Chapter 9
Exploring the Psychosocial Needs of Third Gender People Living with HIV in Hyderabad, India

Sameena Azhar and Jason Vaudrey

9.1 Introduction

HIV remains a pressing public health concern throughout South Asia and particularly for third gender people. UNAIDS estimates that there are 2.11 million [95% CI: 1.7–2.65 million] people living with HIV (PLWH) in India, with a national adult prevalence of 0.26% (UNAIDS 2013; National AIDS Control Organization [NACO] 2016). Prevalence is particularly high in South India with the states of Telangana and Andhra Pradesh bearing the highest adult HIV prevalence rate for the country at 0.90%, a rate that is three times that of the national average (NACO 2012). There are about 500,000 PLWH [95% CI: 424,000–596,000] in the states of Telangana and Andhra Pradesh, accounting for 20% of all HIV infections in the country (NACO 2012). Given the high prevalence of HIV in this region of South India, Hyderabad was selected as our research field site.

Existing research suggests that minority stress is a major driver of health disparities for people living with HIV. PLWH in India are at greater risk for anxiety and depression (Nyamathi et al. 2011). Chronic depression, stressful events, and trauma can negatively affect HIV disease progression in terms of decreases in CD4 T-cell counts, increases in viral load, and greater risk for clinical decline and mortality (Kemeny and Schedlowski 2007; Leserman 2008). In a study of 362 PLWH who were receiving antiretroviral therapy at a government clinic in Kolkata, gender disparities occurred in their experience with depression (Swendeman et al. 2018). Frequently seeking instrumental support was protective for men at all income levels, but only for high-income women; additionally, having a partner was protective against depression for men as they aged, but not for women (Swendeman et al. 2018).

S. Azhar (✉) · J. Vaudrey
Graduate School of Social Service, Fordham University, New York, NY, USA
e-mail: sazhar@fordham.edu

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Third gender people in India are also more likely to experience mental health issues (Landolt et al. 2004; Safren et al. 2009; Thomas et al. 2009; Logie et al. 2012). The rate of depression among men who have sex with men (MSM) in South India has been reported to be three times higher than the general population (Safren et al. 2009; Thomas et al. 2009). Third gender people may also experience long-term psychological distress in adulthood (Landolt et al. 2004). In a study of 200 MSM in India, gender nonconformity was significantly associated with depression with 55% of the sample reporting moderate to severe depression scores (Logie et al. 2012).

The category of third gender people in South Asia includes the subgroup of hijra, a culturally embedded term that is often roughly translated into English as transgender, eunuch (Lal 1999), transvestite, homosexual, bisexual, hermaphrodite, androgynous, or transsexual. As reported by Shalini Jayaprakash in Chap. 2 on re-writing the subject and the self, gender fluidity has historically been sanctioned within both South Asian Hindu and Muslim communities. While previously provided an exalted space in Moghul and Rajput courts and known in some parts of South Asia as khwaja sira, hijra now find themselves to be at the bottom of the social hierarchy, often being forced to earn their livelihoods through sex work and panhandling (Aziz and Azhar 2019; Azhar et al. 2020a). Other modes of mainstream unemployment are often unavailable to gender-nonconforming people in contemporary India. As Jayaprakash notes, traditional narratives of an upper caste, Hindu male who became a khwaja sira have been replaced with narratives of poverty and dissent, exemplified by the persona of the hijra. The experiences of third gender people in India are lived, experienced, and performed in ways that are more complex than what was permitted in the heteronormative, gender binary system offered by British colonialism during the Victorian period. Contemporary framings of hijra communities as "progressive" or "modern" misinterpret gender and sexuality through an inappropriate sociocultural lens. Such framings also do disservice to the historical presence and influential narratives that gender-nonconforming people in South Asia have long occupied. Drawing from the autobiographical accounts of Laxmi and Revathi, Jayaprakash notes how the body of a hijra becomes both a site of coercion and pain within the confines of a patriarchal society.

These themes regarding narratives of gender fluidity, poverty, and social marginalization also relate to Anna Guttman's analysis of Arundhati Roy's book, *The Ministry of Utmost Happiness*, in Chap. 3. Guttman focuses on the central character in the novel, Anjum, and her coming to terms with her gender identity as a young person. Anjum creates her own community which includes a "chosen family" or kinship system that falls outside of traditional patriarchal and heteronormative paradigms. Anjum feels uncertain about using Western language to describe the spectrum of labels that can be used to describe fluidity in gender identity and sexual orientation in Hindi and Urdu. She contrasts the ways in which she describes herself as a hijra to younger people, like the character Saeeda, who is more quickly able to adopt the contemporary language of "transgender," "transgender woman," or simply "trans." For Anjum, being hijra and using the term "trans" means to engage in a Western way of being, an ontology that entails speaking English, wearing Western pants and shirts

instead of a salwar kameez, and generally adopting a Western identity. These differences in the social construction of gender and sexuality in the South Asian context, and the meanings they connote for users of these terms, are embedded in notions of culture and authenticity, and have important implications for our own findings.

9.2 Theoretical Framework

In this chapter, we applied the theoretical framework of minority stress theory (MST), which states that prejudice and stigma toward sexual and gender minorities bring about stressors that result in adverse health outcomes, including mental and physical disorders (Meyer and Frost 2013). Minority stress focuses attention on conditions of stigma and prejudice that can cause or exacerbate health disparities (Meyer 2015). The greatest sources of minority stress are rejection, discrimination, and violence that minority persons experience because of their stigmatized minority position within society (Garnets et al. 1990).

Meyer describes two types of stressors that sexual and gender minorities face: distal and proximal stressors. Distal stressors refer to experiences that occur outside the individual, and proximal stressors refer to experiences for which the individual internalizes particular cognitive processes. Distal stressors could be life events, chronic strain, and daily discrimination, while proximal stressors could be internalized shame, negative social attitudes, or an expectation of rejection or transphobia (Meyer 2015).

As Shane P. Gannon points out in Chap. 6 on colonial censure of transbodies in nineteenth-century South Asia, sources of transphobia have significant roots in the criminalization of cross-dressing and gender nonconformity throughout South Asia. These were processes that were legalized through the passage of the 1871 Criminal Tribes Act during British colonialism (Azhar 2019) and became further criminalized through the passage of Section 377 of the British Penal Code, and then eventually the creation of the Indian Penal Code. Such surveillance systems simultaneously categorized and avoided gender-nonconforming populations. As Gannon notes, subsequent rounds of the census effectively ignored trans populations by reducing all groups of gender-nonconforming people, including khoja, khusra, zenana, and several others, into the monolithic category of hijra. The diversity within these sexual and gender minority communities was far greater than the census category of "hijra" could effectively describe. The failure to account for third gender people in the gender-binary system of Eurocentric demography, as operationalized by the census, is another demonstration of the social marginalization that members of this community have perpetually faced. Indeed, as Gannon argues, the transgender community represents a site of contested meaning that challenged British understandings of gender and sexuality. Often being inaccurately described as male eunuchs, hijra were further classified into various sub-castes. Through the British taxonomy system, the notion of "hijra" became reified into a discrete identity category of caste, a category that simultaneously encompasses notions of occupation, gender, class, and legal access.

Applying MST's constructs of resilience and coping (Meyer 2015), resilience can be viewed as being dependent on the identification of adaptive functioning during distress (Masten 2007) from having been socially excluded from family members, institutions, and employment. Resilience can occur at both the individual and community levels. Individual resilience involves mastery through personal agency, a process which can help or hinder a person's ability to cope with stress (Turner and Roszell 1994). Community resilience explains how communities can assist in developing and sustaining well-being (Hall and Zautra 2010) or how minority communities cope with their multiple marginalized identities (Meyer 2003).

An important application of MST is the intersection of minority stress on sexual and gender minorities of color (Meyer 2010). Meyer hypothesized that sexual and gender minorities of color are both more stressed and more resilient than their White counterparts. Meyer hypothesized the study of sexual minorities of color would provide answers to core questions about social stress as a cause of mental disorders. Sexual minorities and racial/ethnic minorities are exposed to greater stress and have less support and resources as compared to heterosexual and White sexual minority people (Meyer et al. 2008b). Nonetheless, sexual and gender minority people of color are not more likely than their White counterparts to have mental disorders (Meyer et al. 2008a), demonstrating a resilience to stress from communities of color.

MST has also been applied to populations of MSM in South India to test cross-cultural applicability. Discrimination, violence, and stigmatization have been documented in social, legal, and healthcare settings in India (Chakrapani et al. 2008). Meyer applied MST to sexual minority mental health with a focus on sexual stigma (Meyer 1995, 2003). Forms of this stigma are intimately tied to forms of gender identity expression. In India, MSM with more feminine gender expression were found to experience more stigma and discrimination based on their gender nonconformity than those MSM who did not have feminine gender expression (Narrain and Bhan 2005).

Additional stress may also originate from intersectional sources, for example, HIV serostatus (Logie et al. 2012), occupation, marital status, or caste. Intersectional stigma through the lens of MST highlights the devaluing of people who are living with HIV and the negative impacts that stigma has on their physical and mental health (UNAIDS 2007; Logie and Gadalla 2009). To date, few studies have examined the lived experiences and psychosocial needs of third gender people living with HIV in South India. To address this gap in the extant research, we conducted a qualitative study, exploring how minority stress affects the lives of third gender people living with HIV in Hyderabad.

9.3 Methods

The analytic sample was defined as third gender people living with HIV in Hyderabad, India. Inclusion criteria for the study were as follows: (1) self-report as living with HIV, (2) a resident in Hyderabad or Secunderabad, India; (3) proficient

in speaking Hindi/Urdu or Telugu; (4) between the ages of 18 and 50; and (5) identify as third gender, hijra, transgender or otherwise gender-nonconforming (Azhar et al. 2020a, 2020b, 2021).

9.3.1 Data Collection and Recruitment

Purposive and snowball sampling techniques were utilized to recruit study participants. For purposive sampling, participants were recruited through existing collaborations with local non-governmental organizations (NGO) serving individuals living with HIV in Hyderabad. We partnered with four NGOs in Hyderabad for recruitment of study participants. A local research assistant posted recruitment flyers at the collaborating organizations in Hindi and Telugu. Our research team then regularly visited each of the four organizations to recruit and interview participants. To include those who were not currently linked to NGOs, we additionally utilized snowball sampling. Individuals who were initially recruited from the four collaborating organizations were asked to share information pertaining to the study to eligible peers in their social networks. Those who successfully referred another participant received an additional incentive.

The four organizations with whom we collaborated are briefly described below. (1) Avagaahana is an NGO in the Lal Darwaaza neighborhood in Hyderabad, whose mission is to support the hijra community of Hyderabad through health education, crisis intervention, and resource advocacy for social entitlements. (2) HOPES+ is an NGO in Padmarao Nagar in Secunderabad, working to improve the quality of life of people living with HIV. (3) NHP+ is an NGO dedicated to serving the needs of PLWH in Hyderabad with a focus on homeless children and adults. (4) Calvary Counseling Society, operating in the Ramnagar area of central Hyderabad, provides education, health, and psychological services to the local community by applying principles of Christian fellowship.

Interviews were conducted at NGO sites in both Hindi and Telugu by a local research assistant and digitally audio-recorded. For individuals who were illiterate, the interviewer read questions aloud and recorded the participants' answers by hand. For illiterate individuals, a thumbprint was used as a signature for consent documents, which is a commonly accepted legal practice in India. Following completion of interviews, interviews were translated and transcribed into English, then analyzed using thematic content analysis.

9.3.2 Incentives

All participants who completed a 90-minute survey were compensated 200 Rupees, an equivalent exchange rate at the time of data collection, to approximately $3.14 USD. If a participant assisted in recruiting other individuals through snowball

sampling, the recruiter received an additional incentive of 100 Rupees for each completed referral. These amounts were deemed to be fair after consulting with local staff members at community-based organizations, who informed our team of appropriate incentive amounts for research participants in Hyderabad at the time of data collection.

9.3.3 Gender Identity Constructs

Gender identity has been described as being the private experience of gender roles; gender roles have been described as being the public expression of gender identity (Money and Ehrhardt 1972). In Western systems, gender identity is often characterized in binary terms, that is, male and female. As previously described in this chapter, in South Asia there are a myriad of gender identity options outside the traditional binary that include hijra, khwaja sira, kothi, kinnar, aravani, khusra, kojja, zenana, and many others. Due to the more fluid nature of gender identity and sexual orientation in South Asian culture, we did not exclude individuals in the study who did not solely identify with one gender identity over the course of a day or over the course of their lives. The intrinsic gender fluidity, or queerness, of gender identity and sexual orientation is a defining feature of the ways in which these identities are culturally constructed within the South Asian context.

9.3.4 Ethics Review

Informed consent was obtained from all participants, following Institutional Review Board (IRB) approval from the University of Chicago School of Social Service Administration/Chapin Hall in September 2015; the internal ethics committee at our collaborating research institution in Hyderabad, SHARE India, in November 2015; and Fordham University for ongoing data analysis in October 2018. All participants' names and other personally identifying information have been removed or changed in this manuscript to protect participants' confidentiality.

9.4 Results

Four key themes regarding the psychosocial needs of third gender people emerged from the data analysis of the transcripts: (1) limited economic opportunities outside of sex work; (2) lack of accountability for complaints regarding abuses against third gender people; (3) limited access to gender-affirming HIV medical care; and (4) resilience against social stigma.

9.4.1 Limited Economic Opportunities Outside of Sex Work

Throughout the interviews, third gender people reported they were often relegated to panhandling and sex work for their livelihood as they were unable to obtain other employment in the formal labor sector. Many reported being harassed and assaulted for engaging in panhandling. One participant reported:

> When we beg, people will scold us and in turn, we scold them. I don't like that. If we were normal, we would do our jobs and it would be a satisfactory life.

As reported by this participant, hijra who come from lower castes often engaged in panhandling and sex work because of limited alternative employment opportunities. This theme is similar to that reported by Supriya Pal and Neeta Sinha in Chap. 10 regarding the lack of employability of hijra in Gujarat. For hijra living together in guru-chela households, kinship is created through both the sharing of living quarters and gender identities, but also through the existence of mutual economic ties that provide a collective livelihood. Due to the cyclical nature of apprenticeship and debt within these kinship systems, many hijra become locked into systems of perpetual social marginalization and poverty, often earning a subsistence level of earnings and never being able to save or become upwardly mobile. In both contexts of Hyderabad and Gujarat, the hijra identity is intimately tied to experiences of sex work, panhandling, and badhai or the performance of ritualistic blessings offered by hijra to newborns, newlyweds, and travelers. Limited work opportunities create additional forms of social marginalization for hijra and other gender-nonconforming people as reported by the following participant in our study:

> The husband role is very easy. I can do it. As a hijra, it's only sex and it is only for money. I feel bad being a hijra in my daily life. I might have at one time been able to earn money, but now that I am old, I cannot do anything. I think if I was like a man, I would be able to have a job and earn money.

Because of financial and social taboos regarding the acceptability of being a third gender person, many participants were unable to obtain employment in the formal labor sector. This led them to lead double lives: one as a cisgender man with a wife and children and another as a hijra or third gender person among their social and occupational circles. This conflict of having multiple selves, entailing one gender identity that is portrayed among their family and another gender identity among their friends, can potentially contribute to psychosocial distress.

Even for those individuals who always identify as a third gender person, limited work opportunities offer an additional source of financial stress. Many hijra rely on earnings from summer weddings, childbirths, and public performances to maintain a standard of living throughout the year. In this passage, we hear the story of a participant who was offered a potentially lucrative job opportunity at a local news station. But when their gender identity became known to their potential employers, the opportunity was rescinded.

> Once I was offered a crime episode on V6 channel because they saw my photo with makeup and they thought I was a woman. I told them I was a hijra and they rejected me. The

> watchman did not allow me to go inside. The manager said that I was only fit for sex, not fit for this. When I heard those words from him, I felt very bad. It was the saddest in my life I had ever been. Yes, madam, I like anchoring. I got an opportunity in V6 channel on a crime episode. When they saw my photo with makeup, they thought I was a woman.

Because of the stress caused by the limitations in opportunity due to their gender-nonconforming identity, third gender people may attempt to hide their identity in employment settings, thereby also running the risk of being discovered by their coworkers and being subsequently fired by their employers.

9.4.2 Lack of Accountability for Complaints Regarding Abuse Against Third Gender People

Many third gender people also report that there is no accountability when they attempt to file police complaints regarding the abuse they endure in public spaces. This experience is recounted by the following participant, who talks about their experience of being raped at a festival.

> A situation occurred when I was walking on the roadside. There was a festival going on and a crowd of people approached me. They closed my mouth and they raped me. When I went to the police station to file a complaint, the policeman said that I engage in sex for work and that this was my job. He did not file my complaint. From that time on, I have thought very little about my life.

From this passage, we witness how injustices against third gender people are often minimized and ignored by the systems that are purported to protect them. Further, the veracity and integrity of third gender people is often questioned because they are believed to be immoral. Regardless of their employment, they are often assumed to be sex workers and are told that rape should be expected for their social position. Like their experiences in other aspects of their lives, accounts of sexual abuse and rape are questioned by police officers, who often refuse to report these crimes through the completion of a forensic First Information Report (FIR) (Tripathi and Azjar 2021). This leaves third gender people feeling inferior and ignored by the law. Because the complaints of third gender people were not taken seriously, violent assaults were not investigated and violence against these communities persisted. Of course, a belief that the criminal justice system could adequately resolve issues regarding sexual assault requires a reliance on the integrity of juridical systems that protect human rights. In reality, such institutional protection of third gender people has rarely existed throughout time and space.

Probing similar themes, in Chap. 7 Vaibhav Saria describes the confrontations that can occur between hijra and the state. He describes how in 2018 hijra engaged in protest against the police enforcement of soliciting and begging in Green Park, New Delhi, with the protestors being naked. The protest was a result of the Delhi police's motivation to remove hijra from engaging in the solicitation of sex work in public spaces. Appearing at the protest was a defiance not only of the banning of sex

work, but a defiance against social norms about the body, sexuality, and decency. Hijra were taken into custody and an unsuccessful effort was made to provide them with "respectable" jobs under the Yuva Scheme, a national youth employment program.

On the same theme, in Chap. 8 Sangeetha Sriraam discusses the Transgender Persons (Protection of Rights) Act, which was passed in 2019. The act was framed as a means to secure transgender rights, but Sriraam reports that the Act failed to deliver on this promise of social inclusion. The act reversed reservations that the National Legal Services Authority of India (NALSA) had placed regarding representation in reserved seats for scheduled castes in local elected bodies (panchayats) as well as access to education, employment, and other social entitlements. Sriraam states that comprehensive legislation is needed for transgender people to have full citizenship in India, in order to ensure that their human rights are guaranteed and to reverse the social marginalization that has been in place for centuries. Full social inclusion would also allow for an accountable process where third gender people have an accessible means to report hate crimes against them and expect a just institutional response.

9.4.3 Limited Access to Gender-Affirming HIV Medical Care

The main themes in this cluster are related to experiences of limited access to gender-affirming HIV medical care. While there have been international medical advancements in HIV prevention and treatment, HIV remains a highly stigmatized disease in India as it continues to be associated with behaviors deemed to be illicit and immoral, namely, sex between men, injection drug use, and sex work. One participant revealed how they felt that it was inevitable that they would become infected with HIV, given that they were hijra:

> I don't know the exact date, madam—in 1982 or 83. It is written on the walls in the railway station that if we have sex, we will get HIV. I did not know about HIV in Hyderabad. When I went to Bombay, I learned about HIV. But I thought that we wouldn't get this in India. I thought only foreigners could get this disease.

This participant reports a paradox, with the proverbial "[writing] on the walls" of a railway station. They perceived that "only foreigners could get this disease" and also believed that, as third gender people, they would inevitably get HIV.

In light of their treatment by medical care professionals, police officers, and general society, third gender people often internalize shame regarding both their gender identity and their HIV status. The devaluation of self is clear in the following passage:

> People in my community will be rude toward people who are HIV positive. They will keep things separate from us, not touch us, and we cough or sneeze, they will step away from us. They treat us badly. They will make a "small show" of HIV positives. They will not keep all their things separate from that person. They will not touch the person. If the person coughs or sneezes, they will tell them to go away. They will treat the person very badly.

Despite widespread HIV awareness, discriminatory practices against people living with HIV still persist with people publicly ridiculing or making a "small show" of PLWH. This experience of being demeaned in public was repeatedly described by our participants. Coupled with the shame they experience from their HIV status, third gender participants in our study often carried a high degree of stigma throughout multiple spheres of their lives, a stigma that is innately connected to their minoritized status.

> When we go to hospital, they ask, "Are you an MSM? Are you MSM?" They will ask so many times. They ask, "Why did you do this? And how did you do this? And why did you become infected with HIV?" They will ask all these questions. Especially when we go to a STD clinic, they will ask us. It is happening every day. Senior doctors tell junior doctors, "See: he is an MSM. Wear protective goggles and take precautions." They will ask us to show our private parts, but there is no other goal. We need to take this maltreatment and accept the way they talk to us. We feel very badly.

PLWH are often questioned and judged in regard to their HIV status, their gender identity, or their sexual orientation and asked to show their genitalia in order to "authenticate" their identity as hijra. This "medical" authentification most often relies on the healthcare provider confirming the absence of a penis and testicles. These discriminatory experiences hinder third gender people from seeking routine medical check-ups, leading to the avoidance of healthcare until their medical issues have escalated.

> Society thinks that we got HIV due to our bad sexual behavior. They think that if they talk to us, they will get our diseases. They see us like a dirty insect. Though there is a lot of awareness, there is no change in society… People think that we will go wherever we want and that is why we got this disease. And we won't be able to rent a house for ourselves. If they give us a place to stay, they are afraid that we will corrupt their children. They have that fear. Moreover, they will look at us suspiciously every day.

Here the participant reports a common trope of how people fear that third gender people will "corrupt" their children. Taken together, these passages highlight that discrimination and prejudice have prevented many third gender people living with HIV from securing stable housing, permanent employment, inclusive social interactions, and gender-affirming medical care.

9.4.4 Resilience Against Social Stigma

Multiple participants reported how they had to conceal their gender identity in various public spaces for fear of negative social consequences. Rather than taking these experiences to be reflective of the stressful forces of a minoritized status, we view participants' reluctance to share their gender identity or HIV status publicly as an act of resilience against potentially destructive social forces.

> I won't talk too much with that person if he doesn't know that I am MSM. I will greet him and not shy away, but I fear that if I engage with him too long, my true feelings will be

> revealed in front of that person. I will not talk with that person much. I will just say hello and leave. I fear that if I stay too long in that place, my identity will be revealed.

Hiding one's sexual or gender identity can help protect third gender people from experiencing verbal assaults or potential violence, but may also contribute to a sense of internal shame or embarrassment regarding their stigmatized identities. In this final passage, we see that the participant decides that she will continue to live her life fully, despite what others may think of her or the negative social consequences she may endure.

> I am living a bold life and now have a meaningful life. I do not fear my death. By seeing my friends regularly, I started being courageous and bold. Now I am bold because I am living this life with meaning. Why should I fear my death? By seeing all these friends like me, I started living a bold life and became courageous.

In this passage we also witness how social support from other community members can help to buffer the marginalization experienced by third gender PLWH. Resilience is exemplified here in the form of "living a bold life and becom[ing] courageous." But this social support remains insufficient to completely protect people from the negative social impacts of both HIV and gender-nonconformity stigma.

9.5 Discussion

Meyer (2010) concluded that minority stressors require group-level resources because only the group can change gender norms and values that influence societal prejudice. It is only through social change that the group can promote an affirmative support system (Crocker and Major 1989), potentially through the inclusion of role models and peer leaders. The limited opportunities that were available to third gender people outside of sex work, coupled with the robust social support networks upon which they rely, contribute to a sense of community mastery, a concept that posits that "individuals can overcome life challenges and obstacles through and because of their being interwoven in a close, social network" (Hobfoll et al., 856). In light of this perspective, social interventions should be aimed at enhancing resilience, community-building, and social support at the individual, group, and community levels (Meyer 2015).

In our study, participants reported limited access to gender-affirming HIV medical care. The minority stress perspective views social conditions as a direct source of morbidity and distress for minority persons (Meyer 1995). However, social support may be insufficient in reducing depression in confrontational environments (Logie et al. 2012). By better understanding the obstacles that third gender PLWH face in being able to achieve psychological well-being, we can tailor social interventions and health policies to better suit the unique needs of this population. For example, given the limited work opportunities that so many our participants reported, vocational training programs and job placement schemes can be an important means of structurally changing the employment opportunities available to third

gender people. For example, in Saria's Chap. 7, they recount how the Noida Rail Corporation in October 2020 dedicated the Noida Sector-50 Metro station to the hijra community. Six hijra were employed by the Rail Corporation to paint the metro station in bright rainbow colors and rename the station, the Pride Metro Station. This effort was intended to demonstrate the efforts made by the passage of the Transgender Persons Act of 2019 and to encourage more employers to hire third gender people in the formal labor sector.

Our study also found that at least some members of the third gender community were well connected to HIV services and reported being in good physical and mental health. These individuals may be trained to serve as peer counselors or patient advocates in their community, thereby navigating their peers into achieving greater inclusion within the health continuum of care.

9.6 Limitations

Given the diversity within South Asian culture, there are problems regarding generalizability of these findings outside of South India, or perhaps even outside the city of Hyderabad. The context for third gender people in India is not likely to be comparable to other sexual/gender minority populations outside of the South Asian subcontinent, making global generalizations regarding gender-nonconforming PLWH difficult to make. Given the diversity of language, culture, and gender norms in South Asia, the context for PLWH in Hyderabad may also not be generalizable to that of PLWH in other locations, even within South India.

In terms of the sampling method for the study, using an exclusively organizational recruiting method may have created a source of sampling bias (Watters and Biernacki 1989). People living with HIV who are recruited from social service organizations are by definition more connected to resources, so this may be eschewing the very population that we are seeking to find—namely those individuals who are *so* stigmatized by their HIV status that they are avoiding medical treatment altogether. Though we additionally utilized snowball sampling and online recruiting to identify other respondents, this method may also be considered biased because it is not random and selects individuals on the basis of social networks, who are likely to be more open regarding their HIV status or their gender-nonconforming identity (Browne 2005).

9.7 Conclusion

Our findings support previous research that greater attention needs to be paid to fully engage third gender people living in HIV in medical care and mental health support. Especially in the context of HIV, it is necessary to identify those socially created conditions and contexts that exacerbate disease. As Pearlin (1982, 368) notes, "The eventual control of disease caused by stress depends on understanding

the social etiology of the stress." Understanding the variation between gender groups will assist in better tailoring interventions in the South Indian context for subgroups of PLWH (Satyanarayan et al. 2015; Ezell et al. 2019).

Our research highlighted the need for increased gender-affirming HIV medical care and psychosocial support. We also noted the importance of creating vocational and employment opportunities outside of sex work, namely, for those who are interested in exiting that profession. Finally, we note the need for sensitization training for medical staff, law enforcement officers, and social service providers in offering gender-affirming healthcare, legal aid, and social services to PLWH in Hyderabad, particularly in publicly funded settings. Ultimately we find that the psychosocial needs of third gender people living with HIV in Hyderabad, India, remain largely unaddressed and will require social and structural intervention to rectify these gaps in service provision.

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