# Experience of The Hijra Community in Accessing Formal Healthcare in Dhaka City: An Exploratory Qualitative Study

Final Report of Summative Learning Project (SLP) presented to BRAC James P Grant School of Public Health, BRAC University

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# LIST OF ABBREVIATIONS

| | |
|---|---|
| IDI | In Depth Interview |
| KII | Key Informant Interview |
| NGO | Non-Governmental Organization |
| STI | Sexually Transmitted Infection |
| DIC | Drop-In-Center |
| CBO | Community Based Organization |
| NCD | Non-communicable Disease |
| UTI | Urinary Tract Infection |
| NID | National Identity Card |
| ECG | Electrocardiogram |
| SDG | Sustainable Development Goal |

# ABSTRACT

**Introduction:** The Hijra community experience social exclusion in Bangladesh. One of the key aspects of life is health. It is the right of the general population of a country to access formal healthcare services at the public and private healthcare facilities. The people of the *Hijra* community face numerous discriminatory challenges in accessing health services at the hospitals and other community clinics due to gender disparity even after they are legally recognized by the government at the 'Third Gender'.

**Objective:** To understand the experiences of the *Hijra* community members in accessing formal healthcare services.

**Method:** An exploratory qualitative method comprising of 26 In Depth Interviews (IDIs) and 5 Key Informant Interviews (KIIs) were conducted among the *Hijra* persons residing in different locations of Dhaka city. The data were analyzed by using coding strategies and thematic analysis.

**Finding:** The study findings revealed that the *Hijra* people commonly experience cold, fever, allergy, non-communicable diseases (NCDs), sexually transmitted infections (STIs) and insomnia. However, seeking formal healthcare for the mentioned health issues is a challenging experience for them due to lack of service provision for the third genders in the hospital premises, negligence and refusal to provide services by the care providers, verbal and physical harassment by the service providers and surrounding people.

**Conclusion:** The study shows the need to sensitize the society and incorporate *Hijra* identity (third gender) within the administrative service provision of the formal healthcare facilities alongside the 'male' and 'female' gender categories. It also recommends improving the knowledge and attitude of the care providers towards the Hijra community by familiarizing them with their biological and cultural aspects to avoid further discrimination and humiliation when seeking for formal healthcare in future.

# INTRODUCTION

Globally, "*Transgender*" is used as an umbrella term to represent people with gender identities that differ from the usual gender binary (male and female) assigned during birth (Aziz and Azhar, 2019; Ryan et al., 2020). *"Hijra"* people are often addressed by the western term, *"Transgender"* which denies the cultural aspect and historical significance of their identity (Aziz and Azhar, 2019). "*Hijra*" as a popular term is commonly understood as people who are '*neither male or female*' in the South Asian countries and categorized as members of a third gender (Dutta et al., 2022; Hossain, 2022). Depending upon the cultural context of the Indian subcontinent, the members of the Hijra community are widely distinguished into several subgroups such as kothi, panthi, khwaja sara, kinnar, zenana [1]and others (Al-Mamun et al., 2022; Aziz and Azhar, 2019; Ryan et al., 2020). In India, people of the Hijra community are considered to bring upon good luck to the newborns and newlyweds through their art of cultural activities (singing, dancing) and blessings. However, in practical scenario they are seen to collect money and perform sex work for earning their livelihood (Diehl et al., 2017).

In 2014, Bangladesh government recognized *Hijra* people as a separate gender. However, this recognition this recognition addressed them as 'Hermaphrodites', 'Eunuchs' or 'Intersexes' based upon their reproductive anatomy in 2014 (Ministry of Social Welfare, 2014). The sole consideration of biological characteristics for gender identification and to represent the Hijra community gives rise to disputes in social, political, economic, educational and health seeking aspects of life (Al-Mamun et al., 2022; Dutta et al., 2022; Khanam, 2022;

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[1] Definition of *Kothi, Panthi, Khawaja Sara, Kinnar, Khushra* and *Zenana.*
*Kothis* are those men who 'like to do women's work' and desire the receptive position in same-sex encounters with other men. https://doi.org/10.1080/13648470500291410
*Panthis* (or *giriyas* as they are referred to in north India) are the partners of *kothis.* https://doi.org/10.1080/13648470500291410
*Khwaja saras* and *Zenanas* (a category of khwaja sara folk) largely dressed as males and lived and were addressed as men, some of whom had import- ant positions in the courtly culture of per-colonial India. https://open.library.ubc.ca/collections/ubctheses/24/items/1.0378320
*Kinnar* is an identity for Hijra in Northern India as well as Maharashtra and Gujarat. More recently, educated Hijras who are not associated with Hijra gharana have begun to describe themselves as Kinnar. https://doi.org/10.1080/26895269.2020.1845273

Sifat and Shafi, 2020). The society of Bangladesh fails to understand the cultural, gender and sexual aspects of the Hijra people beyond the male-female gender model (Khan et al., 2009). The lack of gender identification of the Hijra persons makes them vulnerable to stigmatization and social discrimination. Therefore, the Hijra community remains marginalized and excluded from social rights and benefits (Al-Mamun et al., 2022; Aziz and Azhar, 2019; Khanam, 2022; Pandya and Redcay, 2021; Pandya and Redcay 2020). The social exclusion deprives them from the attainment of familial and cultural participation, elementary education, profound job opportunities, healthcare access, political involvement, preferable residences, and community engagements (Sifat and Shafi, 2020). Their experience of social exclusion begins from their childhood when they are outcasted by their families and forced to drop out from school due to bullying or in fear of public shaming of their families (Aziz and Azhar, 2019). Lack of education imposes a negative impact on their access to employment in the later part of their life. Unemployment eventually leads to financial burden and forces them to follow the traditional footsteps of "*Hijragiri* (rituals of *Cholla* and *Badhai*)[2]" or adopt the profession of a sex worker for survival (Al-Mamun et al., 2022; Hossain, 2017; Aziz and Azhar, 2019).

Along with the struggles of hijra people in all aspects of their life, their experiences in accessing health care services at the formal health care facilities are no different. The Hijra persons tend to seek health services from the formal health sector at the times of emergency and for critical medical conditions such accidental injuries and severe illness such as high fever, fits, acute pain, severe diarrhea, jaundice (Aziz and Azhar, 2019; Abrar et al., 2016; Hossain and Esthappan, 2021). The Hijra persons also seek care when they suffer from debilitating health conditions such as depression and complications from undiagnosed non-communicable diseases (Diabetes, Hypertension etc.) (Aziz and Azhar, 2019; Hossain and Esthappan, 2021). A certain proportion of the Hijra population seek formal care for sexually transmitted infections like HIV, Gonorrhea, Syphilis (Gourab et al., 2019). The formal healthcare services include secondary to tertiary care with diagnostic facilities both in the public and private

[2]*Cholla* refers to the showering of blessings upon the newborn by holding them in arms (Hossain, 2022). *Badhai* is the process of collecting of money from different rituals or occasions such as weddings, birthdays and *musulmani* (Islamic ritual of circumcision) (Hossain, 2022).

hospitals. It ensures the delivery of consultation by registered medical professionals for better health outcome (Ahmed et al., 2013). However, the health seeking behavior of the Hijra persons is largely influenced by the social acceptance, gender-based medical knowledge and etiquettes of the healthcare professionals, availability and accessibility of the satisfactory healthcare services for the third genders, affordability of the services, service quality in terms of confidentiality, privacy and waiting hours (Al-Mamun et al., 2022; Brookfield et al., 2020; Hossain and Esthappan, 2021; Giri et al., 2019; Pandya and Redcay, 2020). The Hijra persons experience medical negligence, verbal harassment, and physical assaults by the healthcare providers at the hospitals (Pandya and Redcay, 2020; Sifat and Shafi, 2020). In addition to that, the judgmental attitude of the healthcare providers and criminalization of sodomy when approached for sexual health consultation by the Hijra people, act as major driving factors for inhibiting the service uptake (Gourab et al., 2019). The antipathy and terror of being subject to mockery and stigmatization, discourages them from seeking healthcare from the formal health sector (Giri et al., 2019; Pandya and Redcay, 2022). The Hijra people scarcely manage to earn enough for their living. Thus, their financial status and negative experiences often does not support the utilization of the healthcare services at the formal hospitals (Lerner and Robles, 2017). They incline towards the informal health sector and aim to avail health services from local pharmacies, kobiraj (religious healer) and gurumaa (leader of Hijra community) (Hossain and Esthappan, 2021). Some believe in faith-based healing via recitation of holy verses and to avoid misbehavior they refrain themselves from visiting any healthcare sector (Abrar et al., 2016; Hossain and Esthappan, 2021). Such divergence in health seeking behavior leads to poor health outcomes due to maltreatment and medical transgression (Sifat and Shafi, 2020).

During Covid-19 pandemic, the isolation policies further aggravated situation of unemployment, financial crisis, food insecurity, gender-based harassment, healthcare inaccessibility and unaffordability (Sifat and Shafi, 2020). Their source of income via *Cholla*, *Badhai* and sex work ceased during the Covid-19 lockdown. The sudden financial pull due to unemployment during the pandemic, impacted their daily survival to a great extent. Simultaneously, the Covid-19 infected Hijra persons faced several challenges in undertaking covid tests and

accessing covid vaccination due to gender complexities. Both lead to a decline in the quality of their lives (Hossain and Esthappan, 2021).

At present, a few NGOs have stepped forward to provide promotive, preventive, and curative healthcare services considering the restricted access of this minority at the other formal healthcare facilities (Abedin and Sarker, 2022; Sema and Islam; 2020). In addition to that, Bangladesh Government has introduced a policy for the welfare of the hijra community, that is, “Implementation Manual of Livelihood development of Hijra 2013” to ensure that the national rights of the Hijra persons are equivalent to the cis-gendered citizens of the nation (Abedin and Sarker, 2022; Khanam, 2022; Ministry of Social Welfare, 2017). However, the lack of its proper implementation and hindrance from the society still persists (Aziz and Azhar, 2019).

Henceforth, the study is conducted among Hijra members to understand their healthcare needs, the challenges they experience while utilizing formal healthcare services and the factors associated with the decision-making process for seeking formal care. In addition to that, this study will also help to understand the need for informed sensitization and training of the healthcare providers, adoption of Hijra as a gender identity in the health system, and social inclusion of the Hijra community by effective implementation of the existing policies and formulation of new policies to ensure health and wellbeing of hijra community.

## STUDY OBJECTIVE

### General Objective:

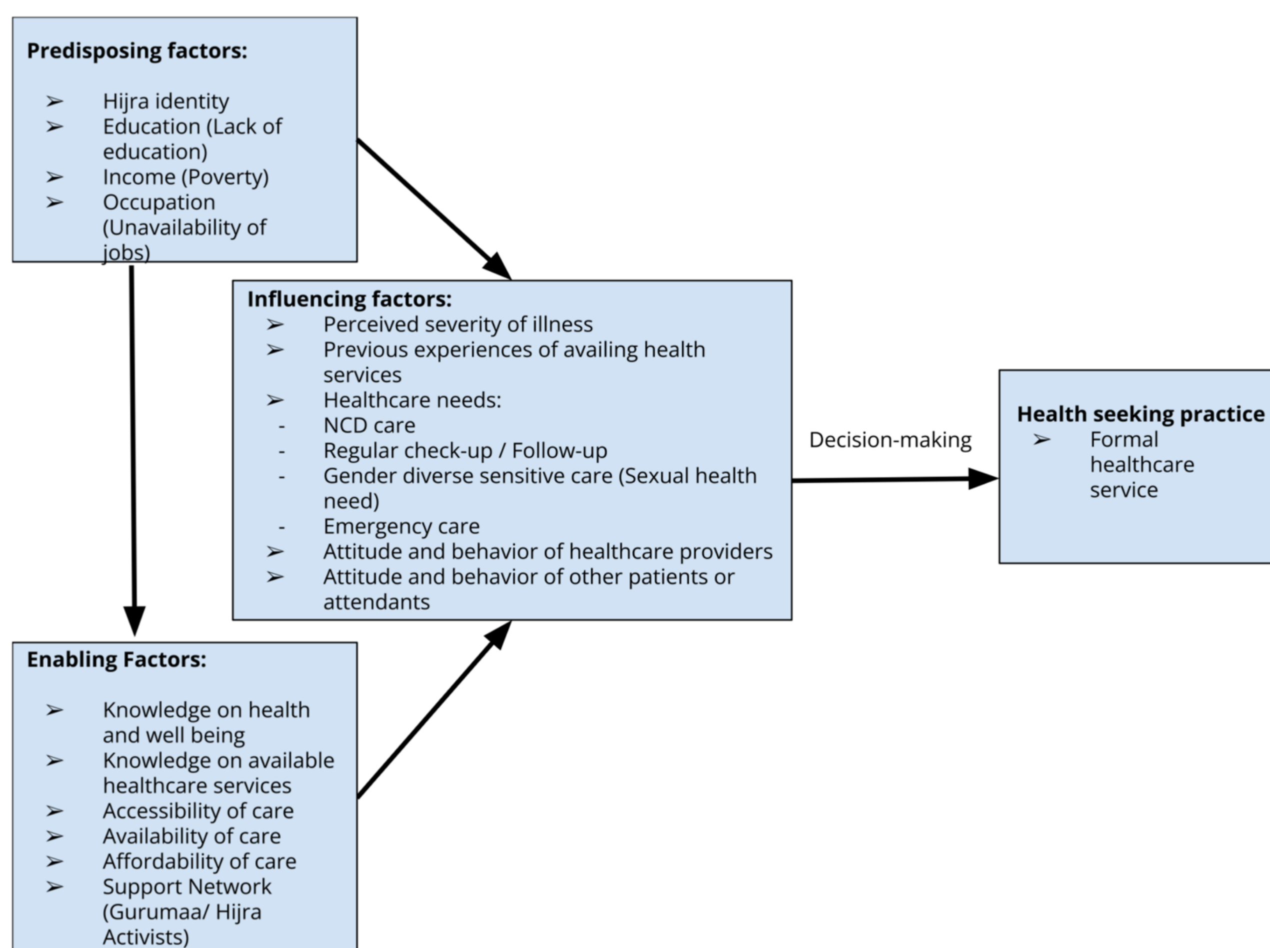
To understand the experiences of the Hijra community members in accessing formal healthcare services in Dhaka city

### Specific Objectives:

- To understand the barriers and challenges faced by the Hijra persons in accessing healthcare services in the formal sector.
- To understand the factors influencing health seeking behavior of the Hijra persons in the formal health sector.

## CONCEPTUAL FRAMEWORK

The conceptual framework has been adapted from Anderson's (1995) Health Seeking Behavioral Model. Anderson's model represents the factors responsible for influencing people's health seeking practices. The model has been slightly modified depending on the context and population of the study.




(Anderson, 1995)

The predisposing factors such as the Hijra identity represents biological imperatives suggesting the likelihood of being socially excluded as the marginalized community and being deprived from accessing formal healthcare facilities. A Hijra person faces discriminatory challenges in acquiring education in the form of bullying and ridicules (Aziz and Azhar, 2019). Education plays an important role in building the perception and knowledge about health. Lack of education creates a negative impact on their understanding about health and its

needs. Most of the Hijra people belong to the low socio-economic status either because of being abandoned by family, inaccessibility to education or for not being able to acquire a good job due to social exclusion. The financial crisis further acts as a disabling factor in their formal healthcare seeking behavior due to unaffordability.

The social exclusion and stigmatization of the Hijra persons from the health sector's and community's scornful perspective discourages them to seek healthcare from the formal sector and inclines them towards the informal health services (such as pharmacies), religious health beliefs or health negligence (Pandya and Redcay, 2022). The Hierarchical relationship between Guru-chela also plays a role in health seeking practices. The Hijra persons follow their leader (Gurumaa) for decision making since she is responsible for their well-being and provides the members of a specific group with shelter. The health seeking behavior is also largely influenced by the severity of illnesses. Severe health conditions such as major injuries or complications from NCDs act as the driving factor for the Hijra persons to seek formal healthcare.

The lack of service provision for the third gendered people acts as a barrier in accessing the formal healthcare services as well. The health needs of the Hijra persons remain unaddressed by the healthcare providers due to scarce knowledge of the gender orientation and cultural features. The lack of sensitization and knowledge gap together impose unsatisfactory health service remarks in terms of service providers negligence and negative attitude.

The framework above guided the analysis by considering the central aspects of predisposing factors and enabling factors which will be reflected in their personal experiences. Role of these factors in influencing the health seeking practices was explored. However, the framework has been modified during the process of data analysis. The behavior of the healthcare providers and other patients or attendants seemed to have an inhibitory impact on the health seeking behavior in the formal healthcare facilities. Therefore, they were incorporated in the influencing factors.

# METHODOLOGY

In order to achieve the above-mentioned objective/s, an exploratory qualitative method comprising both In Depth Interviews (IDIs) and Key Informant Interviews (KIIs) were undertaken among the hijra persons residing in different locations of Dhaka city.

## Study Design

Qualitative exploratory method was used to generate detailed elucidations of the experiences of the Hijra persons in accessing formal healthcare. The prior mentioned method provides flexibility in obtaining required information based on the principles of naturalistic inquiry and answers important issues raised by the researchers. This minor group of *Hijra* people is a hard-to-reach community which does not have the prerogative to speak openly in front of public considering the matter in context. Henceforth, the study design is also a stable method for conducting the research among such marginalized population.

## Sampling

The participants of the study were recruited via purposive sampling technique using three inclusion criteria. The participants were approached for an interview if they, (a) self-identified themselves as Hijra person, (b) were above 18 years of age, (c) resided in Dhaka for past three years or more.

Since the Hijra community of the Dhaka represents a closed and marginalized minor group who has previously encountered humiliation and deceit, it was difficult to get the interview access from random Hijra persons. Therefore, information sources provided by BRAC JPGSPH using existing network were used to schedule appointments with the Hijra community leaders and project coordinator of a local community-based organization (CBO) to avail sufficient number of study participants.

## Study Site

Interviews were conducted in four different locations of Dhaka, that is, Manda, Kuril, Uttar Badda, and Rayerbazar, considering the proposed interview time by the members of the Hijra community.

**Data Collection Tool**

In-depth-interview (IDI) and Key-informant-interview (KII) guidelines were formulated from extensive literature reviews. The interview guide for IDI included nineteen major questions under the following themes with relevant subdivisions and probing: knowledge and perception about health, experience of general health problems, knowledge and perception about formal healthcare facilities, health seeking behavior, experiences in the formal healthcare facilities, experience during COVID-19 pandemic and suggestions for improving the healthcare services. Similarly, the interview guide of KII included thirteen major questions under the similar subsequent themes with subdivisions. The interview guides were prepared in English and later translated in Bengali language before conducting the interviews. A pretest (1 IDI and 1 KII) was conducted in Manda to understand if the pattern of the questions is formulated comprehensively. This also helped to identify the issues in the interview guide that could be problematic for the participants to apprehend. Based on the feedback from the pretesting, both the guidelines were revised further and finalized.

**Data Collection Process**

Once the interview guides were finalized, twenty-six face to face IDIs and five KIIs were conducted in colloquial Bengali language from November 24 to December 6, 2022, following written informed consent. The IDIs were conducted among the Chelas (disciples) to understand and obtain detailed information about the driving factors and major challenges (personal, familial, societal. Institutional, and policy levels) in accessing healthcare. KIIs were conducted among the Gurumaa (leaders) and Hijra activists since they had a better understanding of the community through their years of experience. Twenty-six interviews were recorded with permission. The duration of the interviews varied from 35- 90 minutes. Remaining five interviews were not recorded due to lack of the

interviewee’s permission. However, extensive notes were taken by the interviewer and transcript summaries were prepared.

## Ethical Consideration

The study approach was reviewed and approved by the independent Ethical Review Board of BRAC James P Grant School of Public Health, BRAC University. Considering the sensitivity of the target population group, the ethical grounds of religion, culture, socioeconomic status, and gender, precautions were taken to avoid approaching with any unintentional, hurtful, or offensive question or statement. Informed written consent were collected from all the participants/ respondents. The researcher respectfully approached the participants with self-introduction and a thorough, appropriate rapport building session. The purpose of the research was well explained to all the study participants. The objective, risks and benefits of the study were clarified to the participants verbally. The anonymity of the participants was maintained by using pseudonyms in the findings section. Most of the interviews were recorded with the respondents’ permission. The shared information was kept confidential after returning from the field in a password protected laptop. The recordings and transcripts were saved using specific codes. The names and other details of the participants were not used. The participation of the respondents was voluntary with the option of withdrawal from the study interview at any time of the data collection process. The respondents were provided with the contact details of the researcher in a copy of consent form for further queries.

## Data Analysis

Twenty-six recorded interviews were transcribed into verbatim and translated in English. Five interviews were summarized following extensive notes since there were no recordings. A priori code book was generated based on rigorous literature review prior to the data collection process. The transcriptions and summaries were thoroughly read for data familiarization which supplemented themes based on the a priori code list. Therefore, a mix of deductive and inductive coding strategies were applied. Each code was defined with further usage instructions. Subcodes were developed under each code. Coding was done

manually by the researcher. Color coding technique was applied to the transcribed data. While coding, new codes were added, some codes were merged, and some codes were changed or discarded. The transcribed data was displayed into matrix, clustered to form categories, and compared to identify emerging patterns and trends. Finally, seven themes were produced, and the study findings were reported in the result section with relevant supporting quotations. At every step, the researcher kept a memo to account for any emerging topics.

## FINDINGS

The main findings of this study among this marginalized population group are discussed under seven specific themes- **(i)** Socioeconomic characteristics of the study participants, **(ii)** Perception of the Hijra people about health and wellbeing**,** **(iii**) Health concerns experienced by the Hijra people and perceived reasons behind it**, (iv)** Knowledge about available formal healthcare facilities among the Hijra people, **(v)** Health seeking behaviour of the Hijra community members**, (vi)** Experiences of the Hijra persons in seeking formal healthcare services, and **(vii)** Experience of the Hijra community during COVID-19.

### Socioeconomic characteristics of the study participants

A total of 26 In depth interviews (IDIs) and 5 Key Informant Interviews (KIIs) are conducted as part of this qualitative study (a brief details of the socioeconomic status of the participants are given in Table 1). The average age of the IDI participants is 25 years and all of them reside in Dhaka. The participants are from different Hijra communities led by separate *Gurumaas* (Hijra community leader). Among the 26 IDI participants, 20 were not privileged enough to complete their education beyond primary level and 11 did not have the ingress to education facilities at all.

Majority of the IDI participants do *hijragiri* to earn their livelihood. Rest of them are involved with sex work, NGO services, nursing, and household jobs. Even though the income of the Hijra persons vary according to their occupations, their expenditure is similar. As shared by the participants, they earn between BDT 6000- 40000 (USD 55.5- 370) a month from *hijragiri*, depending on the locality,

duration of collection, experience in this field and disbursement of the collectively earned sum between the members of the group and *Gurumaa*. The Hijra sex workers manage to earn BDT 8000- 12000 (USD 74- 111) per month depending upon their number of customers and duration of stay in the red zones at night.

Table 1: Socio-demographic status of the interviewed participants.

| ***Characteristics*** | ***Number of participants*** | |
|---|---|---|
| | ***In depth Interviews*** | ***Key informant interview*** |
| ***Age*** | | |
| *18- 25 years* | *12* | *1* |
| *26- 33 years* | *6* | *2* |
| *34- 41 years* | *5* | *1* |
| *Above 42 years* | *2* | *1* |
| ***Educational attainment*** | | |
| *Never got an access to education* | *11* | - |
| *Primary incomplete* | *2* | - |
| *Primary complete* | *8* | *1* |
| *Secondary complete* | *1 (Hafezi)* | - |
| *HSC/ Equivalent* | *3* | - |
| *Bachelors* | *1* | *1* |
| ***Occupation*** | | |
| *Unemployed* | *1* | - |
| *Hijragiri* | *14* | - |
| *Sex work* | *4* | - |
| *Social Welfare for Hijra Community in NGO* | *4* | *All work for the same purpose* |
| *Intern Nurse* | *1* | *1* |
| *Baburchi (chef)/Household Chores* | *2* | - |
| *Hijra Activist* | - | *4* |
| *Program Manager* | - | *1* |

Most of the five key informants completed their higher secondary education and beyond. Four of them are the Hijra activists who work as the founders and research informants of the Hijra welfare organizations. One of the key informants is the program manager of an ongoing project conducted by a Hijra welfare organization.

**Perception of the Hijra people about health and wellbeing**

Given the background and educational attainment of the study participants, their insight about living a healthy life reflected their perceived knowledge from day-to-day life experiences.  Four out of 26 IDI participants perceived that health in general comprises of both physical and mental components. Along with physical illness, stress, anxiety, and feeling low can also contribute to poor health outcome. However, they also shared their concern about unavailability of any prevention or cure for such emotional health conditions which they experience frequently.

*"Tension… tension is another thing that matters. There is medicine for every disease, but none for tension. Tension is the main issue. Disease comes later. If someone gets a disease, it gets cured by taking medicine. But there is no escape from tension."- Runa, Age 18*

A KII participant also shared that, to live a healthy life, one must have sound state of mind besides being physically healthy. She emphasized on mental health being an important aspect of life as most of the Hijra people have no family or personal lives. The social exclusion makes them mentally and emotionally vulnerable.

Almost half of the IDI participants believed that seeking medical care from hospitals, pharmacies, clinics, and occasionally even self-medication, whenever there is any divergence from the usual state of health is useful to restore a healthy life. Few of the participants mentioned that proper nutrition and sanitation are required for good health.

*"I don't understand much about health. But all I know is that to live a healthy life, I have to eat well, stay clean and maintain some rules and regulations." - Mala, Age 40*

One of the IDI participants mentioned about her faith in Almighty for living a healthy life but in correspondence to that she also believes that it is the responsibility of the individual to refrain oneself from harmful aspects of life such as intake of drugs and practicing unprotected sex to stay healthy. Only one IDI participants shared that good health can be achieved by proper guidance and consultation from doctors since they have medical knowledge.

**Health concerns experienced by the Hijra people and perceived reasons behind it**

Majority of the IDI participants mentioned that they frequently suffer from common health conditions**,** such as cold, fever, headache, and body ache. Often time they experience dizziness due to nutritional deficiencies. In addition to that, non-communicable diseases (NCDs) like Diabetes, Hypertension, and heart disease are also seen in their community. Seven of the IDI participants mentioned that they also suffer from allergy, diarrhoea, skin problems (dermatitis), digestion problems (gastritis), abdominal pain and complications from nutritional deficiencies. Participants could highlight weak eyesight due to vitamin A deficiency, bone pain and weakness due to calcium deficiency.

*"...I suffer from cold, allergy and fever frequently. There have been days when I had a cold for a couple of months. Till today I cannot eat or drink anything cold... I had sore throat. Apart from this there are a lot of health problems. Normally we do not have issues like menstruation. Yet I feel very weak and cannot even walk properly. "- Laila, Age 26*

In recent market of fluctuation, the prices of the basic commodities are high. As a result, it becomes difficult for the leaders of the Hijra community to provide their *chelas* (disciples) with fundamental amenities of life such as nutritious food, spacious accommodation, hygienic environment and so on. People of the Hijra community live together in a crowded environment and share the monotonous food cooked under the supervision of *Gurumaa* which is deficient in most of the nutritional elements. Lack of proper nutrition leads to poor immune system, making them vulnerable to conditions like allergy, diarrhea, abdominal pain, and indigestion. Crowded living spaces and shared washroom facilities also make them susceptible to contagious diseases like dermatitis.

*"I have these diseases (headache, dizziness, weakness, itching, diabetes) because I don't eat properly and cannot maintain proper hygiene. In this (crowded) situation, if my shissho meye (apprentice) has an infection, I will get the same. With proper nutrition and environment, I believe I could have a better and health life. - Bobita, Age 35*

Besides, Sexually Transmitted Infections (STIs) are one of the major concerns for Hijra community as many of them are engaged in sex work. Other than the four sex workers, most of the IDI participants had *parikhs* (partners) and are sexually active. Four out of 26 IDI participants informed that STIs like HIV AIDS,

Syphilis and Gonorrhea are commonly prevalent among the members of this community due to unsafe coitus. However, all the key informants mentioned that only a certain proportion of the Hijra population who are involved with sex work are commonly exposed to developing STIs due to their mode of sexual contact (anal sex), unprotected sexual practice (sexual contact without using gels/condoms), lack of awareness regarding safe sex practices, and lack of knowledge about the consequences of unsafe sex. Besides, they also mentioned about experiencing Herpes, Anal Ulcerations and Urinary Tract Infections (UTI) due to repeated unprotected sex. At times the Hijra sex workers keep taking customers one after the other and do not clean themselves. Long term exposure of the thighs and genitalia to the fluids (semen), leads to skin conditions like itching, ulceration, and cysts as perceived one of the IDI participants.

*"Disease like HIV, gonorrhea and many other occur to the people of our community because we do unprotected sex work. They don't understand how it can be safely done. It is risky for both the partners…the one who is giving and the one who is receiving."*
*- Ramna, Age 20*

Noyon, 26 years old Hijra activist added that Hijra people experience depression and other mental health issues such as anxiety and aggression, which might not be reflected through their activities. However, it is always present as an underlying reason for living an unhealthy life. Noyon's perception regarding depression being camouflaged among the members of the Hijra community, is supplemented by the Lipi's statement,

*"Another thing is that the disease that my members face is sadness (bishonnota). This is the primary disease. They suffer from the dilemma of loneliness…'What can I do? Who are my close ones?'……They go into depression…They might cut their hands. This mental issue is harmful... They need to do something about this mental health problems."- Lipi, Age 42*

Study participants also shared that often time they get entangled in disputes either within the community itself or with the strangers leading to a physical brawl and imposes detrimental physical health impacts such as fractures, cuts, or abrasions. Almost half of the IDI participants involved with *Hijragiri* think that the daily strenuous activity to earn livelihood is the crucial reason behind their physical health problems. The Hijra persons walk for miles to reach their specific

destinations for collecting money. Somedays, the collection is not enough to buy food and they have to extend the duration of the collection period.

*"As I have to walk a lot to earn my livelihood, I get sprain in my legs frequently. Most of the times, my legs are swollen, and it feels numb. Skin of my thighs are sore and tear due to continues friction. "- Maya, Age 26*

**Knowledge about available formal healthcare facilities among the Hijra people**

Even though all the IDI participants are aware of formal healthcare facilities in their locality, they have better knowledge about Non-Governmental Organizations (NGOs) run healthcare facilities than the others. These NGO based healthcare facilities have separate projects that mostly encompasses the services which are solely arranged to provide preventive and curative assistances (for general health and STIs) to the Hijra people. The Hijra people are also cognizant about the existing local small clinics (by private practitioners), community clinics (government clinics) and Drop-In-Centers (DICs). One of the KII participants mentioned that her organization works for the welfare of the marginalized population which includes the Hijra people and other discriminated communities. They provide a wide range of healthcare services which incorporates counselling, diagnostic and management facilities. They also supply required amenities (condoms/ gels/ lubricants) to Hijra people. The government hospitals, private hospital, diagnostic centers, and local pharmaceuticals are also well known to 15 of the IDI participants from their prior experiences during *Hijragiri* or from seeking medical attention. However, many of them lack the knowledge to differentiate between a pharmacist and a doctor. Three of the IDI participants mentioned that a wide range of healthcare services are available in the hospitals in comparison to the NGO based healthcare facilities. One of them experienced a cut injury in her finger for which when she went to the NGO facility and then was referred to a public facility due to lack of surgical equipment.

*"And we have this NGO office where sometimes I get tested and treatment (if required). But unlike the hospitals, not all the health services are available here. .... So, I often go to the Mugda 500 Bed Government Hospital....I have also heard about Dhaka Medical, but never went there."- Mina, Age 37*

## Health Seeking Behaviour of the Hijra Community Members

### *Reasons to seek formal healthcare*

The purpose of seeking formal healthcare varied among the participants. Ten out of fifteen IDI participants shared that they sought formal healthcare from nearby hospitals due to the unbearable severe health conditions such as excruciating pain from sprains, fractures, cuts or cysts, severe allergy, chest compressions, stroke, high fever, and extreme exhaustion. Shonali, a 25-year-old Hijra sex worker and one of the IDI participants reported about seeking healthcare for her injury during a fight with her *parikh* (partner),

*"I got involved in a fight and got hit in my arm. I thought there was a fracture. So, I went there (hospital). Then the doctor excluded the possibility of a fracture and prescribed me some medications." Shonali, Age 25*

Malati, an 18-year-old IDI participant described the severity of her health condition due to sudden chest pain, which led her to seek formal healthcare on an emergency basis,

*"Few days ago, I went to Dhaka Medical with severe chest pain and breathing difficulty. I spent almost 9000 taka on diagnostic tests there. I had to stay in the ICU for 4 days."*

The other participants seek medical attention from the nearby pharmacies or opt for self-medication and homespun remedies when they suffer from conditions like cold, watery diarrhea, fever, indigestion, minor infections, and cuts. One of the IDI participants mentioned that whenever she had a cut, it took longer time than usual to heal. One of her disciples took her to the nearby pharmacy for treatment and later she got diagnosed with Diabetes.

### *Health seeking Pattern*

Four of the IDI participants mentioned about visiting a formal healthcare before going to the pharmacy. Among these four participants, two of the experienced NGO workers expressed their concern that the irrational prescribing of medications at the pharmacy can be harmful for health conditions, hence they prefer formal health care. Three of the IDI participants mentioned that they try to avail the services at the hospitals under the appearance of a man or a woman due to fear of discrimination. An IDI participant mentioned that she prefers visiting

the hospitals for receiving the utmost treatment facilities and visits the pharmacy only when the doctors provide her with prescriptions.

*"I don't think it's good to bring medicines directly from the pharmacies. Whenever I need any medicine, I make sure I consult a doctor first and then according to his prescription, I buy the medicine from the pharmacy. I don't even buy Napa directly from the pharmacy if I have fever.."- Moina, 40 years old*

Even though, general healthcare services are available at the formal healthcare facilities, yet the major concern lies in their accessibility for the Hijra persons, mentioned by all the key informants. Most of the IDI participants shared that the service provision has not changed even after their recognition by the government. More than half of the IDI participants expressed their eagerness towards availing the affordable government healthcare services as their citizen's right, even after the discriminatory behavior of the care providers and lack of service quality. Rupa, one of KII participants supplemented the preferences of the IDI participants by stating,

*"The 'friendly' health service environment, which we need, a safe space, no government hospital has this. And we are not that rich to go to a private hospital. So, we are bound to go to the government hospitals, and there they mistreat us. "- Rupa, Age 28*

One of the key informants mentioned that a very important factor in accessing formal healthcare services is the power relationship between the leaders of the Hijra community and the healthcare providers. A meaningful and beneficial communication between the Hijra activists or *Gurumaa* and the authorities of the healthcare facilities, ensures the availability of the respectful healthcare services to the people of the Hijra community at minimal cost.

*"Now when they (Hijra persons) go to Mugda hospital, they will get priority and will be looked after. Why does this happen now? Because of me. I have direct contact and acquaintance with the director of the hospital. This connection helps. Because without connection in Bangladesh, you can't really make any changes…."- Lata, 40 years old Hijra activist*

All the IDI participants referred visiting the similar NGO based healthcare facilities for accessing both general and sexual healthcare services. Seeking for sexual health services is stigmatized in our society in general and it becomes more challenging for the Hijra people to avail such services from a formal

healthcare without undergoing any ignominy. Moreover, the healthcare providers are not always welcoming or empathetic while treating them for sexual health issues. In the NGO run facilities, Hijra people do not face any discrimination or humiliation as the healthcare providers are sensitized, better trained to treat Hijra people and the services are free of cost.

*"As a hijra person I prefer NGOs mostly, even though its far. Because NGOs work with us and they give us the proper respect and care that we need. Services are free of cost, they provide free health checkup, and give free medicines in a friendly manner. They also provide us with the transportation cost."- Shompa, Age 32*

Three of the KII participants mentioned that most of the Hijra people are uneducated and thus carry upon the beliefs from their ancestral community leaders (*Gurumaas*). They believe in the process of spiritual healing. However, the Hijra persons of following generations are advanced in terms of the health seeking perception due to the influence of social media.

*"Yes "pani pora" [laughing], many people still do this. They go to hujur (religious healer) for "pani pora" (holy water), sometimes to homeopathy, these two are preferred mostly…People who go there are mostly the old generation Hijras. Sometimes young ones are bound to go because the elders say so."- Rupa, Age 28*

The health seeking pattern depends upon the molded knowledge, lived experiences and influence of the shared stories by the other community members. The preexisting notion of humiliation due to social unacceptance causes most of the IDI participants to avoid visiting formal facilities and incline towards informal healthcare facilities like pharmacies and drug shops,

*"I never prefer to go to a government healthcare facility; I never want to go there at all for their misbehavior. When I get sick, I always prefer to go to a pharmacy as the the pharmacies are usually empty, and there are no waiting lines."- Rumi, Age 18*

**Experiences of the Hijra persons in seeking formal healthcare services**

The study participants mentioned about the experienced challenges in accessing the formal healthcare facilities due to the lack of service provision for the 'third gender' people. They also mentioned about the negligence, discrimination, and humiliation they come across from the care provider's end while reaching out for medical attention.

***Challenges experienced at the reception***

Six out of 26 IDI participants mentioned that there are only two gender-specific counters serving male and female patients separately in the outpatient departments of the hospitals. Due to the facility's failure to acknowledge the hijra identity, they are not officially entitled to have a separate queue and health services. To avail the healthcare services, they present themselves either as a male or a female (often time whichever identity is aligned with the National ID card). In such cases, when they stand in the line of the male, they are subjected to harassment. On the contrary, when they stand in female line, they make the women feel uncomfortable.

*"I went there (government hospital reception) wearing a saree. Part of my waist was uncovered and visible. The man standing behind my shamelessly pinched me and behaved in a way like nothing happened". – Maya, Age 26*

All KII participants shared similar thoughts towards the lack of queue for the third gender. However, two of the key informants believed that lack of health system policies and implementation barriers for the existing action plans led to this situation.  A key informant shared her dreadful experience in a formal facility,

*"It was an emergency and I had to enter the room with the patient (disciple).  I told an accompanying person (another Hijra) to bring a ticket with her name. She went there and got kicked out from the women's line. Then she went to the men's line and got kicked out again. She was told that we are neither man nor woman…in fact, we are not humans. So, what is our identity? What is the procedure for us to take tickets? We don't even know where we should stand."- Beli, 51 years old Hijra activist*

***Denial to provide healthcare services***

Two of the IDI participants mentioned that the best way to sought health care services from a formal healthcare facility is by introducing themselves as male or female and not as Hijra. Many a time due to social stigma, they have been refused with the healthcare services by the healthcare providers if they identified themselves as Hijra. Through service denials, people of the hijra community are deprived from their basic rights to healthcare access.

*"When my breathing stopped, I was initially taken to a private hospital at Uttar Badda. The staff of that hospital refused to admit me there and misbehaved with my attendants.*

*They didn't even allow me to step inside the hospital even after seeing my condition. They told me directly "No no, we don't have any place here for you. Take her to Dhaka Medical, we can't treat her here."" - Chompa, Age 34*

In addition to the response of IDI participants, all the key informants mentioned about the lack of separate facilities at the hospitals for the Hijra people as a reason for service refusal. One of the KII participants also mentioned that the healthcare providers lack the knowledge about diverse gender identities and possible medical needs of the Hijra people. Joba, a 50-year-old Hijra activist, stated that the healthcare providers refusal to provide services is just an outcome of the national level identity crisis of the Hijra community,

*"If you think about a Hijra going to the hospital to get admitted, there is no different bed for them. Will they go for a male bed or female bed?...They acknowledge that they are neither male nor female in our country's context. They were acknowledged as hermaphrodites or eunuchs…. because of that, if it is a transgender woman, would it be better for her to be sent to the women's bed or men's bed?…. There is no change in their NID. Like, she became a woman but her NID is still a man's. So, in that case, it is very tough for the people of the Hijra community to receive the government healthcare service."*

***Challenges faced during doctor's consultation***

Nine of the IDI participants reported that the doctors do not pay attention to their health issues and the attitude of the healthcare providers at the formal facilities is dismissive. The participants mentioned that the doctors don't invest enough time to examine them. In some cases, the doctors misbehave with them once they identify themselves as Hijra persons. Laila, a 26-year-old IDI participant was neglected at the government hospital when she sought care for her painful cyst,

*"They didn't even give me importance as a patient. After seeing me they said that the doctor was busy. I waited for three hours, yet they didn't call me in to visit the doctor. I felt ashamed and left the place."*

All the key informants mentioned that the people of the Hijra community are subjected to humiliation when recognized as a Hijra person by the doctors during consultation, especially at the public facilities. One of the KII participants shared,

*"So, a Hijra from my house went to a Government Hospital wearing saree and bangles. When she went to get the x-ray done, the provider said, 'Remove your cloth.' She refused. Then doctor yelled, "Why aren't you removing your clothes?". She said, "Sir, I am a Hijra." The doctor shouted, 'Hijra! Go away! Go away!" – Rupa, Age 28*

Three out of 5 of the key informants mentioned that in some cases, when the Hijra people go to the hospital for sexual health issues, the doctors blame *hijra* patients for their unnatural sex (anal sex) and unsafe sexual practice and use this que to humiliate and insult them.

*"If any of the Hijras with sexual problem go to them, they (healthcare providers) ask, 'Why have you done these kinds of things (sexual activities)? This is not natural sexual relationship. We won't see your problems. I won't give you this kind of treatment." - Rupa, Age 28*

Apart from being subject to misbehavior, negligence and being questioned upon their sexual preferences, some of the IDI participants also reported of verbal harassments while seeking for doctor's consultation for any sexual health issue. Doctors twist the conversations and start probing for intimate details of their personal lives. Sometimes they also make inappropriate offers for sex.

***Lack of privacy and confidentiality***

Most of the IDI participants face breech of privacy during consultation, and diagnosis in the formal healthcare facilities. It is the fundamental duty of the healthcare providers to ensure patient's confidentiality. But the Hijra population being mostly uneducated, remain unaware of such ethical obligations of the providers and don't take any actions. Shonali, the 25-year-old IDI Hijra participant who is an intern nurse elaborated one of her observations when an intersex person was humiliated along with the loss of privacy while changing in the dressing room,

*"When the ward boy went to get her dressed for OT, he came back running and shared with his colleagues what he saw…tiny penis...no nipples.. Everyone started laughing about this incident."*

Shonali also mentioned that it is the lack of knowledge of the hospital staff regarding the anatomical configurations of the intersex person which is responsible for giving rise to such situations.

Majority of the IDI participants who go to formal healthcare facilities for consultation, reported cases of sexual harassment. The healthcare providers at the

facilities take the advantage of their vulnerability, knowing that there's no one to come forward if they raise their voice against the harassment.

*"I showed the nurse my lower part because I trusted him as a person who will give me treatment. Two of the nurses where mingling with my assets in the lower part. I told them to give the treatment since they have already seen that part. They told me it wasn't complete; they need to see more. They were laughing (sobs).... I was feeling uncomfortable."- Laila, Age 26*

***Attitude and behaviour of other patients and attendants***

Nine out of 26 IDI participants encountered uncomfortable situations in the formal healthcare facilities when other people showed their repugnance towards them either verbally or through their body language. Such circumstances appear due the lack of social acceptance and misconception about them. Josna, the 18-year-old Hijra person who newly joined the Hijra community expressed her frustration,

*"Of course, I feel annoyed. People start whispering as soon as they see me around, 'See that's a Hijra. She might have done bad things or eaten something bad. That's why she has a disease. She deserves it because of people's curse on her'."*

Shonali, the 25-year-old IDI participant narrated her experience in the government hospital when she visited the facility with her mother and was waiting at the reception queue. She was humiliated and mocked for her body language and gestures by one of the other patients at the reception.

Three out 5 KII participants mentioned about the society's wrong perception towards the people of the Hijra community. One of the key informants explained that it is because of the profession of *Hijragiri*, people in the surrounding fail to accept the fact that Hijra persons can also visit the healthcare facilities and pay for the services without asking for money from them. Noyon, the 26-year-old Hijra activist also stated with deep sigh regarding the society's detestation towards the existence of the Hijra people,

*"When they (Hijra people) stand in line for tickets, people show such an attitude that they are disgusting, ugly things or animals. Such hatred, neglect, and sarcastic stares. They (other patients) move away from them (Hijra)."*

**Experience of the Hijra Community during COVID-19**

All the IDI and KII participants referred to the period of COVID-19 as the most dreadful phase of their lives. Most of the IDI participants lost their financial stability and lived under the assistance of their *Gurumaas.* Some of them survived depending upon their savings, while some returned to their villages. Nineteen out of 26 of the IDI participants denied of developing any illnesses during the pandemic. However, 7 of the IDI participants reported to develop health conditions like cold, fever and chest tightness for which they did not seek any medical attention at the healthcare facilities. Two of them took pharmaceutical advice and consumed medicine accordingly. The rest of them claimed that their conditions resolved on their own.

One of the KII participants mentioned that during the initial phase of COVID-19, none of the Hijra members continued *Hijragiri*, sex work or any other job. They maintained strict isolation. However, as per her knowledge 1 member from her community died from corona and 12 were infected. Another key informant, Keka, the 45-year-old Hijra activist shared her dire experience of being refused to get treated when she tested positive for COVID-19,

*"I went to Mugda 500 Shojja (500 bed hospital). Seeing my disguise, they were not letting me in. Then I shouted. They said, 'Later, later'. I went there at 11:15am…Then at 3.30pm, they said, 'How will we know where you will stay!'"*

Most of the IDI participants could avail the two doses of COVID vaccine only after the third phase of the pandemic because initially there was no option of 'others' or 'third gender' in the *Shurokkha* app (the national app to register for COVID- 19 vaccination). Two of the IDI participants have not received the vaccine yet. According to the information provided by one of the KII participants, there was a delay in ensuring vaccination of this minor community due to the discrepancies between the information in the NID and the practical appearance of the Hijra people. She also mentioned that during mass vaccination there was no separate line for the third gender people. Due to the lack of this service provision, they had to face immense challenges in the public crowd when they tried to fit in either as a male or a female. Beli, the 51-year-old Hijra activist said,

*“During COVID, Hena (a Hijra person) went to get vaccinated with her NID. They told her, ‘You are not this woman. Why have they brought another person’s NID card?’ So, she did not get the vaccine. Then, when they were doing the mass vaccination program there were only male-female lines and no line for us. How will we get vaccinated?”.*

## DISCUSSION

Findings from the present study identified that Hijra people are aware of the physical and mental aspects of health and wellbeing. However, mental health being an important component of health, is only known to the Hijra people who acquired higher education beyond the primary level. The Hijra people who have the experience of working for the NGOs are also aware of the need for a sound mental health among the Hijra people for living a better life since they have observed how mental health has created detrimental impacts on the physical health of several Hijra persons. Even though mental health is a subject of concern among the Hijra community, yet there are no such counselling facilities for the them in the formal healthcare sector. Mental health is a global concern among the transgender community since social exclusion makes them susceptible to develop depressive disorder (Sartaj et al., 2020).

The people of the Hijra community are aware of the formal healthcare facilities. Nevertheless, most of them have knowledge about the NGO based health facilities because of the widespread awareness raising programs for the cost-free services which are centered around the healthcare needs of the Hijra people. The NGO based healthcare facilities are mostly concerned with HIV prevention and detection services (Abedin and Sarker, 2022; Sema and Islam; 2020). Their allocated budget fails to cover other aspects of the health services such as surgical procedures, extensive investigations such as x-ray, ultrasound, ECG and biopsies (Aziz and Azhar, 2019). Besides this, they have limited knowledge about the existence of government and private hospitals due the lack of service seeking experiences in such facilities. The Hijra activists and gurumaas have the knowledge about public and private healthcare facilities through their work-based communication sources.

The Hijra persons usually seek healthcare from the informal healthcare facilities like the pharmacies. Their lack of educational background is the main reason behind such health seeking behavior. However, they tend to seek formal healthcare only when they come across serious health issues such as injuries or complications from chronic NCDs. The health seeking pattern of the Hijra community has evolved over the period. Hijra persons who could acquire education beyond the primary level, they prefer formal healthcare services over informal care due to their acquired knowledge about the benefits of formal services and the demerits of informal services by unskilled service providers. Elderly Hijra people seek care mostly from the spiritual healers due to their beliefs and knowledge gap.

Even though "Health for all" as a global policy is adopted by World Health Organization (WHO) for all the nations including Bangladesh, yet people of the Hijra Community, come across several discriminatory challenges at every step of their lives in our bipolar-gendered society (Sifat and Shafi, 2019). This study findings focus on the fact that the people of the Hijra Community lack access to the formal healthcare services due to the restricted opportunities within the conventional healthcare facilities in which the gender binarism is deeply ingrained. Similar results were obtained in a study conducted in India by Rizvana SAM et al. in 2021, where it was mentioned that even though the bill to ensure the health rights of the transgenders was reintroduced in 2019, yet the people of this community are still denied healthcare services in formal health sector due to lack of social awareness (Sarker, 2019).

The Hijra persons have restricted opportunities to avail education and this in turn narrows down their options to employment and pushes them towards poverty. Their earnings via *Hijragiri* do not suffice their health needs. However, they choose to seek healthcare mostly from the government facilities to circumvent out of pocket expenditures. The negative attitude of the healthcare providers in the government facilities, and failure to accept the people of this community as their patients depicts the idea of the prebuilt notion of stigma within the minds of the healthcare providers towards Hijra people. A similar study was conducted by Manzoor et al. in Lahore-Pakistan, in 2022, where a significant relationship was

affirmed among the 70% of the study participants who sought healthcare at the government facilities due to financial constraints and received poor quality of care (Abedin and Sarker, 2022; Khanam, 2021).

A non-uniform power relationship exists between the healthcare providers and the Hijra people in the cycle of health seeking. The doctors and nurses often tend to exploit their superiority by harassing their Hijra patients either verbally or physically. None of the studies mentioned about physical harassment during consultation, treatments, or tests. Nevertheless, a study conducted among the LGBTQ community by Giri et al. in the Kathmandu Valley of Nepal in 2019, presented with similar results where about 63.2% of the study participants reported low levels of behavior from the healthcare providers in terms of verbal harassment and unacceptance.

The invidious behavior of other patients or their attendants towards the Hijra persons at the formal healthcare facilities is another challenge. The root cause of public abhorrence is the continuation of marginalization of this community since primeval times. Although, no studies have been found in this regard, yet in a study conducted by Aziz and Azhar in Dhaka, the results revealed that the healthcare providers deny services to the Hijra people, forwarding the excuse of other patients' discomfort by the presence of Hijra persons at the premises.

Even after the maximum effort of the researcher to obtain in depth information from the participants during data collection, the study has some limitations. Certain information might have been missed due to time restriction and hasty nature of the participants to leave for work since the interviews were conducted during the lunch time which served as their leisure time in between two sessions of *Hijragiri*. Five of the Hijra interviewees felt uncomfortable and did not allow the researcher to record. Some data might have been missed despite of taking ample notes during these interviews. During some of the interviews, the participants were reluctant to share information with the interviewer. To minimize the above-mentioned limitations, the number of interviews was increased to obtain data saturation and gather detailed information in the required fields.

## RECOMMENDATIONS FROM THE HIJRA COMMUNITY TO MAKE FORMAL HEALTH CARE MORE ACCESSIBLE

1. Sensitization of the formal healthcare providers about gender diversity to ensure inclusive and empathetic health services for Hijra community.

2. Initiate gender sensitive policy (separate queue at the reception, separate wards, and washrooms) to ensure an inclusive health system to avoid discrimination against Hijra community in the formal health care facilities. Proper coordination between different ministries and government/ non-government bodies working for the betterment of Hijra community for efficient and meaningful implementation of these action plans.

3. Ingraining gender specific biocultural knowledge in the medical curriculum and clinical training facilities of the healthcare providers so that they can address the health needs of the Hijra people.

4. Scaling up of NGO run clinics across Dhaka city for the Hijra community to ensure widespread availability of their services.

5. Ensuring affordable healthcare services via quota system for the Hijra community to reduce out of pocket expenditure.

6. Inclusion of Hijra representative while formulating policy, law and action plans that are catered for their needs to better understand their perspectives

## CONCLUSION

Every individual has the socio-economic right to live in a liberal society free from gender discrimination. The opportunities in the educational field, job sector, housing status and healthcare facilities should be available to all irrespective of their gender identification. However, the Hijra community in Dhaka faces numerous challenges in their daily lives to avail the fundamental rights. One of

the most climacteric facets of life is health. Even after the recognition of the Hijra community as the ‘third gender’, this minor group is widely neglected in the formal healthcare facilities due to perceived gender conflicts. The members of the Hijra community experience general, sexual, and mental health issues which are attributable to personal, educational, economic and a social exclusion. The lack of proper treatment facilities incurs poor health outcome. Therefore, the study findings infer the need to ensure the proper implementation of the existing health policies and incorporate gender sensitive care within the formal healthcare facilities. Incorporation of gender-oriented clinical education can avoid gender bias negligence towards Hijra people. Separate service provision for Hijra people in the formal healthcare sector is required to address their health needs. Developing parentships with organizations which are working for the Hijra community can be useful to deliver cost-effective healthcare services. Nevertheless, the government’s role for raising awareness to sensitize the community people and change their perception towards the Hijra people is mandatory. Further research should be conducted to explore the ways of integrating Hijra sensitive healthcare within the health system. Several public health interventions are applied to achieve the Sustainable Development Goals (SDGs). The study findings will help us to identify the necessary imperatives take a step forward towards achieving SDG 3 (To ensure healthy lives and promote well-being for all at all ages) and SDG 5 (To achieve gender equality) by making formal healthcare of Bangladesh more inclusive for the gender diverse population.

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# ANNEX

## ANNEX-1

## CODEBOOK

| CODES | DEFINITION | WHERE TO USE | WHERE NOT TO USE | `SUBCODES |
|---|---|---|---|---|
| **Knowledge and Perception about health** | Can be defined as a word or phrase used to describe or to express any concept related to health or wellbeing by the hijra community | Used for any kind of physical, mental, emotional or social health issues for the hijra community | Do not use for stigma or discrimination issues for the hijra community other than health | |
| **Health problems** | Can be defined as a word or phrase used to describe or to express any concept related illness, health issues, disease and/or symptoms | Used for illnesses, diseases, symptoms after being identified as a Hijra person | Do not use for any illness, diseases, or symptoms before being identified as a Hijra person | **Common illnesses in the hijra community**<br>**Perceived reasons behind common diseases**<br>(Merged later during analysis) |
| **Knowledge about available formal healthcare facilities** | Can be defined as a place used to describe any formal providers who provide services addressing health issues of any kind. | Knowledge about formal healthcare facilities where any general health issues of hijra communities are addressed | Knowledge about other services for hijra community other than healthcare | **Available formal healthcare facilities**<br><br>**Available healthcare services**<br>(Merged later during analysis) |
| **Health seeking behavior** | Description of the use of formal | Include all the formal healthcare services | Do not include any formal | Reason (illnesses) to seek health care |

| | | | | |
|---|---|---|---|---|
| | health services or pathways to seek healthcare by hijra people for the purpose of preventing and curing health problems, promoting maintenance of health and well-being, or obtaining information about one's health status and prognosis | utilized after being identified as a Hijra person | healthcare facilities visited before they identified themselves as Hijra person | including severity (including frequency of illness and visit)<br>**Health seeking pattern**<br>Preferences towards a formal healthcare facility (decision making)<br>Availability<br>Accessibility<br>Affordability<br>Previous experience(*belief*)<br>Support network *(Decision maker-Gurumaa, Accompany-friends*) |
| **Experience in seeking healthcare in the formal health sector** | Refers to the overall experience including incidences, events, encounters, circumstances and conduct from surrounding people, faced by the respondents when visiting the formal healthare facility for their ailments | Include all the experiences in formal healthcare facility after being identified as a Hijra person<br><br>Include experiences of the other members of the Hijra community known to the respondent | Do not include any healthcare experiences before they identified themselves as Hijra person | **Challenges at the Reception**<br>(Emergent subcode)<br><br>**Healthcare Service Provider's Attitude**<br>Misconduct<br>Abuse<br>- Negligence<br>- Harassment<br><br>**Service Availability**<br>Refusal to provide service<br>- Acceptance<br><br>**Attitude of other patients and attendants**<br><br>**Quality of service**<br>Privacy<br>Confidentiality |
| **Covid-19 Experience** | Refers to the lockdown in Bangladesh during the year 2020 and their overall experiences of | Overall healthcare experience associated with any health issues during the Covid-19 lockdown period in 2020 | Any experience not associated with healthcare during the Covid-19 lockdown period in 2020 | **Covid Treatment**<br>Refusal to admit<br>**Covid Test**<br>Discrepancies between NID gender and physical appearance |

| | | | | |
|---|---|---|---|---|
| | healthcare service uptake | | | **Covid Vaccine**<br>Line<br>Privacy<br><br>(Merged later during analysis) |
| **Recommendations** | Recommendations by the hijra community for improvement of the healthcare services in terms of easy accessibility, affordability, quality of service and social inclusion | Any recommendations suggested for the healthcare services for the Hijra community | Any recommendations suggested for the Hijra community other than the healthcare services | **Integration of gender-based knowledge in medical education and training of healthcare providers**<br><br>**Separate healthcare facilities for Hijra Community**<br><br>**More NGO Clinics for Hijra people**<br><br>**Making the healthcare services more cost-effective**<br><br>**Improving the behavior of the healthcare providers** (emergent subcode) |