HIJRAS/TRANSGENDER WOMEN IN INDIA: HIV, HUMAN RIGHTS AND SOCIAL EXCLUSION

Issue Brief (December 2010)

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Acronyms & Abbreviations

ART	Antiretroviral Treatment
CBO	Community-based Organisation
GIPA	Greater Involvement of People Infected and Affected by HIV/AIDS
HIV	Human Immuno-deficiency Virus
HSV	Herpes Simplex Virus
HCV	Hepatitis C Virus
HBV	Hepatitis B Virus
IPC	Indian Penal Code
MDG	Millennium Development Goals
MSM	Men who have Sex with Men
NGO	Nongovernmental Organisation
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
SRS	Sex Reassignment Surgery
STIs	Sexually Transmitted Infections
TG -	Transgender
TI	Targeted [HIV] Intervention

1. INTRODUCTION

Asian countries have centuries-old histories of existence of gender-variant males - who in present times would have been labelled as 'transgender women'. India is no exception. Kama Sutra provides vivid description of sexual life of people with 'third nature' (Tritiya Prakriti).

In India, people with a wide range of transgender-related identities, cultures, or experiences exist - including Hijras, Aravanis, Kothis, Jogtas/Jogappas, and Shiv-Shakthis (See glossary). Often these people have been part of the broader culture and treated with great respect, at least in the past, although some are still accorded particular respect even in the present.

The term 'transgender people' is generally used to describe those who transgress social gender norms. Transgender is often used as an umbrella term to signify individuals who defy rigid, binary gender constructions, and who express or present a breaking and/or blurring of culturally prevalent stereotypical gender roles. Transgender people may live full- or part-time in the gender role 'opposite' to their biological sex.

In contemporary usage, “transgender” has become an umbrella term that is used to describe a wide range of identities and experiences, including but not limited to: pre-operative, post-operative and non-operative transsexual people (who strongly identify with the gender opposite to their biological sex); male and female 'cross-dressers' (sometimes referred to as “transvestites”, “drag queens”, or “drag kings”); and men and women, regardless of sexual orientation, whose appearance or characteristics are perceived to be gender-atypical. A male-to-female transgender person is referred to as 'transgender woman' and a female-to-male transgender person, as 'transgender man'.

The terms 'transgender' or 'transgender populations/people', used in this brief, while more encompassing than transgender women, are used to refer to transwomen given this brief's focus. Sometimes, for brevity, the abbreviation 'TG' is used to denote transgender women.

Until recently, HIV programs in India included transgender women under the epidemiological and behavioural term - 'men who have sex with men' (MSM), although many transgender people did not want to be included under that term. In addition to respecting the preferred term to be used by the transgender women, it is increasingly recognised that transgender people have unique needs and concerns, and that it is better to view them as a separate group that is not under the rubric of 'MSM'.

Even the umbrella term 'transgender' may hide the complexity and diversity of the various subgroups of gender-variant people in India and may hinder development of subgroup-specific HIV prevention and care interventions, and policies. For example, some Hijra activists may prefer others calling them 'Hijras' and not to subsume Hijras under the broader category 'transgender'. One reason for this is that they feel Hijras have a long history, culture and tradition in India, which would not be evident or which might be overlooked when using the catch-all term 'transgender'. Though some Hijra activists may also identify as 'transgender' for outsiders or in the global platform, they prefer the label 'transgender women' to be applied to those transgender women who are not part of the Hijra communities. However, some other Hijra/Aravani (Hijras in Tamil Nadu) activists may identify as both 'Hijras/Aravanis' and 'transgender woman'.

Transgender people face multiple forms of oppression. The focus of this brief is to summarize the various issues faced by Hijras and transgender women by using the social

exclusion framework, and highlight the relation between this exclusion and vulnerability to HIV and other health risks.

2. HIV AND HEALTH-RELATED RISKS

HIV and STI prevalence among transgender populations in India
The estimated size of MSM and male sex worker populations in India (latter presumably includes Hijras/TG communities) is 2,352,133 and 235,213, respectively. No reliable estimates are available for Hijras/TG women.

HIV prevalence among MSM populations was 7.4% as against the overall adult HIV prevalence of 0.36%. Until recently, Hijras/transgender people were included under the category of MSM in HIV sentinel serosurveillance. Recent studies among hijras/transgender (TG) women have indicated a very high HIV prevalence (17.5% to 41%) among them.

A study conducted in a Mumbai STI clinic reported very high HIV seroprevalence of 68% and high syphilis prevalence of 57% among Hijras. In Southern India, a study documented a high HIV seroprevalence (18.1%) and Syphilis prevalence (13.6%) among Hijras. A study conducted in Chennai documented high HIV and STI prevalence among Aravanis: 17.5% diagnosed positive for HIV and 72% had at least one STI (48% tested seropositive for HSV-1; 29% for HSV-2; and 7.8% for HBV).

Published data on sexual risk behaviours of Hijras/TG women are limited but available data indicate high risk sexual behaviors. The available information from the Integrated Biological and Behavioural Assessment (IBBA) survey 2007 conducted in select districts of Tamil Nadu, reported that, among Hijras/TG, the condom use during last anal sex with commercial male partners and 81% with non-commercial male partners is 85% and 81% respectively. Also, the survey documented low level of consistent condom use among Hijras/TG women: 6% with commercial male partners and 20% with non-commercial male partners.

Sexual health
Hijras/TG communities face several sexual health issues including HIV. Both personal- and contextual- level factors influence sexual health condition and access to and use of sexual health services. For example, most Hijras/TG are from lower socioeconomic status and have low literacy levels that pose barrier to seeking health care. Consequently, Hijras/TG communities face some unique barriers in accessing treatment services for STIs.

Mental health
Mental health needs of Hijras/TG communities are barely addressed in the current HIV programs. Some of the mental health issues reported in different community forums include depression and suicidal tendencies, possibly secondary to societal stigma, lack of social support, HIV status, and violence-related stress.

Most transgender people, especially youth, face great challenges in coming to terms with one's own gender identity and/or gender expression which are opposite to that of the gender identity and gender role imposed on them on the basis of their biological sex. They face several issues such as: shame, fear, and internalized transphobia; disclosure and coming out; adjusting, adapting, or not adapting to social pressure to conform; fear of relationships or loss of relationships; and self-imposed limitations on expression or aspirations.

Alcohol and substance use

Available evidence suggest the need to address alcohol and substance use among Hijras/TG communities. An unknown but significant proportion of Hijras/TG communities consume alcohol possibly to forget stress and depression that they face in their daily life. Hijras provide several reasons justifying their alcohol consumption that range from the need to 'forget worries' (because there is no family support or no one cares about them) to managing rough clients in their sex work life. However, alcohol use is associated with inability to use condoms or insist their clients to use condoms, and thus increase risk for HIV transmission and acquisition.

Box 1. National AIDS Control Programme (NACP-III) and Hijras/Transgender women

NACP-III (20072012) has included “MSM and transgender” people among the 'core groups' for whom intensified HIV prevention and care programs are implemented. Interventions for transgender women are currently subsumed under 'MSM interventions'. Nevertheless, in some states (e.g., Tamil Nadu and Maharashtra) separate interventions for Hijras/TG are being implemented for some years. Some gaps that need to be addressed in relation to interventions among TG include the following.

Need for separate HIV sero-surveillance centres: In India, separate HIV sentinel sites for MSM were introduced only in 2000 and for Hijras/TG in 2005. As of 2008, there were 66 sites for MSM and one site for TG.

Need for interventions that provide holistic care to Hijras/TG: Preventing HIV and mitigating the impact of HIV epidemic is the primary focus of NACP-III. However, other health-related components which would have significance effects on HIV such as mental health counselling and counselling on sex change operation are not part of the existing MSM/TG interventions. Thus, there is a lack of holistic and comprehensive approach that includes health and social services for transgender people.

Greater involvement of Hijras/TG communities in decision-making processes: In line with the guiding principles of NACP-III that include community involvement and greater involvement of people infected and affected by HIV/AIDS (GIPA), it is crucial to include representatives of Hijras/TG communities in HIV policy formulation and program development. National GIPA policy needs to explicitly articulate the importance and ways of including Hijras/TG representatives in decision-making processes.

Need for CBO formation and strengthening: NACP-III envisions that 50% of TIs would be transitioned from NGOs to CBOs by the end of 2012. However, so far, there are only a countable number of CBOs of Hijras/TG communities, with various levels of capacities. The capacities of existing and emerging CBOs need to be strengthened so that they can effectively implement TI projects and other programs.

Box 2. Feminising Procedures and Sex Reassignment Surgery (SRS)

The Indian legal system is silent on the issue of sex change operation. According to Section-320 of the Indian Penal Code (IPC), 'emasculating' (castrating) someone is causing him 'grievous hurt' for which one can be punished under Sec 325 of the IPC. Thus, technically speaking even if one voluntarily (with consent) chooses to be emasculated, the doctor is liable for punishment under this provision and the person undergoing emasculation could also be punished for 'abetting' this offence. However, under Section-88 of IPC, an exception is made in case an action is undertaken in good faith and the person gives consent to suffer that harm. The section reads: “Nothing which is not intended to cause death is an offence by reason of any harm which it may cause or intended by the doer to cause any person whose benefit it is done in good faith, and who has given a consent…to suffer that harm, or to take the risk of that harm”. Given the legal stand for SRS in India, there are no India-specific medical guidelines for sex reassignment surgery.

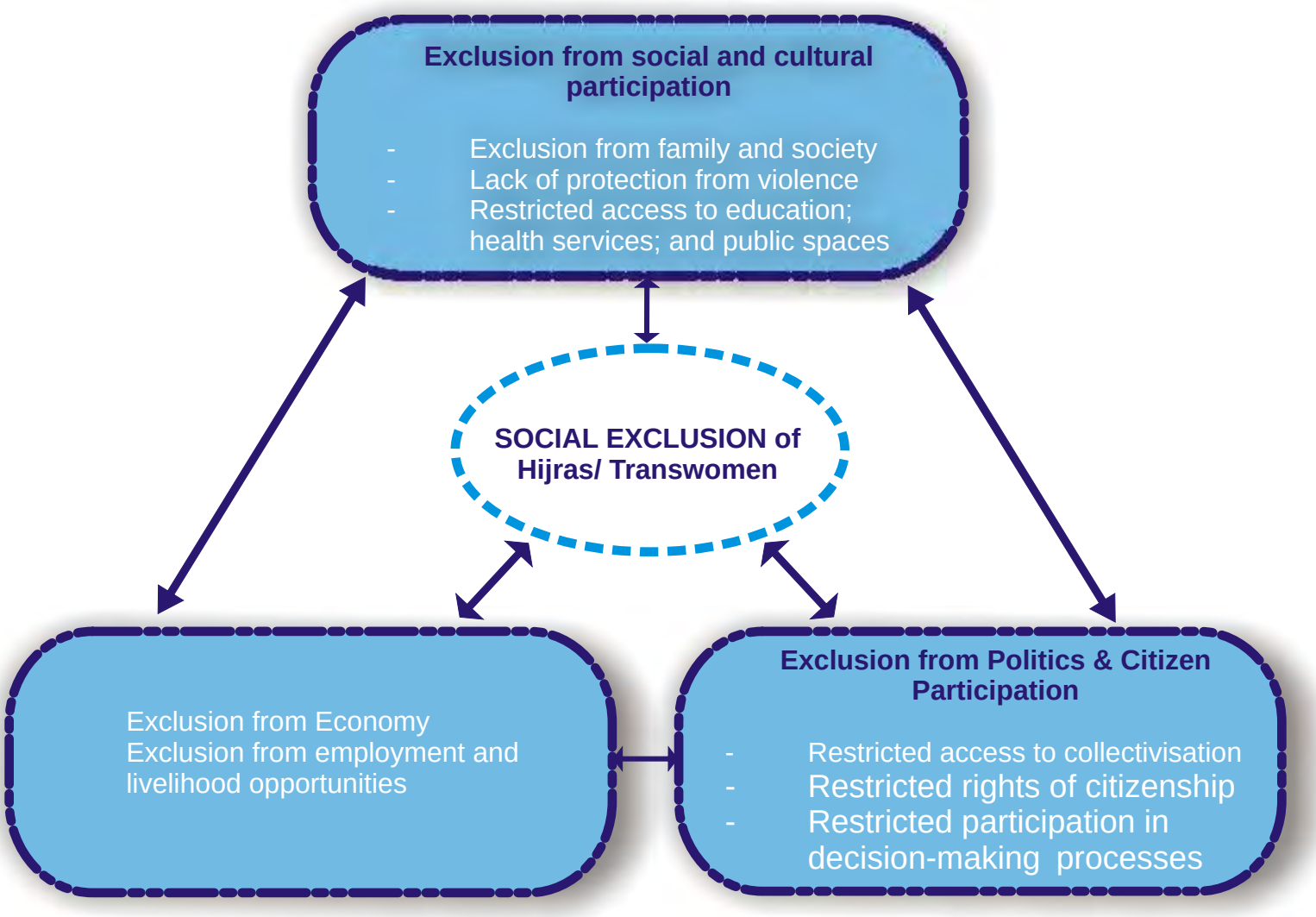
Only in the state of Tamil Nadu free SRS is performed in select government hospitals. Majority of Hijras/TGs could not afford to pay private plastic surgeons who charge heavily. Thus, most Hijras resort to unqualified medical practitioners for undergoing 'emasculation' (removal of entire male external genitalia). Getting 'emasculated' by a senior Hijra (called Thaiamma in Tamil Nadu) seems to be rare now. Due to bad surgical procedures adopted by unqualified medical practitioners (or quacks), 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. Even those Hijras who approach urologists for treatment of post-operative complications often have bad experiences; they report not receiving proper and prompt treatment even for post-operative (post-emasculation) wound infections.

3. SOCIAL EXCLUSION OF 'HIJRAS'/TRANSGENDER WOMEN

Social Exclusion Framework is increasingly used in highlighting the issues and problems faced by disadvantaged and disenfranchised groups. It provides a multidimensional and dynamic framework that focuses attention on both the causes and consequences of social disadvantage. Social Exclusion Framework is seen as having particular salience in addressing the barriers to meeting the Millennium Development Goals, particularly where these relate to exclusionary social relations and institutions.

Adapting the Social Exclusion Framework to Hijras/TG women, one can understand how TG communities have been excluded from effectively participating in social and cultural life; economy; and politics and decision-making processes. This section uses this framework to illustrate the multiple forms of oppression faced by Hijras/TG communities.

Diagram 1. Social exclusion of Hijras and Transgender women



A. EXCLUSION FROM SOCIAL AND CULTURAL PARTICIPATION

Exclusion from family and society

In general, Indians tolerate, accept, and respect a wide range of differences in cultures, religions, languages, and customs. Despite Indian society's general climate of acceptance and tolerance, there appears to be limited public knowledge and understanding of samesex sexual orientation and people whose gender identity and expression are incongruent with their biological sex. Human rights violations against sexual minorities including the transgender communities in India have been widely documented.

Most families do not accept if their male child starts behaving in ways that are considered feminine or inappropriate to the expected gender role. Consequently, family members may threaten, scold or even assault their son/sibling from behaving or dressing-up like a girl or woman. Some parents may outright disown and evict their own child for crossing the prescribed gender norms of the society and for not fulfilling the roles expected from a male child. Parents may provide several reasons for doing so: bringing disgrace and shame to the family; diminished chances of their child getting married to a woman in the future and thus end of their generation (if they have only one male child); and perceived inability on the part of their child to take care of the family. Thus, later transgender women may find it difficult even to claim their share of the property or inherit what would be lawfully theirs. Sometimes, the child or teenager may decide to run away from the family not able to tolerate the discrimination or not wanting to bring shame to one's family. Some of them may eventually find their way to Hijra communities. This means many Hijras are not educated or uneducated and consequently find it difficult to get jobs. Moreover, it is hard to find people who employ Hijras/TG people.

Some members of the society ridicule gender-variant people for being 'different' and they may even be hostile. Even from police, they face physical and verbal abuse, forced sex, extortion of money and materials; and arrests on false allegations. Absence of protection from police means ruffians find Hijras/TG people as easy targets for extorting money and as sexual objects. A 2007 study documented that in the past one year, the percentage of those MSM and Hijras (n=75) who reported: forced sex is 46%; physical abuse is 44%; verbal abuse is 56%; blackmail for money is 31%; and threat to life is 24%.

Discrimination in healthcare settings

Hijras face discrimination even in the healthcare settings. Often, healthcare providers rarely had the opportunity to understand the sexual diversities and they do not have adequate knowledge about the health issues of sexual minorities. Thus, TG people face unique barriers when accessing public or private health services. Barriers in accessing HIV testing, antiretroviral treatment and sexual health services have been well documented.

Types of discrimination reported by Hijras/TG communities in the healthcare settings include: deliberate use of male pronouns in addressing Hijras; registering them as 'males' and admitting them in male wards; humiliation faced in having to stand in the male queue; verbal harassment by the hospital staff and co-patients; and lack of healthcare providers who are sensitive to and trained on providing treatment/care to transgender people and even denial of medical services. Discrimination could be due to transgender status, sex work status or HIV status or a combination of these[23].

B. EXCLUSION FROM ECONOMIC PARTICIPATION AND LACK OF SOCIAL SECURITY

Hijras/TG communities face a variety of social security issues. Since most Hijras run away or evicted from home, they do not expect support from their biological family in the long run. Subsequently, they face a lot of challenges especially when they are not in a position to earn (or has decreased earning capacity) due to health concerns, lack of employment opportunities, or old age. . Some of the important issues and concerns faced by Hijras/TG communities in relation to social security measures are given below.

Lack of livelihood options

Most employers deny employment for even qualified and skilled transgender people. Sporadic success stories of self-employed Hijras who run food shops, or organise cultural programs are reported in some states. However, those are exceptions. Lack of livelihood options is a key reason for a significant proportion of transgender people to choose or continue to be in sex work - with its associated HIV and health-related risks. Recently, there have been isolated initiatives that offer mainstream jobs to qualified TG women such as agents for Life Insurance Corporation of India.

Lack of specific social welfare schemes and barriers to use existing schemes

Social welfare departments provide a variety of social welfare schemes for socially and economically disadvantaged groups. However, so far, no specific schemes are available for Hijras except some rare cases of providing land for Aravanis in Tamil Nadu. Recently, the state government of Andhra Pradesh has ordered the Minority Welfare Department to consider 'Hijras' as a minority and develop welfare schemes for them. Stringent and cumbersome procedures need for address proof, identity proof, and income certificate all hinder even deserving people from making use of available schemes. In addition, most Hijras/TG communities do not know much about social welfare schemes available for them. Only the Department of Social Welfare in the state of Tamil Nadu has recently established 'Aravanigal/Transgender Women Welfare Board' to address the social welfare issues of Aravanis/Hijras (See box 3). No other state has replicated this initiative so far.

Lack of access to Life and Health insurance schemes

Most Hijras are not under any life or health insurance schemes because of lack of knowledge; inability to pay premiums; or not able to get enrolled in the schemes. Thus, most rely on the government hospitals in spite of the reality of the pervasive discrimination.

C. EXCLUSION FROM POLITICAL PARTICIPATION

Legal, civil, and political rights

In 1871, the British enacted the Criminal Tribes Act, 1871, under which certain tribes and communities were considered to be 'addicted to the systematic commission of non-bailable offences'. These communities and tribes were perceived to be criminals by birth, with criminality being passed on from generation to generation. In 1897, the Criminal Tribes Act of 1871 was amended and under the provisions of this statute, “a eunuch [was] deemed to include all members of the male sex who admit themselves or on medical inspection clearly appear, to be impotent”. The local government was required to keep a register of the names and residences of all the eunuchs who are “reasonably suspected of kidnapping or castrating children or of committing offences under Section 377 of the Indian Penal Code. And “any eunuch so registered who appear dressed or ornamented like a woman in a public street…..or who dances or plays music or takes part in any public exhibition, in a public street……[could] be arrested without warrant and

Hijras were also reportedly harassed by police by threatening to file a criminal case under Sec-377 IPC. In July 2009, the Delhi High Court ruled that consensual same-sex relations between adults in private cannot be criminalized. Soon after that judgement, appeals in the Indian Supreme court objecting to the ruling were lodged; the Indian government has yet to submit a formal response.

Legal issues can be complex for people who change sex, as well as for those who are gender-variant. Legal issues include: legal recognition of their gender identity, same-sex marriage, child adoption, inheritance, wills and trusts, immigration status, employment discrimination, and access to public and private health benefits. Especially, getting legal recognition of gender identity as a woman or transgender woman is a complicated process. Lack of legal recognition has important consequences in getting government ration (food-price subsidy) shop card, passport, and bank account.

Transgender people now have the option to vote as a woman or 'other'. However, the legal validity of the voter's identity card in relation to confirming one's gender identity is not clear. Hijras had contested elections in the past. It has been documented that the victory of a transgender person who contested in an election was overturned since that person contested as a 'female', which was thus considered a fraud and illegal. Thus, the right to contest in elections is yet to be realised.

Challenges in collectivisation and strengthening community organisations

A recent mapping study showed that only 103 organizations and networks (that include agencies providing services for MSM) were found to be working with transgender people in India[32]. Even among these, only half (46/103) of these organisations are community-owned organisations. Given the importance given by the government to CBOs in leading the HIV responses, one would expect Hijras/TG people not to face any problems in forming or sustaining organisations of their own. Experiences of these communities suggest otherwise. Many have faced a lot of challenges in community mobilisation and legally registering their organisations.

Stringent registration and legal procedures

Some of the legal provisions (e.g., Indian Trust Act, Societies registration Act) that enable a group of individuals to form a legal association pose challenges for Hijras/TG communities. For example, the need of address proof and identity proof of all members of the group is the basic requirement to register an association. However, most Hijras/TG do not have identity and/or address proof or because they have documents only with their male identity. Similarly, opening a joint bank account to carry out financial transactions of their association proves to be difficult.

Lack of sensitivity among public department officials

In spite of the above challenges, a few CBOs of Hijras across India were able to meet the legal requirements for registration. However, Hijras reportedly had issues with the government officials who are in-charge of processing the registration formalities they were asked unnecessary and irrelevant queries and there was unnecessary delay

Buying or hiring office space

Hiring an office space for the legal association is very difficult. Even if they get one, the landlords quote unfair rent prices.

Lack of funding support

Hijras/TG associations rarely get external financial support. Even those funders who might want to support primarily want to fund for HIV prevention activities. Through the National AIDS Control Programme, only a few CBOs of TG/Hijras have been granted TI projects[33].

Need for community systems strengthening

Many of the existing Hijra/TG organizations lack basic systems that are essential for effectively running an organization. It is crucial that the capacity of these organisations be enhanced for effective community mobilisation and providing quality services.

Box 3. Tamil Nadu Aravanigal (Transgender women) Welfare Board: A landmark initiative

In a pioneering effort to address the issues faced by transgender people, the government of Tamil Nadu (a state in South India) established a transgender welfare board in April 2008. It is the first of its kind by any state government in India. Social Welfare minister serves as the president of the board. This effort is touted to be the first in India and even in the whole Asia-pacific region. The board would potentially address a variety of concerns of transgender people that includes education, income generation and other social security measures. As a first step, the board has conducted the enumeration of Transgender populations in all 32 districts of Tamil Nadu and in some places identity cards - with the gender identity mentioned as “Aravani” - are being issued[34]. The government has also started issuing ration cards (for buying food and other items from government-run fair-price shops) for transgender people. In addition, Tamil Nadu government issued a government order in May 2008 to enrol transgender people in government educational institutions and to explicitly include 'other' or 'third gender' category in the admission forms[35]. Furthermore, only in the state of Tamil Nadu, in collaboration with the Tamil Nadu Aravanigal Welfare Board, free sex reassignment surgery is performed for Hijras/TG in select government hospitals.

4. RECOMMENDATIONS

Multiple problems are faced by Hijras/TG, which necessitate a variety of solutions and actions. While some actions require immediate implementation such as introducing Hijra/TG-specific social welfare schemes, some actions need to be taken on a long-term basis changing the negative attitude of the general public and increasing accurate knowledge about Hijra/TG communities. The required changes need to be reflected in policies and laws; attitude of the government, general public and health care providers; and health care systems and practice. Key recommendations include the following.

1. **Address the gaps in NACP-III:** establish HIV sentinel serosurveillance sites for Hijras/TG at strategic locations; conduct operations research to design and fine-tune culturally-relevant package of HIV prevention and care interventions for Hijras/TG; provide financial support for the formation of CBOs run by Hijras/TG; and build the capacity of CBOs to implement effective programmes[2].
2. Move beyond focusing on individual-level HIV prevention activities to **address the structural determinants of risks and mitigate the impact of risks.** For example, mental health counselling, crisis intervention[3] (crisis in relation to suicidal tendencies, police harassment and arrests, support following sexual and physical violence), addressing alcohol and drug abuse, and connecting to livelihood programs all need to be part of the HIV interventions.
3. **Train health care providers to be competent and sensitive** in providing health care services (including STI and HIV-related services) to Hijras/TG as well as develop and monitor implementation of guidelines related to gender transition and sex reassignment surgery (SRS).
4. Clarify the ambiguous legal status of sex reassignment surgery and provide **gender transition and SRS services** (with proper pre- and post-operation/transition counselling) for free in public hospitals in various parts of India.
5. Implement **stigma and discrimination reduction measures** at various settings through a variety of ways: mass media awareness for the general public to focused training and sensitization for police and health care providers.
6. Develop action steps toward taking a position on **legal recognition of gender identity of Hijras/TG** need to be taken in consultation with Hijras/TG and other key stakeholders. Getting legal recognition and avoiding ambiguities in the current procedures that issue identity documents to Hijras/TG are required as they are connected to basic civil rights such as access to health and public services, right to vote, right to contest elections, right to education, inheritance rights, and marriage and child adoption.
7. Open up the existing **Social Welfare Schemes** for needy Hijras/TG and create specific welfare schemes to address the basic needs of Hijras/TG including housing and employment needs.
8. Ensure **greater involvement of vulnerable communities including Hijras/TG** women in policy formulation and program development.

Hijras/Transgender women require understanding and support of the government, health care professionals, general public as well as their family members. We need to understand and accept that humans are diverse. People have the right to be what they are and what they want to be. For transgender people, the same holds true.

1 Recently, UNDP-India has commissioned preparation of Hijras/TG-specific targeted HIV intervention guidelines.
2 Support for some Hijra/TG CBOs are likely to be available from the Global Fund (GFATM) Round-9 through the principal recipient India HIV/AIDS Alliance.
3 Again, some CBOs may be supported for offering these services through the Global Fund Round-9
4 National Legal Services Authority has proposed to provide free legal aid to transgender people and to initiate legal literacy classes on the rights of Transgender people in January 2011.

5. GLOSSARY

Hijras
Hijras are biological males who reject their 'masculine' identity in due course of time to identify either as women, or “not-men”, or “in-between man and woman”, or “neither man nor woman”. Hijras can be considered as the western equivalent of transgender/transsexual (male-to-female) persons but Hijras have a long tradition/culture and have strong social ties formalized through a ritual called “reet” (becoming a member of Hijra community). There are regional variations in the use of terms referred to Hijras. For example, Kinnars (Delhi) and Aravanis (Tamil Nadu) (See below). Hijras may earn through their traditional work: 'Badhai' (clapping their hands and asking for alms), blessing new-born babies, or dancing in ceremonies. Some proportion of Hijras engage in sex work for lack of other job opportunities, while some may be self-employed or work for non-governmental organisations.

Aravanis and 'Thirunangi'
Hijras in Tamil Nadu identify as “Aravani”. Tamil Nadu Aravanigal Welfare Board, a state government's initiative under the Department of Social Welfare defines Aravanis as biological males who self-identify themselves as a woman trapped in a male's body. Some Aravani activists want the public and media to use the term 'Thirunangi' to refer to Aravanis.

Kothi
Kothis are a heterogeneous group. 'Kothis' can be described as biological males who show varying degrees of 'femininity' - which may be situational. Some proportion of Kothis have bisexual behavior and get married to a woman. Kothis are generally of lower socioeconomic status and some engage in sex work for survival. Some proportion of Hijra-identified people may also identify themselves as 'Kothis'. But not all Kothi-identified people identify themselves as transgender or Hijras.

Jogtas/Jogappas[37]
Jogtas or Jopgappas are those persons who are dedicated to and serve as a servant of Goddess Renukha Devi (Yellamma) whose temples are present in Maharashtra and Karnataka. 'Jogta' refers to male servant of that Goddess and 'Jogti' refers to female servant (who is also sometimes referred to as 'Devadasi'). One can become a 'Jogta' (or Jogti) if it is part of their family tradition or if one finds a 'Guru' (or 'Pujari') who accepts him/her as a 'Chela' or 'Shishya' (disciple). Sometimes, the term 'Jogti Hijras' is used to denote those male-to-female transgender persons who are devotees/servants of Goddess Renukha Devi and who are also in the Hijra communities. This term is used to differentiate them from 'Jogtas' who are heterosexuals and who may or may not dress in woman's attire when they worship the Goddess. Also, that term differentiates them from 'Jogtis' who are biological females dedicated to the Goddess. However, 'Jogti Hijras' may refer to themselves as 'Jogti' (female pronoun) or Hijras, and even sometimes as 'Jogtas'.

Shiv-Shakthis
Shiv-Shakthis are considered as males who are possessed by or particularly close to a goddess and who have feminine gender expression. Usually, Shiv-Shakthis are inducted into the Shiv-Shakti community by senior gurus, who teach them the norms, customs, and rituals to be observed by them. In a ceremony, Shiv-Shakthis are married to a sword that represents male power or Shiva (deity). Shiv-Shaktis thus become the bride of the sword. Occasionally, Shiv-Shakthis cross-dress and use accessories and ornaments that are generally/socially meant for women. Most people in this community belong to lower socio-economic status and earn for their living as astrologers, soothsayers, and spiritual healers; some also seek alms.

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