

Pushed to the Margins: Post-diagnosis Experiences of *Hijra* (Transgender) Sex Workers Living with HIV Infection

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Sexual health rights of *hijra* (transgender) sex workers are not usually given due attention by the conventional frameworks of AIDS intervention in Pakistan. This study examines the perceptions and experiences of HIV infected HSWs regarding their post-diagnosis identity, sexual conduct with clients, religious life, and social support system. In-depth interviews were conducted with the HSWs residing in Lahore city, Pakistan. Purposive sampling technique was used to select the study participants. Data was analyzed using thematic analysis technique. The study found that the diagnosis of HIV infection adds to the social stigmatization of HSWs and further declines their social standing. *Hijras* usually carry on with paid sex after being diagnosed with HIV infection. There is less sensitivity among HSWs about the use of condom and other precautionary measures, while having sex. Many clients continue to have sex with HSWs despite knowing about their illness. In the post-diagnosis phase, *hijras* are likely to experience humiliating behavior of their fellow *hijras*. As a result, these *hijras* tend to avoid interaction within their community setting and face isolation after being diagnosed with HIV. The

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study recommends that collaborated efforts and concentrated actions are needed from the governmental bodies and law making authorities to ensure human rights for *hijras*. Also, there is a dire need to raise community awareness among *hijras* regarding HIV/AIDS through awareness campaigns and AIDS control programs.

Keywords. *Hijra*, transgender, sex workers, HIV, discrimination, Pakistan

AIDS is one of the most serious health challenges in contemporary world. At the end of 2015, there were around 36.7 million individuals living with HIV/AIDS. Latest estimates by UNAIDS show that around 35 million people have died from AIDS since the start of epidemic. In 2015, nearly 2.1 million new cases were identified globally that were reduced from 3.4 million in 2001 (UNAIDS, 2016). During recent years, there have been considerable efforts by the global health community and civil society organizations to address HIV related illness and create awareness among masses (Friedland, 2016). HIV virus can be controlled through effective treatment nowadays. However, despite scientific advancements in prevention and treatment of HIV, most people living with HIV do not have access to health care system. An overwhelming majority of HIV infected people are living in low and middle income countries of the world (UNAIDS, 2016).

HIV/AIDS and Stigmatization

There is substantial evidence available about the stigmatization of HIV infected individuals in all parts of the world (Khan & Khan, 2010). High stigmatization associated with HIV/AIDS is due to the fears attached with this disease; HIV/AIDS is taken as a threat to people's safety and health (Pryor & Reeder, 1993). In 1991, a survey was conducted in which 20.5% of the respondents cited that HIV infected individuals got what they deserved. In 1997, the number of respondents who agreed to the same statement was increased to 40%. And 55.1% of the respondents agreed to a less harsh statement that HIV infected individuals were themselves responsible for their illness. In addition to this, people who get infected through sex and injection drugs are more likely to face rejection from society than those who contract infection through blood transfusion (Herek & Capitanio, 1999). Moreover, it is evident from the previous studies that homosexual HIV infected individuals are more stigmatized compared with heterosexual individuals even if the route of getting infection is

same in them that is sexual contact with multiple sex partners (Anderson, 1992; Fish & Rye, 1991; Murphy-Berman & Berman, 1993).

Sex Workers and HIV/AIDS

Sex work is commonly known as exchange of sex for financial benefits. The framework of sex work might vary in different parts of the world; it may operate independently or through some controllers or managers. They may operate through bars, brothels, saunas or in public places like parks, roads or festivals. Nowadays, many sex workers operate through internet (Harcourt & Donovan, 2005). There are many groups of population that are involved in sex work. These groups include men, women, and transgender (Jami, 2005). In Pakistan, it is indicated in national surveillance data that 60 million sexual acts are sold to 30 million clients each year (Khan & Khan, 2010). Sex work is a profession which is rarely opted willfully and is associated with a number of risks including stigma and discrimination attached with this profession (Rekart, 2005). According to UNAIDS estimation, less than 50% of the sex workers worldwide are covered by current HIV preventive programs despite of increasing number of initiatives in this field (UNAIDS, 2016). Sex workers have limited access to preventive health, HIV and other STIs services, and treatment; which increases the risk of HIV infection among them. Other factors which contribute in prevalence of HIV/AIDS among sex workers include poverty, discrimination, social exclusion, and lack of empowerment to negotiate safer sex practices (Friedland, 2016). Availability of safer work places, increased promotion, and use of condom and empowerment of sex workers may contribute to reduce the risk of HIV infection among them (Baral et al., 2012).

Transgender Communities and HIV/AIDS

Transgender communities have historical existence in many societies and represent all the racial, ethnic, and religious backgrounds. They are identified differently in different cultures, such as *xaniths* in Oman, *bakla* in Philippines, *serrers* in Kenya and *hijra*, *jogappas*, *jogtaor shiv-shaktis* in South Asia. *Hijras*, also known as third gender or eunuchs, have long been existed in Indian subcontinent (Reddy, 2003). While, the visibility of transgender communities is increasing with time, they continue to face severe discrimination, stigmatization, and inequality in most of the societies. Insecurities and deprivations of transgender communities have long been neglected in development agendas. They are usually deprived of basic citizenship

rights, especially, in the developing world, and cannot mostly benefit from the social and legal services because of their marginalized status (Abdullah et al., 2012). Provision of their sexual rights has, especially, been a challenge in most of the developing world (Khan et al., 2009a). It is indicated by recent data that HSWs (HSWs) are major contributing factors for spread of a number of sexually transmitted infections (STIs). Specifically, the risk HIV prevalence potentially increases when men have sex with men because it involves anal sex and unprotected anal sex carries high risk of HIV infection transmission. Almost 5 to 10% of HIV infections occur through sex between men worldwide because men who have sex with men may also have sex with women and if they are infected they can transmit infection to their female partners or wives (United Nations Program on HIV/AIDS, 2006).

Transgender Community in Pakistan and HIV Stigmatization

History of transgender people in Pakistan has its roots back in sixteenth century of *Mughal* era, where transgender, mainly castrated males and eunuchs, were employed in royal court for taking care of *harem*. The transfer of rule from the *Mughals* to the British in mid nineteenth century also brought momentous change in the standing of transgender community. The British applied Penal Code 1860 and Criminal Tribes' Act 1871, which catalyzed the process to diminish the social sphere of transgender community (Pamment, 2010). In South Asian region, specifically in India, Pakistan and Bangladesh, the term "*hijra*" is most commonly used for transgender that explains a distinctive gender where men behave like women. *Hijra* is a comprehensive term which encompasses all forms including bisexuals, hermaphrodites, cross dressers, homosexuals or transgender. *Hijras* are further categorized as *zanana*, a biological male who identifies as a female; *narban*, a castrated man; and *khusra*, eunuch or one born with a sexual deformity (Jami, 2005). In Pakistan, for a long time, *hijras* were not allowed to have national identity cards. A few years ago, the Supreme Court of Pakistan approved the registration of *hijras* as Pakistani nationals with a right to vote (Abdullah et al., 2012).

In contemporary Pakistan, *hijras* live in highly organized communities, usually led by a *guru* (a teacher or a leader). These communities adopt young boys, who are disowned by their families or who left their homes willfully, to continue their own legacy. *Hijras* have long been earning through singing and dancing at weddings, festivals, and births. Social acceptance of *hijras* in Pakistan decreased

with time that pushed them to start begging in streets and consequently they got attached with paid sex (Altaf, Zahidie, & Agha, 2012). Hence, they became vulnerable to STIs and their transmission. Hijra sex worker (HSW) is the term used for those who recognize them as *hijras* and sell sex for financial interests (Altaf, Abbas, & Zaheer, 2008). In socio-religious context of Pakistan, sex work is subjected to severe stigmatization and discrimination and social unacceptability further increases with homosexuality (Rekart, 2005). Social exclusion is a significant issue with reference to discriminating treatment of *hijras* (Rehan, Chaudhry, & Shah, 2009).

According to National AIDS Control Program (2011), there are about 23,317 HSWs in fourteen big cities of Pakistan who are involved in sex trade. Furthermore, the HIV epidemic has increased many folds in Pakistan with the involvement of commercial sex (Abdullah et al., 2012). According to National HIV Surveillance of 2008, 6.4% of HIV prevalence was estimated among HSWs. In 2011, HIV infection was 7.2% prevalent among HSWs and 3.1% among male sex workers (MSWs) in Pakistan, which demonstrates recent elevation of infection (National AIDS Control Program, 2011). Although the heterosexual activities are the major source of sexual transmission of HIV infection, homosexual activities contribute in its spread. Another reason for this rapid increase lies in the fact that sex outside marriage, commercial sex and sodomy are considered criminal under *Hudood Ordinance* 1979 and the convict is liable to punishments that include lashing and death by stoning. Consequently, sex workers have to hide themselves and adopt unsafe sexual practices due to limited access to health services and health service providers (Thompson et al., 2013). HIV epidemic is found to be an important factor responsible for social exclusion of *hijras* in Pakistan (United Nations, 2007).

In Pakistan 97% of population is Muslim. According to socio-religious customs extra marital sexual practices are strongly prohibited. Particularly, after the introduction of *Hudood* laws in 1979 for prevention and punishment of promiscuity commercial sex went undercover due to crackdown campaigns for shutting down brothels and red-light areas (Khan & Khan, 2010). Consequently, commercial sex evolved from conventional brothel-based framework to more diverse and easy to access pattern. Now sex workers including female, male and HSWs approach their clients in public places like parks, streets and roads (Altaf et al., 2008). Some of them also operate at their homes. Term "*Kotikhana*" is used for the place from where a female sex worker operates and "*Dera*" is commonly referred to work place of a *hijra* sex worker. Recent estimates reveal that only 23% of

female and HSWs operate through red-light areas or brothels (Khan & Khan, 2010). Studies from Thailand and other parts of the world indicate that clients of sex workers may serve as source of transmission of HIV infection from high-risk groups to the general public (Morris, Podhisita, Wawer, & Handcock, 1996; Shah et al., 2011) as many male clients of HSWs have girlfriends or married or have contact with female sex workers. However, in South Asia, there is not even a single published research which addresses the clientage process of HSWs (Qian, Altaf, Cassell, Shah, & Vermund, 2011). Furthermore, there is a dearth of literature in Pakistani context regarding post-diagnosis sexual conduct of HSWs, especially in terms of their involvement with clients after knowing the repercussions of having unsafe sex. Additionally, in highly religious society of Pakistan, there is a need to conduct more research to examine the trends among HSWs to adopt religious coping against life threatening disease like AIDS. It will be important to see how HSWs negotiate between religion and their sexual conduct during the post-diagnosis phase. In order to address these gaps and add to the existing body of literature, this study attempts to examine the views of HSWs regarding their self-image after being diagnosed with HIV positive. The study furthermore explores the post-diagnosis sexual conduct of HSWs, their religious and spiritual life, and the clientage process they adopt in order to examine their feelings towards stigma and discrimination.

Method

Research Design

The researchers adopted qualitative research methods to know the views and experiences of HIV infected HSWs about their post-diagnosis identity, sexual conduct with clients, and social support system. We used interpretive approach for a deeper and richer insight into the social aspects of HIV/AIDS associated with HSWs (Silverman, 2001). Semi-structured in-depth interviews were conducted with the HSWs of different age groups diagnosed with HIV/AIDS. Using an inductive approach, a theory was developed through the analysis of the data collected during fieldwork (Mason, 2017).

Selection of the Participants

The participants were traced through an AIDS diagnostic center being run by an NGO in Lahore. A '*guru*' *hijra*, working as a

volunteer at the diagnostic center, was approached to get access to the HSWs infected with HVI-AIDS. Initially, 24 *hijras* were contacted who met the criteria for the selection of participants; 16 of them agreed to participate in study. Purposive sampling technique was used to select the study participants. Criteria for their selection included age, post-diagnosis time period, and HIV status. Only the *hijras* with HIV positive, at least one year of post-diagnosis, and above eighteen years of age comprised the sample. All of the participants were HIV positive with 18-55 years of age. The majority of them (14 of 16) were involved in paid sex after being diagnosed with HIV.

Table 1

Demographic Characteristics of Sample (N = 16)

Characteristics	<i>f</i>
Age	
18-35	7
36-55	9
Education level completed	
Illiterate	11
Primary	3
Middle	1
Secondary	1
HIV status	
Acute HIV infection stage	0
Clinical latency stage	12
AIDS	4
Duration of diagnosis	
More than 1 year	6
More than 2 years	7
More than 3 years	2
More than 4 years	1
Post-diagnosis paid sex	
Yes	11
No	5

In-depth Interviews

The researchers conducted sixteen in-depth interviews of the selected participants in order to generate qualitative data. An interview guide was designed comprising of the major themes and questions to be explored, which mainly revolved around the feelings, perceptions and experiences of HSWs concerning their post-diagnosis phase. Questions regarding post-diagnosis identity, sexual conduct,

community support, and their religious and spiritual life were asked. For example, in one of the question the researchers asked “please tell about the behavior of your fellow *hijras* after it was revealed that you have AIDS.” Similarly in another question, the researchers inquired “what do you think about your appearance and the physical changes in you after HIV infection.” Interview guide was pilot tested before conducting actual interviews; changes were made in the interview guide after the pilot testing. Digital voice recorders were used to ensure the smooth and dynamic development of the interviews and to capture the full details of conversation. However, almost half of the interviews (7 of 16) were not voice recorded on the request of the participants. Field diaries were used to take written notes for unrecorded interviews. Interviews were conducted in *Punjabi* and *Urdu* languages and ranged from 45 minutes to one and half hour.

Ethical Considerations

The study participants were informed about the purpose and specifics of study and possible use of the data collected through interviews. Their verbal consent was taken to participate in study. Additionally, the time and place for an interview was also decided beforehand as per their consent and convenience. Before starting an interview, the participants were informed about expected duration of an interview and that they were free to withdraw at any stage. Furthermore, the researchers strictly ensured the confidentiality and privacy of the data obtained from the participants during the process of data collection and data analysis. Names of the participants were changed, by giving them the alternative names, in order to ensure their anonymity (Neuman, 2013).

Data Analysis

Thematic analysis technique was used for analyzing data through the process of organizing, general sense making, coding and drawing themes. Finally, data was interpreted by making meanings out of the collected data (Creswell & Creswell, 2017). After the fieldwork, all the interviews were transcribed and translated from *Urdu* to English. Transcriptions were carefully read and reread in order to comprehend the basic codes. In total 40 codes were identified including post-diagnosis identity, body image, sex life, clients, clientage process, fellow *hijras*, community support, spirituality, and religion. A code list was prepared using the data from four interviews and given a name and a concise definition to each code. The researchers developed

a set of standard rules for coding procedure to achieve inter-coder agreement. Inter-coder agreement refers to consensus among multiple researchers who are coding a data set. In order to see inter-coder agreement, transcript of same interview was given to all the researchers and they were asked to code data. Code titles and definitions were further refined after this practice. The final coding list helped to code the remaining twelve transcripts. Coded data was clustered in different categories in order to develop themes for analysis (Bailey, 2008).

Findings

In order to facilitate the data analysis, the findings of study are organized under following major themes: Post-diagnosis identity and body image; sexual conduct and clientage process; religious and spiritual life; and social support system.

Post-diagnosis Identity and Body Image

Nearly all of the study participants (14 of 16) were concerned about their status as citizen due to their nonconformist sexual conduct in the socio-religious context of Pakistani society. Diagnosis of stigmatized disease as of HIV further declines their social standing. K. Natasha (personal communication, January 15, 2016) summed up his feelings as *“people do not respect us just because we are neither men nor women. And if they know about AIDS, they make our life miserable by pushing us to the margins”*. Twenty years old B. Neeli (personal communication, January 22, 2016) shared her thoughts about his social status after being diagnosed with AIDS and said that *“Life was never easy for me but now it is like a bed of thorns.”*

In addition to their social status, the study participants were worried about their appearance and the physical changes after HIV infection. The changes were visible enough to catch the attention of other people and made them curious to investigate about the reason behind it. A thirty five years old participant T. Sonia (personal communication, January 24, 2016) said that *“I look dull and unattractive now. People usually ask me why I do not look fresh and I do not like talking about my illness with every other person though I have to tell them when they deeply investigate”*. There was only one participant who was not concerned about his physical changes after the disease. Twenty years old B. Neeli (personal communication, January 22, 2016) at clinical latency stage shared his thoughts: *“I don’t think that AIDS has affected my appearance. I consider myself as attractive and charming as I used to feel before diagnosis. Only difference I feel is the early fatigue and tiredness”*.

The study participants talked about different misconceptions among common people regarding the route of transmission of HIV/AIDS. For example, it was shared that, it is commonly believed that AIDS can spread through casual contact, by shaking hands, sharing meals or simply by talking to HIV infected individual. It is specifically linked with the commercial sex work and having multiple sex partners. People distance themselves from the individuals with HIV infection. The majority of participants (12 of 16) reported humiliating behavior of people after knowing about their illness. Thirty three years old S. Rekha (personal communication, January 15, 2016) shared his feelings and said that: *“People treat us like animals and openly express their hatred. Their disrespectful behavior really hurts. They consider AIDS a transmittable disease that might damage their health as well”*. Similarly, a twenty two years old participant K. Natasha (personal communication, January 15, 2016) mentioned that: *“People do not talk; they stab my heart. They insult me for being sinful, like I got infected with AIDS by myself. They should know that one responsible for my sinful disease comes from their virtuous clan”*.

Post-diagnosis Sexual Conduct and Clientage Process

Most of the study participants (12 of 16) revealed that the social discrimination compelled them to become a part of *hijra* community. Contrary to them, a few of the participants (4 of 16) willfully joined and gradually adopted commercial sex. Almost all of them (14 of 16) were still involved in paid sex after being diagnosed with HIV/AIDS. They told that paid sex is the source of livelihood for them, and therefore, despite having HIV infection they continued with paid sex. Twenty nine years old P. Baali (personal communication, January 24, 2016) said that *“my presence at home was cause of embarrassment for family. So, father brought me here. I gradually accepted the realities of this community and opted for commercial sex. I couldn’t quit my profession, even though it has caused me AIDS”*. The study also revealed sexual harassment and forceful sexual acts against *hijras*. S. Rekha (personal communication, January 15, 2016) shared that *“sometimes people take us forcefully while begging at roadside and rape us without knowing about our illness”*. When asked about forced sex, HSWs told that people take benefit of their poverty, vulnerability, and inability to report sex crime against them.

While talking about the process of clientage, the participants mentioned that they were being approached by their clients, while begging at roadside or performing at events like weddings. Most of

them (13 of 16) said that they always reveal their illness to their clients before having sex. Twenty nine years old P. Baali (personal communication, January 24, 2016) mentioned that *“people take my mobile number while I am begging or performing on weddings and later on we negotiate money and place for sex. I always reveal my illness to them”*. Conversely, a few participants (3 of 16) hid their illness from clients, so that they are not deprived of an opportunity to earn money. The study showed that the commercial sex offered by HSWs is very cheap. The participants charged their customers between 150 to 1000 rupees per intercourse. When asked about offering cheap sex, HSWs told that the clients approaching them usually come from lower socio-economic class and they do not have much money to pay. Twenty three years old A. Resham (personal communication, January 22, 2016) said that *“most people bargain, I charge 500 to 800 rupees. They pay more to younger workers. My older fellows do it for as low as 150 to 200 rupees.”*

The study participants were less sensitive about the precautionary measures while having sex. P. Baali (personal communication, January 24, 2016), at clinical latency stage of HIV, stated that *“the use of condom is up to the customers. I will not be bothered if a customer does not use it.”* Only two participants were found to be aware about the importance of using condoms. Feelings of revenge and rage were observed among a few participants (3 of 16) as a reason for not having safe sex. Twenty years old C. Rani (personal communication, February 2, 2016) expressed her vengeful feelings and said that *“why should I use condom? I did not deserve HIV. I wish everyone who approaches me for sex gets infected”*. It was mentioned that most of the clients continue to have sex with HSWs, even after knowing about their illness. They only stress on the use of condoms. As previously mentioned HSWs considered that their clients generally come from lower economic classes and seek out cheap sex with *hijras*. They are usually less aware about the consequence of having sex with HIV infected HSWs. While sharing his experiences, F. Dolie (personal communication, February 9, 2016) told that *“they (clients) cannot help their urge for sex. Telling them about infection does not make any difference. They use condoms and have sex”*.

Decline of Community Support

The majority of participants (14 of 16) were being isolated and left alone within their community after being diagnosed with HIV/AIDS. They reported to face humiliating attitude of their fellow *hijras* because of the stigma attached with HIV. Twenty two years old

B. Neeli (personal communication, January 22, 2016) summarized his feeling of community exclusion: *"Everybody used to love me for my young age, bubblyness, and beauty but now they cannot tolerate my presence. I earn on my own and live on my own. I do not have community support"*. Further investigation revealed humiliating attitude of fellow *hijras* towards HIV positive HSWs. For example, E. Chanda (personal communication, February 16, 2016) shared his thoughts as follows:

Despite living in this community, I am no more part of it. I left sex and adopted the profession of giving massages to men. I also earn through performing on fairs. I feel very bad when my fellow *hijras* make fun of me by calling me *"malshan"* (masseur) and treat me as their servant.

Only two participants mentioned about the positive attitude of their fellow *hijras*. Thirty five years old T. Sonia (personal communication, January 24, 2016) said that *"everybody loves me like they loved me before. But now they treat me like a patient, which make me feel bad."* Another participant F. Dolie (personal communication, February 9, 2016), at advance stage of AIDS, mentioned that *"all are more sympathetic and loving towards me. They always encourage me to live with my full potential."*

Due to stigmatized behavior of fellow *hijras*, the majority (14 of 16) of HIV positive HSWs isolated themselves in order to avoid interaction with people displaying painful attitudes of. A 29 years old participant Z. Buble (personal communication, February 2, 2016), at advance stage of AIDS, said that *"I do not interact with other hijras of my community. They all are uncaring and cruel. I was nearly leaving this community, but then thought that being an AIDS patient I might not live a happy life anywhere."* It was observed that discriminatory behavior put nearly all the participants (14 of 16) in depression and anxiety. Consequently, this led them to indulge in drug abuse. Twenty four years old E. Chanda (personal communication, February 16, 2016) said that *"I kill my painful thoughts through drugs. This brings me to a world that is free of worries, fears, and tensions."* Only one participant, forty years old G. Chambeli (personal communication, February 9, 2016), was not a drug addict. He said that *"I never bother what people say. I know tension is not good for my health so I keep myself free from any painful thoughts."*

Post-diagnosis Religious and Spiritual Life

In the religious society of Pakistan, the trends of adopting spiritual and religious practices to cure the life threatening disease like AIDS are very common. The patients try to spiritually heal themselves through reciting holy verses and frequently visiting the holy places such as mosques and shrines. It has been observed that the patients find the peace of mind through connecting themselves to the God and performing religious rituals. The sample of this study included the Muslim HSWs; however, the majority of them (12 of 16) revealed insignificant association with the religion in their post-diagnosis phase. One of the participants shared his views saying that:

I offer prayers and visit tombs where mystic poetry and spiritual songs put my soul in another world filled with satisfaction. But I have not adopted this routine after being diagnosed with AIDS. I used to do it before my illness as well (S. Rekha, personal communication, January 15, 2016).

A few of the participants (4 of 16) reported to have increased inclination towards religion after being diagnosed with AIDS. They mentioned that the association with religion gives them hope and peace of mind. F. Dolie (personal communication, February 9, 2016) said that *"I have started to offer prayers regularly to develop a connection with God. I feel satisfied and believe that He will listen to my prayers and give me a healthy life soon."* On the other hand, a few of the participants (6 of 16) blamed God for their illness and found it less important to perform religious rituals to improve their mental stress caused by the disease. One of the participants at advance stage of AIDS said that:

I blame nobody but God to make me suffer from this disease. My punishment is far more than my sins. My miserable condition is a sign of God's unkindness. I do not offer prayers now because I feel that none of my noble acts could change my fate now. So it's all useless and wastage of time (Z. Buble, personal communication, February 2, 2016).

It has been found that an overwhelming majority of the participants (15 of 16) considered it a moral obligation to avoid sex, as it could possibly transfer the disease to others. However, the majority of them (14 of 16) admitted that they could not leave their profession because it is the source of livelihood for them.

Discussion

This study revealed that *hijras* in Pakistan do not fit into the mainstream society due to their deviant sexual identity. After being diagnosed with HIV/AIDS, they are further pushed to extreme margins of society. They experience double stigma of confronting prejudice based on their gender identity, while also coping with the societal bias against HIV infected people (Kowalewski, 1988). Similarly, a study conducted in Bangladesh revealed that the *hijras* go through strenuous situations to be recognized as *hijra* and to cross dichotomous sexual standards of society to find safe position within the mainstream society. Consequently, they are compelled to adopt unhealthy lifestyle exposing them to dangers like HIV/AIDS (Khan et al., 2009b).

In line with previous studies, the findings suggest that the *hijras* with HIV/AIDS are concerned about their deteriorating physical appearance, which seemed to be responsible for disclosure of their illness among people. This disclosure of illness makes them more vulnerable towards stigmatized behavior and subsequently increases their social exclusion. The reason behind discriminatory behavior of people is that HIV/AIDS is commonly perceived as a fatal, transmittable, and untreatable disease that spreads through casual contact with its patients. As a result, people tend to avoid interacting with patients of HIV-AIDS, which leads towards their social isolation and feelings of discrimination (Pryor & Reeder, 1993). Another reason for their social exclusion is the perception among common people that HIV infected patients deviate from established norms about sexual conduct. As a result, their social acceptance is reduced for not complying with moral values of society. It is important to consider that HIV-AIDS infection is already associated with socially deviant groups such as homosexuals and drug users (Herek & Capitanio, 1999). Thus, in case of HSWs, they experience double stigma; presence of AIDS provides a locus for studying the effects of a new stigma on an already stigmatized group that is *hijra* identity (Kowalewski, 1988).

Consistent with the previous research, the present study suggests that the clientage process of HSWs is simple and accessible. Clients approach HSWs through mobile phones, *gurus* and at public places like roads where they beg or events where they perform (Thompson et al., 2013). Moreover, HSWs offer cheap sex affordable for the majority of men population. According to a study, HSWs charge 100-200 rupees per intercourse in Pakistan (Khan, Rehan, Qayyum, & Khan, 2008). As indicated in other studies, condom use among HSWs

as well as among their clients is very low, which makes them vulnerable towards HIV/AIDS infection (Qian et al., 2011). The present study found that in Pakistani context, the clients of HSWs generally come from lower economic classes who seek out cheap sex with *hijras*. They are usually less aware about the consequence of having unsafe sex with HSWs that may result in AIDS.

The study findings reveal that most of the HSWs are rejected by their families and are compelled to join *hijra* community. Afterwards they adopt commercial sex as a source of their earning. It is evident from the previous researches that the *hijras* face social exclusion right from their childhood till old age. They are deprived of educational, occupational, and social opportunities and adopt commercial sex as the last resort of earning a livelihood (Abdullah et al., 2012). When infected with HIV positive, *hijras* face discriminating behavior within the *hijra* community as well, which results in development of negative emotions in them. Similarly, it has been revealed by various studies that AIDS patients with the passage of time develop the feelings of being socially isolated and rejected. Social stigmatization of such patients at times gives rise to extreme psychological stress among them that can possibly lead them to commit suicide (Habib & Rahman, 2010). Minority stress theory describes how interpersonal prejudice and dissemination results in high level of stress faced by the members of stigmatized minority group, like HSWs with HIV infection in Pakistan (Meyer, 2003). These stigmatizing behaviors may also lead HSWs towards isolation, drug abuse and high risk behaviors by demolishing their self-esteem and human dignity (Abdullah et al., 2012; Khan et al., 2009b). This study finds that drugs are used by HSWs as a coping strategy to handle emerging distress out of increased stigmatization.

Two types of religious and spiritual coping strategies that are “positive religious coping”, for example, seeking God’s love and asking for forgiveness; and “negative religious coping”, for example, expressing rage and anger and feelings of punishment from God were found in this study (Pargament, Smith, Koenig, & Perez, 1997). Previous studies indicate that religion and spirituality play important role in adding value and hope to the life of people suffering from HIV infection (Arnold, Avants, Margolin, & Marcotte, 2002; Richards, Acree, & Folkman, 1999), but the researchers have given little attention towards negative religious coping methods among people with HIV/AIDS (Jenkins, 1995).

Limitations and Suggestions

Clients of HSWs serve as source of transmission of HIV infection from high-risk group to the general public. However, there is a serious shortage of literature addressing the perspective of clients of HSWs. This study briefly deals with the clientage process from the sex workers' point of view. It is recommended to conduct more research that involves the views of clients of HSWs regarding risks of transmission of HIV infection.

Only the HSWs working in Lahore city were taken as sample in the present research. It is important to conduct more studies that include HSWs from smaller cities and remote areas. The problems of HSWs living in smaller cities and villages might be different and perhaps intense as compare to their counterparts living in cities like Lahore.

Religion and spiritually act as important coping strategies in different diseases including cancer, drug abuse, and HIV. This study briefly handles the themes of religion and spirituality in the life of HSWs in post-diagnosis phase of HIV infection. Considering that Pakistanis is a highly religious society, a more detailed study is needed to address the involvement of religion and spirituality in the life of HSWs with HIV infection.

Collaborated efforts and concentrated actions are needed from the governmental bodies and law making authorities to provide all human rights to *hijras* that are given to other citizens, so that they are not compelled to become a part of commercial sex industry.

There is a dire need to raise community awareness among *hijras* regarding HIV/AIDS through proper awareness campaigns and AIDS control programs.

Conclusion

In Pakistani context, *hijras* belong to an underprivileged, disadvantaged and socially excluded group of population. Due to deprivation of basic human rights, *hijras* are pushed to join commercial sex or paid sex. Commercial sex exposes them to a number of sexually transmitted infections (STIs) including HIV/AIDS. HIV/AIDS further marginalizes them not just in general society, but also within their very *hijra* community. Adding to this, feeling of isolation is supplemented by poor body image after being diagnosed with HIV infection. Because of lack of awareness regarding

HIV/AIDS, many misconceptions about route of transmission of HIV prevail among HSWs like spread of HIV through casual contacts. Consequently, they are further stigmatized within their own *hijra* community. Thus, with declined community support *hijras* are left with only one choice of paid sex for their living. Once infected with HIV, they serve as source of HIV transmission in general public through easy to access and cheap paid sex. The study found that the *hijras* usually carry on with commercial sex after being diagnosed with HIV infection. There is less sensitivity among HSWs about the use of condoms and other precautionary measures while having sex. Moreover, the study discovered both positive and negative religious coping strategies among HSWs with HIV/AIDS. Paid sex by HIV infected HSWs compromises the efforts to control transmission of HIV/AIDS among general public.

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