothing could be done without involving the community leaders (Hijra Gurus). Pawan Dhall reminded them to think about strategies for involving and winning over Hijra Gurus, however difficult this might seem. Satya Sundar Mishra said it was not impossible to do this. In Bhubaneswar, Kinner populations had started asking for their own voter ID cards and the lead had been taken by the community leaders.

6) Group work: Agniva Lahiri explained the objectives of the group work to the participants. Based upon the regions they had come from, five groups were created: North-East, Orissa, Kolkata 1, Kolkata 2 and West Bengal. The topics for discussion in each group were:

i) Health – General, sexual, mental and reproductive
ii) Violence – Domestic, state, institutional
iii) Stigma and discrimination
iv) Social security
v) Access to appropriate information and services
vi) Regional issues

The gists of presentations made by each group are presented below:

a) North-East:

i) General health: Medical practitioners did not behave well with TG persons. Even if they had a cold or cough, the doctors and others would tell them that it was because of their gender / sexual orientation.

Mental health: Family and social environment was such that depression was common among TG people. Parents often failed to understand their child.

ii) Violence: There were cases of sexual harassment and rape of TG persons by state related stakeholders. Institutional violence: They had to face this in schools, colleges and workplaces.

iii) Stigma and discrimination: Harassment in workplaces was common.

iv) Social security: Pallab Toy, a transsexual person and the presenter of the North East group, said that because of her gender identity, her parents had tried to confine her movements. People like her rarely had social security.

Discussion: Tista Das asked Pallab Toy whether she had to face any discriminatory behaviour by health staff. She replied that they did not want to listen to her while she was undergoing the sexual reassignment surgery (SRS) process, which remained incomplete for other reasons.

Satya Sundar Mishra asked her if she had faced any problem regarding getting personal identity documents as a transwoman. Pallab Toy replied that people in the North East had as yet not thought about acquiring fresh identity documents in their desired gender identities[1]. This was a big difficulty, and for receiving many services they had no option but to act as if they were men. Sonu Arjun, another participant from the North-East, mentioned that around 2005, there was a murder of a transwoman in a disco in Shillong.

Amitava Sarkar asked whether Hijra communities existed in north-eastern states. Pallab Toy said they lived only in Guwahati, Assam. None of the other states in the region had Hijra communities.

b) Orissa:

i) Health: In most of Orissa, Hijras and Maichiyas (local equivalent of TG) had a fear of interacting with doctors. There were chances of facing discrimination by health staff in clinics. Even getting admission into clinics could be a problem. The doctors didn't behave properly with them. Also: There were no options available for hormone therapy and related counselling.

ii) Social security: There were various development schemes for the under-privileged introduced by the government, but these were hardly accessible to TG persons. They wanted voter identity cards in their desired gender identities, but this was not possible in Orissa. They also had problems in opening bank accounts as they did not possess any legal identity proof.

iii) Stigma and discrimination: Many Hijras or Maichiyas in Orissa had to drop out of school because of unrelenting discrimination and harassment by other students and teachers.

iv) Access to information and services: There was lack of information about human rights and issues like sexual and reproductive health.

v) Violence: Hijras and Maichiyas in Orissa were often physically forced into having unsafe sex. Larger community leaders often took decisions against them and had them thrown out of their villages.

Discussion: Tista Das asked about their situation at the family and community levels. Satya Sundar Mishra answered that mothers were by and large friendlier in accepting their TG children than the fathers or other family members. Villagers often created problems in relation to their gender identity and feminized appearance.

c) Kolkata 1 (In and Around Kolkata):

i) Health: There was a lack of health services availability as well as accessibility. Stigma against these communities forced them to remain invisible most of the time.

ii) Violence: Hijras, TG and other similar groups were not treated equally in society. The law of the land also remained vague on how violence against them was to be treated, thereby making them more vulnerable to violence. Equality in the eye of the law was the need of the hour.

iii) Stigma and discrimination: It was observed that Hijras and TG persons faced stigma and discrimination in all walks of lives. There was a need to generate more advocacy material on these issues.

[1] As different from biological sex at birth

iv) Social security: Voter identity cards, ration cards, and other similar identity proof documents were needed to be introduced for these individuals in their desired gender identities.

v) Access to information and services: There was little information available about health and development services and human rights.

Discussion: Tista Das commented that more mental health services should be made available for TG populations.

d) Kolkata 2 (Greater Kolkata):

i) General health: There was need for sensitizing health service providers towards Hijras and TG persons. Advocacy was needed to ensure that health service providers did not discriminate against these groups of people, who also needed proper guidance to avail of the best possible medical services.

Sexual health: If possible, a specific system was needed to facilitate quality SRS and related services. There was also need for an exclusive HIV targeted intervention programme for Hijras and other TG persons.

Mental health: A separate counselling facility designed as per the needs of TG and Hijra populations was needed. There was no old age support available for many TG persons. They currently had little scope to deal with their depression.

ii) Violence: Domestic and state level: Lack of sensitivity towards TG persons lead to violence against them, whether in the home or outside it.

Institutional level: TG persons were often denied employment opportunities in spite of possessing the required qualifications, and this lead to poor self-esteem.

iii) Stigma and discrimination: Most people in larger society had little or no knowledge about TG persons and Hijras. This resulted in myths, unfounded fears and stigma against them.

iv) Social security: There was little security for Hijras and TG persons in various walks of lives. There was no guideline for these communities to access information and services. They also did not have enough education to be able to access the services that were available.

v) Regional issues: In suburban Kolkata, TG persons had closer knit community structures, but larger society was unaware about them.

e) West Bengal:

i) Health: The state's health system lacked an understanding of TG and Hijra health concerns. As a result, health service providers were insensitive towards them.

ii) Violence: Violence was a common problem in families. But outside the biological families, it was also prevalent in the *deras*, communal residential units of Hijras. The Guru-Chela system of Hijras could be quite rigid, leading to disputes and disagreements.

iii) Stigma and discrimination: There was stigma and discrimination against Hijras and TG persons in all spheres of society.

iv) Social security: TG persons and Hijras needed socio-economic security like any other lower income group of society. A new system or structure was needed to address these concerns.

v) Regional issues: Hijra community leaders (Nayaks and Gurus) had total control over their communities but they did not necessarily possess information or the means for the development of their communities. Unfortunately, the rigidity of their hierarchical community structure meant that their Chelas (disciples or followers) could not question their authority and suggest new ways of community development.

Discussion: Pemba Bhutia added that these days there were few Hijras remaining in Darjeeling. Earlier they were there, but since no work was initiated for their health and development, they had to leave. Many of them were currently living in Siliguri.

Prity Sengupta asked Pemba Bhutia about incidents of violence against TG or Kothi sex workers. Pemba Bhutia informed that they were often treated as substitutes for women. The cases of harassment had reduced a little. In one of the cases, a drunk client had harassed one of her friends. But she did not take this lying down and filed a complaint against him with the police, who put him behind bars.

7) Addressing the Needs and Gaps:

Anindya Hajra took the responsibility to explain the process and he mentioned that there might be various problems but there is a need of logical thinking regarding how to address these issues not just planning activities without proper plan of execution. He wanted to know how to deal with the violence, since things are different as it was before ten years and there was no common place of discussion. He repeated Pawan Dhall's points to address these issues beyond HIV/AIDS. He emphasized that there is a strong need of practical strategies to implement within a given timeline

a) Kolkata 1 (in and around Kolkata):

Needs and gaps	How to solve	Whom to work with	Challenges
Health: Access to general health services	To make doctors aware through training; old age support for TG people	Departments of Health & Family Welfare and Social Justice & Empowerment, West Bengal; government hospitals; municipal bodies	Lack of self-empowerment, willingness and unity; lack of financial support
Violence: i) Institutional violence	Change existing framework for sex education, to make it more supportive and inclusive at the school and college levels	Government educational bodies; mental health professionals	Lack of financial support; lack of community mobilization, self-empowerment and acceptance from others
ii) Domestic violence	To start work with families: Sitting together with parents for solving problems related to their TG children	Mental health professionals; NGO workers; larger community key persons; role model families that had accepted their TG children	Lack of financial support, community mobilization, self-empowerment and acceptance from others
Stigma and discrimination: Transphobia, homo-phobia and lack of social acceptance	Bringing TG communities together through networking and ensuring unified visibility	Various NGOs, CBOs, informal TG networks	Lack of financial support; mis-representation of TG persons in the media

Needs and gaps	How to solve	Whom to work with	Challenges
Access to information and services: Lack of information and awareness about human rights	Training for TG persons; using the internet and other options to develop training material	NGOs, CBOs and individuals from the TG communities	Lack of support for community mobilization; lack of financial support

b) Kolkata 2 (Greater Kolkata):

Needs and gaps	How to solve	Whom to work with	Challenges
Sexual health: Castration using unscientific processes	Encouraging TG people to go for scientific SRS procedures through government hospitals and other accredited doctors	Human rights lawyers; Department of Health & Family Welfare; relevant doctors	Indian legal system; lack of financial support and sensitization among doctors
Mental health: Lack of old age support	Building old age homes for TG people; old age pension for them	Municipal bodies; Department of Health & Family Welfare; individuals from TG communities	Lack of human and financial resources
Violence: Domestic violence	Sensitizing larger community, parents, mass media	TG individuals and their families; mental health professionals; media persons	Lack of media links and financial support; few qualified psychiatrists
Stigma and discrimination	Sensitizing larger community, mass media; guiding TG individuals on how to deal with stigma and discrimination through life skills, negotiation skills, human rights	TG individuals, including those who have already overcome such situations	Lack of safe spaces for free interaction; distance among TG individuals; problems and challenges within TG communities; lack of funds
Social security	Interaction and coordination with administrative officials, political leaders	Block and Sub-divisional Development Officers; District Magistrates; police; lawyers; political parties; PRI leaders; municipal chairpersons; larger community	Time manage-ment; lack of financial, human, other resources; problems and challenges within TG communities
Access to information and services: Poor educational levels acting as a barrier to accessing information and services	Formal and non-formal education (through pictorial tools) for TG individuals; advocacy with educational bodies	Teachers associations; human rights lawyers; NGO workers	Lack of supportive teachers, financial and other resources

Needs and gaps	How to solve	Whom to work with	Challenges
Regional issues: Fear of outcome of becoming visible	Training to impart basic knowledge of human rights and how to tackle stigma and discrimination	CBOs, NGOs, activists; administration bodies; TG individuals	Lack of financial, human resources

c) Orissa:

Needs and gaps	How to solve	Whom to work with	Challenges
Sexual health: No facilities for SRS; STI treatment services inadequate	Training on how to tackle STIs, on SRS issues; advocacy with doctors and other health personnel	NGOs, CBOs, doctors, funding bodies, media	Lack of financial and technical support
Violence: Experiences of misbehaviour and sexual harassment; poor level of family acceptance; lack of acceptance in larger society; lack of sexual health education	Advocacy with all key stakeholders	Police, human rights and other lawyers, community leaders, media	Poor evidence base to start the advocacy processes
Stigma and discrimination: In health settings, government offices, even NGOs and CBOs	Advocacy with health service providers and government officials; building bridges within MSM and TG groups	Health service providers; government bodies; MSM and TG individuals and groups	Lack of financial resources
Social security: Lack of employment support; poor access to government welfare schemes; problems in accessing BPL cards, ration cards and in opening bank accounts	Building rapport with different government departments	BDOs, municipal chairpersons, Panchayati Raj leaders, bank managers, councillors	Lack of financial resources; lack of unity among TG individuals and groups
Access to information and services (around health, human rights)	Training TG persons on issues concerned; building links with health service providers	NGOs, CBOs, human rights lawyers, TG individuals	Lack of financial support
Regional issues: No initiative by Orissa government to deal with social inequity faced by TG persons	Training for TG persons to make them aware about their rights	NGOs, CBOs, TG individuals	Lack of financial support

3) Proceedings (Day 2)

1) Registration for Day 2: The activities started with the registration process for Day 2.

2) Addressing the Needs and Gaps Continued

a) North-East:

Needs and gaps	How to solve	Whom to work with	Challenges
Immunity from violence	Legal rights awareness training for TG communities; legal aid	Lawyers, police, family members, support groups	Support groups lack knowledge and skills; lack of financial resources
Regional issue: Larger community unaware of TG persons and their issues	Reach out to common masses through support groups, media, mass education	Support groups, lawyers, media	Lack of financial resources
Stigma and discrimination:	Strengthen support groups so that they can provide legal aid and undertake information dissemination	Support groups, family members, legal stakeholders	Absence of awareness and training programmes for support groups
Social security: Insecurities faced by TG and Hijra communities	Educating families, judiciary, other government departments	Families, support groups, media, government bodies	Full fledged support groups who can take up such work absent

Feedback from participants:

- Which government departments could be approached for tackling domestic violence? The plan should be specific about this
- Awareness is a big term again. More specific planning needed for implementation
- Whatever listed here is commonly known, but there are some core needs as well. Family counselling and generating awareness among common people are important but not practical

Explanations:

- Media can play a big role in spreading awareness among the common masses. Documentary films and street plays can be utilized
- Anindya Hajra and Amitava Sarkar mentioned that some resources in this regard are already available. Example: Documentation on TG issues in North Eastern states, films like “Rupantar – Transformation”
- Amitava Sarkar also mentioned that Swikriti, Kolkata often organizes an event involving parents and families of queer people, which proves helpful in sensitizing families

b) Priyanka, who is currently based in a Hijra *Dera* in Delhi but born and brought up in Kolkata, reiterated that working with Hijras was not easy. It would be necessary for community workers to sit with the Hijra Gurus and arrive at a mutually acceptable strategy for community development. Only then would some success be possible.

Feedback from participants:

- TG and Hijra persons often faced a big dilemma about choosing their gender identity while applying for life insurance policies
- The same problem was experienced with regard to voter identity cards. Very few individuals had managed to acquire these documents in their desired gender identities. Example: Asha Devi in Gujarat
- Hijras also commit nuisance sometimes. How to start advocacy with them to convince them to change their behaviour? Also asking for money in public places (Challa*)*: Is it justified?
- How to deal with paramedical staff, since most of the time they do not behave properly with TG or Hijra individuals

Explanations:

- Prity Sengupta mentioned that in their *Dera* (also in Delhi), most of the Hijras had acquired voter identity cards in the female gender identity. With the help of these voter identity cards, they also planned to apply for passports where their gender identity would be female
- Anindya Hajra added that the Indian Constitution included several personal laws on marriage, adoption, custody and inheritance. To fix the problems faced by TG and Hijra communities, it would be necessary to acquire a basic idea of all these laws
- Regarding paramedical staff, Tista Das mentioned that sensitization programmes were needed in all government hospitals

c) West Bengal:

Needs and gaps	How to solve	Whom to work with	Challenges
Health: Lack of community mobilization among Hijras; unavailability of health systems suitable for TG and Hijra persons	A platform needs to be created where all Hijra Gurus can give their inputs for community mobilization and how advocacy can be undertaken with the government on Hijra and TG concerns	Hijra Nayaks, Gurus and TG activists; West Bengal Department of Health & Family Welfare	The focus of Hijra groups on earning money and entertainment – to the exclusion of other concerns
Violence: Domestic violence at family level; and in Hijra *deras*	Sensitization of family members; awareness through mass media; meetings with Hijra Gurus to discuss how to settle disputes without violence	Hijra Gurus and family members of TG individuals	Rigidity of the hierarchy in the Hijra communities
Stigma and discrimination: In all walks of life against TG and Hijra persons; Hijra community leaders (mainly Nayaks) not collectivized	Organizing events to generate awareness; counselling support; visiting Hijra leaders to convince them to work together and build a common platform, and to explain them rationale of health programmes	Hijra Gurus, Nayaks and their Chelas	Ignorance among Gurus and little desire for focusing on other activities, lack of space in there *deras*

Needs and gaps	How to solve	Whom to work with	Challenges
Social security: No facilities for TG persons who fall in the lower income groups	Advocacy with relevant departments of government	Government staff, policy makers	Lack of identity proof documents; existing rules and policies set by the government
Regional issues: Lack of respect for the Hijra culture	To consult Nayaks and develop strategies for sensitizing larger society	Nayaks, donor agencies, media	Widespread social prejudices against Hijras; convincing Hijras to work in a joint group

3) Group presentations on TG related definitions, concepts, regionally prevalent gender identities:

a) North-East:

Local identities: Chakka, Sitang Sitang, 'A' MSM and 'B' MSM (in Manipur), Miti (in Assam), Bahkong and Koena (in Meghalaya)

Hijra: An Indian term for those who are neither male nor female (*napunsaka* or genderless person)

Transgender: Who want to live their lives as women, but there are some TG people who are comfortable with their male bodies as well

Transsexual: A male person who wants to physically become a complete woman

b) Kolkata 1:

Local identities: Kothi, Dhurani, Boudi, 50/50, Gandu

Transgender:

i) Gender is a societal norm. When a biological male adopts female behaviours, he or she begins to be identified as a transgender person

ii) This is an umbrella term for cross dressers, transvestites etc. The extreme stage is being a transsexual (either male to female or female to male)

Hijra:

i) Hijra is a cultural identity

ii) It is a professional term for those who belong to the "Hijra profession"

c) Kolkata 2:

Hijra:

i) Hijra is a cultural identity

ii) This is a profession and as important as worship

Transgender:

i) This is a gender identity (the local term is Rupantarkami)

ii) There are a variety of TG people, for example, she-males, versatile, Sada Suhagan (common among Muslim TG persons)

d) Orissa:

Hijra: They always remain in female attire and sometime identify themselves as women. This is a profession as well.

Local identities: Hijra, Chakka, Maichiya, Rango, Dhurani, Maigonia

Transgender: Those who look like males but behave like females

Feedback from participants:

- Tista Das mentioned that terms like female-to-male or male-to-female transgender are nothing but medical terminologies. She mentioned another medical term – pre-femisexual, which refers to a transsexual who is crossing the gender barriers from male to female, but has not yet undergone genital surgery
- Anindya Hajra added that negatively defined identities are not accepted by community members and there is a debate whether the TG term should include Hijra
- Agniva Lahiri mentioned that Hijra can be a part of the TG umbrella term. Amitava Sarkar informed that in India different local terms are used as identities among male-to-female TG populations, and there was need for a common term that could be accepted and understood by everyone.

Agniva Lahiri informed all the participants that based on the inputs received from them for definitions and local TG identities, a common definition would be created which would be sent to all the community groups and individuals that had participated in the consultation. This would be done within the next 10 days. The participants would have to send in their comments on the definition (after internal discussions in their groups) to SAATHII within June 20, 2009.

4) Open Space to Collect Recommendations

(1) Human rights for Kothis
(2) Police and doctor services
(3) Health facilities
(4) Reduction in domestic violence
(5) Old age support
(6) Livelihood opportunities
(7) Service providers to maintain confidentiality
(8) Sensitive hearing and administrative support
(9) Intercommunity peace
(10) Old age home
(11) Responsible behaviour within the community
(12) Availability of ration cards, voter identity cards, PAN cards
(13) Establish legal support for transsexuals, including SRS facilities
(14) Income generation programmes
(15) Training on gender, body and health
(16) Education and livelihood support for rural TG people
(17) Support for backward communities
(18) Safer castration facilities
(19) Alternative action and reservation for TG / Hijras in all walks of lives

(20)Change the notion of being sexy
(21)Reservation of seats in transport facilities
(22)Transgender organizations and safer spaces
(23)Specifically designed targeted interventions for TG persons and Hijras
(24)Orientation and awareness programmes focused on rural and backward groups
(25)Where is our public toilet?
(26)TG welfare boards
(27)Acceptance from the government
(28)To unite for a common struggle
(29)TG and Hijra sex workers to get more emphasis in the upcoming activities
(30)Anti-discrimination law addressing TG and Hijra issues
(31)Funding support

The two-day long consultation was concluded by a formal thanks giving to all the participants, organizers and supporters by Anindya Hajra.

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5) Common definition of "transgender": Created based on information received during the consultation

Transgender is a gender identity. Transgender persons usually live or prefer to live in the gender role opposite to the one in which they are born. In other words, one who is biologically male but loves to feel and see herself as a female could be considered as a male to female transgender person. It is an umbrella term which includes transsexuals, cross dressers, intersexed persons, gender variant persons and many more. In eastern India there are various local names and identities, such as Kothi, Dhurani, Boudi, 50/50, Gandu, Chakka, Koena, Sitang Sitang, 'B' MSM, Miti, Bahkong, Sada Suhagan, Maichiya, Rango and Maigonia. Among these, the most common identity is Kothi. A few transgender persons also believe in a traditional culture known as Hijra. It is a historical cult with its own hierarchical social system (consisting of the Nayaks, Gurus and Chelas) and set of rules and activities.

Feedback received:

i) Given by Souvik Ghosal, Northern Black Rose, Jalpaiguri (through e-mail):

Transgender: Those who are biologically male but physically female are called transgender.

ii) Given by Pallab Toy, Impulse NGO Network, on June 20, 2009 (over phone):

Transgender is a gender identity. Transgender persons usually live or prefer to live in the gender role opposite to the one in which they are born. In other words, one who is biologically male but loves to feel and see herself as a female could be considered as a male to female transgender person. It is an umbrella term which includes transsexuals, cross dressers, intersexed persons, gender variant persons and many more. In eastern India there are various local names and identities, such as Kothi, Dhurani, Boudi, 50/50, Gandu, Chakka, Koena, Sitang Sitang, 'A' and 'B' MSM, Miti, Bahkong, Sada Suhagan, Maichiya, Rango and Maigonia. Among these, the most common identity is Kothi. A few transgender persons also believe in a traditional culture known as Hijra. It is a historical cult with its own hierarchical social system (consisting of the Nayaks, Gurus and Chelas) and set of rules and activities.

The final definition of "transgender" from Eastern India:

After considering the above inputs, the final definition could be as follows:

Transgender is a gender identity. Transgender persons usually live or prefer to live in the gender role opposite to the one in which they are born. In other words, one who is biologically male but loves to feel and see herself as a female could be considered as a male to female transgender person. 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. In eastern India there are various local names and identities, such as Kothi, Dhurani, Boudi, 50/50, Gandu, Chakka, Koena, Sitang Sitang, 'B' MSM, Miti, Bahkong, Sada Suhagan, Maichiya, Rango and Maigonia. Among these, the most common identity is Kothi. A few transgender persons also believe in a traditional culture known as Hijra. It is a historical cult with its own hierarchical social system (consisting of the Nayaks, Gurus and Chelas) and set of rules and activities.

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Appendix 1: Consultation Schedule

Day 1
09.00 am – 09.30 am > Introduction to the regional consultations ▪ Orientation of the participants on the rationale for the regional consultations ▪ Where the consultations were conceptualized and by whom ▪ What will follow from the regional consultations
09.30 am – 11.00 am > Introduction of participants ▪ Presentations by participants introducing themselves and their areas of concern ▪ Establishing code of conduct for the consultations
11.00 am – 11.15 am > Tea break
11.15 am – 01.00 pm > Group discussion on gaps / needs of transgender / Hijra persons ▪ Participants to form small working groups of 3-4 persons. ▪ Each group to take up a theme and discuss problems related to it. ▪ Suggested themes: o Violence, stigma, discrimination o Lack of social security o Access to information and services o NACP III rollout in relation to transgender / Hijra issues ▪ Apart from the suggested themes, any issues that may emerge during the introductory session could be taken up for discussion by a group.
01.00 pm – 02.00 pm > Lunch
02.00 pm – 03.30 PM > Presentations on gaps / needs ▪ Each working group presents its findings to the larger plenary
03.30 pm – 03.45 pm > Working tea
03.45 pm – 05.00 pm > Discussion on solutions ▪ Discussion in the larger group on possible solutions to the gaps/needs identified by the small working groups

05.00 pm – 06.00 pm > Discussion on a common broad definition to cover transgender and Hijra identities ▪ Participants to form small working groups of 3-4 persons ▪ Each small working group to work on articulating a common definition
Day 2
09.30 am – 10.00 am > Presentation of definitions ▪ Each working group presents its definitions to the larger group. ▪ Discussion on definitions presented.
10.00 am – 11.00 am > NACP III presentation
11.00 am – 11.15 am > Working tea
11.15 am – 01.00 pm > Recommendations ▪ Presentation by the Recommendations Committee ▪ Discussion on recommendations by the participants ▪ Adoption of recommendations ▪ Next steps ▪ Winding up and feedback