Understanding decision-making and health-seeking practices of the Hijra community in accessing informal healthcare services in Bangladesh: An exploratory qualitative study

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Abstract

In Bangladesh and other South Asian countries, Hijra people, mainly a community of transgender women who follow a particular cultural system, faces a multitude of barriers while trying to access their right to healthcare services. In this paper, we aimed to understand decision-making factors and health-seeking practices of Hijra community in accessing informal healthcare services, focusing on their common health problems, their perception and knowledge of health, patterns of healthcare utilization along with the challenges faced and reasons for decision making in seeking healthcare from informal facilities in Bangladesh.

The exploratory qualitative study was conducted among 26 self-identified Hijra persons, and 5 key informants affiliated with the Hijra community, during the period of November to December of 2022 in different areas of Dhaka. Two qualitative guidelines were used to collect data via face-to-face in-depth and key-informant interviews. Thematic analysis was used to identify key concepts, cluster themes into patterns and conclude meaning from those patterns.

Findings reveal that Hijra persons have poor knowledge and understanding about their own health, and sought healthcare services from informal health facilities more than formal health facilities, particularly from pharmacies, *kobiraji, hujur*, homeopathy and through self-medication. The Hijra population reported a number of reasons in opting for informal services, including better availability and accessibility, influence from peers and support network, negative attitude of formal healthcare providers, non-friendly interaction and discrimination from other patients, attendants and staff, along with long waiting times and harassment in formal health facilities. Our findings highlight the need for understanding of gender orientation, and sensitization of Hijra lifestyle for formal healthcare providers, policies for Hijra inclusivity in healthcare services.

Introduction

Globally, the term "transgender" is used as an umbrella concept in various cultures to describe people whose gender identities deviate from the conventional gender binary of male or female (Aziz and Azhar, 2019; Ryan et al., 2020).

In South Asian countries of India, Pakistan, and Bangladesh, the term ‘Hijra’ is commonly used for a community of transgender women who follow a particular cultural system (Jalil et al., 2021). As defined by Hossain in the SAGE Handbook of Global Sexualities (2020), “Hijra is a publicly institutionalized subculture in South Asia comprising people typically assigned a male gender at birth who later in life often rid themselves of their genitals and become feminine-identified 'non-men'.” However, all of the Hijra persons in Bangladeshi society do not get rid of their male genitalia, rather a Hijra person with male genitalia primarily identifies as a woman in both conduct and attitude (Abedin & Sarker, 2022). The term "Hijra" is frequently perceived by the general public to refer to a person who is sexually challenged or even does not have any sexual organs.

Hijra persons, who are typically regarded in Bangladesh as neither men nor women, were given official recognition as a third gender by the government of Bangladesh in November 2013, receiving praise as a significant accomplishment (Hossain, 2017) and the Government of Bangladesh published a gazette on 26 January 2014 (Ministry of Social Welfare, 2014). According to the verdict of the Government, solely biological characteristics are considered based on their reproductive anatomy to identify a Hijra person. This approach overlooks the complexity of the Hijra identity and fails to recognize that gender is a spectrum rather than a binary construct and is based on the identity they feel from within (Al-Mamun et al., 2022).

In order to address the economic disparity, government agencies launched “Implementation of Livelihood development of Hijra 2013” to integrate and "rehabilitate" the Hijra community and mainstream this recognition into the employment scheme, planning to employ Hijra people as clerks in 2015 (Aziz and Azhar, 2019; Hossain, 2017). Following the selection of 12 Hijra for a medical examination, the results determined that they were not proper Hijra, rather all of them

were ‘genetically male’ based on the understanding that Hijra people are intersex and have ambiguous genitalia.

The results of these gender tests quickly gained public attention, with various media detailing the "fakery" committed by a group of males posing as Hijra (Hossain, 2017). The failure to develop a proper definition of "Hijra" and the lack of effective execution continue to be key obstacles to the policy's objectives (Khanam, 2022).

More importantly, because the government and everyone else involved in the process had no knowledge of diverse gender identities and their many manifestations, not only was their identity reduced to mere pathologization, but also their bodily integrity and their human rights were violated, and their dignity as human beings was shamefully vilified (Rajeeb, 2019).

Lack of understanding on gender diversity by society as well as government policy also creates another kind of vulnerability and discrimination along with existing social exclusion of Hijra community. which results further exclusion in social, political, economic, educational, and health-related opportunties of life (Al-Mamun et al., 2022; Dutta et al., 2022; Khanam, 2022; Sifat and Shafi, 2020).

The main barrier to the advancement of Hijra person’s quality of life in our nation is the lack of awareness and familiarity with the sexual orientation and gender identity of Hijra persons among those in charge of programs for this population (Bay, 2019). This poor understanding and knowledge also impact health service provision of health systems and utilization of healthcare by the Hijra peoples.

Health disparities for vulnerable Hijra communities in healthcare settings are influenced by social prejudice, which is also reflected in the discriminatory attitude of the healthcare providers. (Safa, 2016). Deeply ingrained stigma and a lack of gender sensitization within the health systems also make it difficult for Hijra persons to receive essential medical care (Sifat and Ahmed, 2021). The healthcare professionals, who mostly are groomed in mainstream culture, scarcely comprehend the gender orientation and cultural features of Hijra patients (Sarker, 2019). They are reluctant to treat and rather mistreat Hijra persons, hence they are unable to provide them with proper medical treatment (Sarker, 2019).

In terms of access to healthcare services, social exclusion is seen to be the cause of poor health. Hijra patients are frequently stigmatized, and ignored (Safa, 2016; Sifat and Shafi, 2020). On the other hand, the service system's rigid dichotomous gender division is so entrenched that it severely restricts opportunities for Hijra people, who are seen to violate societal gender standards (Sarker, 2019).

The Covid-19 epidemic in Bangladesh has had a detrimental effect on the Hijra population, especially during the period of national lockdown (Matin et. al., 2020). The pandemic has severely impacted the Hijra community because of their marginalized and socially excluded status (Jalil et al., 2021). They faced several challenges in accessing and utilization of formal healthcare services due to gender identities, which further impacted their quality of life during Covid-19 in 2020 (Hossain and Esthappan, 2021). The absence of understanding of gender diversity in the public healthcare system shows that public hospitals are unprepared to treat Hijra patients and formally include them in their service offerings (Sifat and Shafi, 2020).

As the Hijra people live in a marginalized environment, they lack information of health and different health problems, thus they have a lack of understanding about their illness and treatment (Sarker, 2019). Moreover affordability and accessibility to health services also impacts the decision-making of utilization of formal and expensive formal healthcare services (Matin et al., 2020). They have many negative experiences to receive services in formal health services, such as discrimination against their gender identity, and medical negligence, verbal harassment, and physical assaults by the healthcare providers. These barriers in accessing formal health care coupled with other beliefs and accessibility to informal health care influence them to seek healthcare in the informal sector, which remains unexplored (Pandya et al.,2021; Sarker, 2019; Sifat and Shafi, 2020). Major informal healthcare service providers in Bangladesh include traditional healers, unqualified allopathic providers, village doctors, drug sellers, and semi-formal unregulated, private institutions (Ahmed et. al.,2009). Due to mistreatment from formal and neglect from formal services, and its related different health-seeking behavior have a negative impact on health outcomes in terms of early morbidities and fatalities among Hijra people (Aziz and Azhar, 2019; Hossain and Esthappan, 2021; Sifat and Shafi, 2020).

There have been relatively few studies on the Hijra population and their stance on health services in Bangladesh, and those that have been done did not specifically address health service utilization, their decision-making factors or challenges in accessing formal or informal healthcare

facilities (Sarker, 2019). As a result, it has been difficult to comprehend their health-seeking behavior and accessibility to health care system. This study aims to understand the experiences of the Hijra community in accessing informal health services and identify the factors that influences the decision of accessing and receiving health services from informal health care facilities. This understanding will inform health systems to better equip public health professionals to build capacity for providing quality health services for this marginalized and neglected group. This will also program implementers for focused interventions to fulfill the gaps within their health service delivery. The learnings from this study will further inform policy makers to undertake appropriate decisions and contribute to the universal principle of the 2030 UN agenda 'Leave No One Behind', reducing discrimination, exclusion and inequalities.

General Objective:

To explore the health-seeking practices and the decision-making factors of Hijra persons in accessing informal healthcare services in Dhaka

Specific Objective:

- To understand the health-seeking practices of the Hijra community in accessing informal healthcare services in Dhaka
- To understand the decision-making factors of the Hijra community in accessing informal healthcare services in Dhaka

Conceptual Framework:

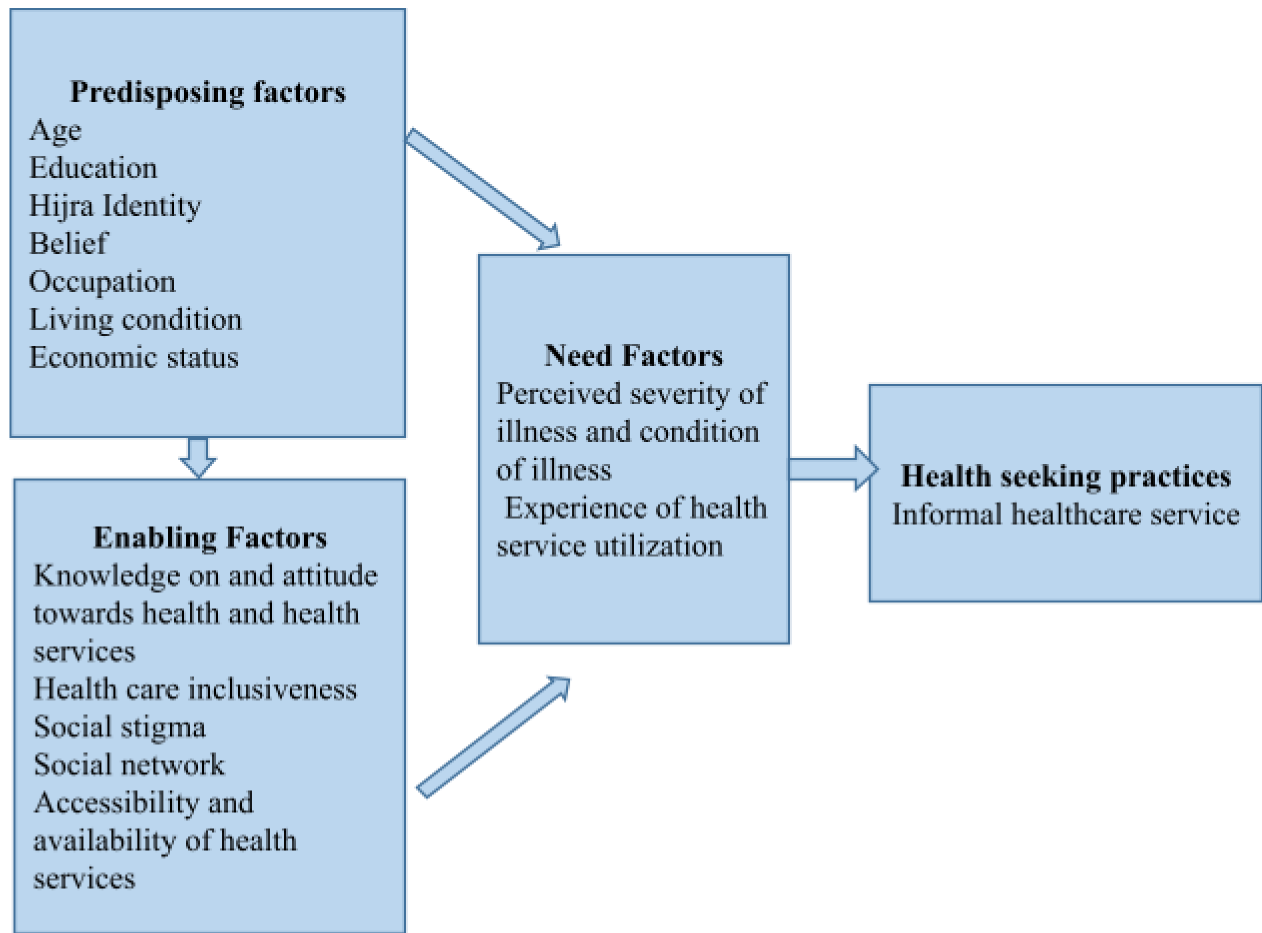

Figure1: Conceptual framework of health service utilization of Hijra peoples adapted from "Behavioral Model and Access to Medical Care" of Anderson (1995)

This conceptual framework was adapted from the "Behavioral Model and Access to Medical Care" framework proposed by Anderson (1995), suggesting the health-seeking practice and decision-making of choosing healthcare services are governed by their socio-demographic characteristics along with certain enabling factors and need factors incorporating both contextual and individual level predictors.

The disposing factors includes sociodemographic characteristics comprising age, education, occupation, knowledge and attitude towards health, valuses and belief. In this study, Hijra identity of the respondents makes them a marginalized and underprivileged community with social exclusion and stigmatization which also have influence of health service utilization and choosing paticular health facilities. Moreover knowledge, understanding and attitude towards

health also have impacts on health service utilization. The people of Hijra communiyt usually have low level of educationa, thus they have poor knowledge on health. They usually live in unhygenic environment, their occupation also have impacts on their health status. Such as many of colelct monet from other people for the whole staying on road, hot sun or rain. Many of the Hijra people also woek as sex worker. Many of the Hijra people have multiple sex partners also have impacts on their helath particularly, they are vulnerable to STDs. So, theiur health needs are also varied and impact of particular health service utilization.

The enabling factors or organizational, structural and financial issues which directly influence access to healthcare and health knowledge as well as use of healthcare services (Jahangir et al, 2012). For exaple, regrding belief, if an individual who belive that partucular health service is effective treatment for an illness, is more likely to seek services from that particular service. In the context of Bangladesh, health system is not inclusive for providing service for gender diverse communities as service providers are not well equipted with their understandings, have infrastructural limitaitons to serve effective and quality health services. Moreover, attitude and behaviour of the health service providers are also not well received by the Hijra community as they sometimes health service providers verbally-physically harrass Hijra people. Hijra community seek support from their community as they face social exclusion. So, they get information and help from their own Hijra communiyt network, has a strong influence of choosing particular helath services. Moreover, they cannot seek hogh cost services due to their low economic condition,

The needs facors are embedded with the percieved severity of the illness and health problems and the previous positive or negative experiences of seeking healthcare infleunces their health-seeking practices in the individual and contexual levels (Jahangir et al, 2012). Based on percieved illnes, people evaluate needs and choose for particular services (Kadushin, 2004). We assume, due to their social exclision, discriminatiory experiences from seeking services, their socio-economic condition inclding other soial and structural factors have influence of choosing informal health services, will be explored through this study.

Methodology:

Study Design:

An exploratory qualitative research was carried out in urban city areas of Dhaka between November and December of 2022, to understand the experiences of the Hijra persons in accessing informal healthcare services.

Study Site:

A total of 5 study sites were chosen from different areas of Dhaka city to get a varied perspective of experiences, considering time, resources allocated and information source. The study sites included Manda, Rayerbazar, Badda, Kuril and Mohammadpur because of the presence of different clusters of Hijra communities and their accessibility.

Study Population:

The sample for in-depth interviews included self-identified Hijra persons aged between 18-60 years of age, who has been living in Dhaka at least the past 3 years. The key informant interviews involved hijra rights activists, NGO health program affiliates, representing and working for Hijra health and rights, and Hijra leaders or 'Gurumas'.

Sampling Method:

Before beginning fieldwork, the researchers contacted *Shocheton Hijra Odhikar Shongo*, along with *Somvob Foundation Bangladesh, Badhan Hijra Sangho* and *Somporker Noya Shetu*, some of the Hijra community based organizations in Dhaka working for Hijra rights and welfare. Through these organizations, the research team was introduced to several participants of the study. Purposive sampling method was used to trace the potential participants for acquiring desired information, through snowball sampling technique. A total 26 in-depth interviews (IDI)

and 5 key-informant interviews (KII) in 5 areas of Dhaka city were conducted to collect information to reach the study objectives.

Study Tool:

Two separate qualitative guidelines were developed for IDI and KII based on an extensive literature review. The IDI focused to collect information about the perception and knowledge about health and health service provision, their health seeking behaviors particularly from the informal facilities and identify the decision-making factors those influences to seek service from informal healthservice facilities of the Hijra population in Dhaka city. The KII guideline focused expert opinion about attitude towards and practice of health service and health care utilization of Hijra peoples in the Dhaka city. The guideline was pre-tested in the same context and modified and finalized to prepare a more systematically appropriate guideline to capture issues to reach study objectives.

Data Collection Method:

Data collection was carried out by three researchers of BRAC JPGSPH's MPH Summative Learning Project team. The team was guided by senior researchers of BRAC JPGSPH with extensive experience in the field. The face-to-face in-depth interviews (IDI) and key informant interviews (KII) were conducted between November 22 to December 06, 2022. The interviews were conducted maintaining confidentially and privacy. The conversation of the interviews were in native Bangla language. The duration of each interviews were between thirty minutes to one hour twenty minutes. 26 out of 31 interviews were audio recorded with the participant's consent, and shortly transcribed and translated into English by the data collectors and research assistants. The researchers took extensive written notes of the interviews which were not permitted to record and were summarized by the researchers the same day.

Data Analysis:

The interviews were first transcribed from the audio recordings, then translated from Bangla to English. The interviews not recorded were summarized thoroughly. Apriori codes were

generated prior to data collection. The transcripts were read repeatedly for data familiarization and supplemented capturing the main themes and sub-themes based on the apriori code list. Emerging codes identified during data familiarization and coding were also added to the code list.

The data was coded using Dedoose version 9, a coding software and the results were displayed in a data matrix. Thematic analysis was used to identify key concepts, types of information, compare and cross check among and between participants and sites. This data matrix also helped to cluster themes by patterns, and identiy other emerging themes to conclude meaning from these patterns.

Ethical Consideration:

The study protocol was approved by the Ethical Review Board of BRAC JPGSPH before proceeding with the data collection. Prior to the procedure of data collection, the ethical grounds of religion, culture, socioeconomic status, and gender was taken into consideration to avoid approaching any unintentional, hurtful, or offensive question or statement. The respondents were respectfully approached by the researchers with a self-introduction and thorough rapport-building session. The purpose of the visit was explained to the respondents. Written informed consent was taken from all respondents. The objective, risks, and benefits of the study was clarified to the respondents verbally along with the written consent form. The anonymity of the respondents is maintained throughout the study. Interviews were recorded only if the respondents permitted. The shared information were kept confidential after returning from the field in a password-protected laptop. The participation of the respondents were voluntary, and they had the right to withdraw from the study interview at any time they wish. The respondents were thanked for their cooperation at the end of data collection and were provided with our contact details in another copy of the signed consent form for further queries.The researchers always maintained respect to the Hijra culture's unique local traditions, customs, and linguistics.

Limitations

A major limitation to our study the short study time as determined by the MPH programme for this Summative Learning Project. Another constraint was to identitify and access potential participants as they remain a marginalized group scattered in different parts of Dhaka. Thus the team reached out to 4 Hijra community based organizations to identify Hijra persons who were willing to be interviewed for the study. As the interviews were being conducted within the organization's office premises, the respondents would speak positively and not answer genuinely sometimes, due to presence of NGO staff. As the Hijra people work throughout the day, it was sometimes difficult to set up meetings during the working hours. When the interviews were conducted during the dat, some of the respondents hurried their responses in order to get back to work, which may have resulted in some information loss. Our team also conducted interviews after working hours in the evenings, to accommodate the convenience of the participants. Some participants of the study did not agree for the interviews to be audio recorded. In these cases, extensive notes were taken in account of their responses and later the interviews were summarized. Intitially the data collection plan was to conduct 10-15 interviews, however, in order to reach saturation of data and mitigate the information loss, the team conducted 31 interviews in total with 26 IDIs and 5 KIIs.

Findings:

Sociodemographic profile of the respondents:

The study conducted 26 respondents In-Depth Interviews (IDIs), and 5 Key-Informant Interviews (KIIs). The age range of the IDI respondents ranged from 18 years of age to 60 years of age. Their educational qualification varied from receiving no education and studying at undergraduate level. Most participants were involved in '*Hijragiri'*, meaning collecting cash and tolls from general public in streets, from shops and vendors, from households for newborn babies and from weddings. 4 of the IDI participants were involved in sex-work earlier in their life, 2 participants worked as staff of an NGO focusing on Hijra rights, and 1 respondent studying in nursing college. The monthly income of the respondents ranged from six thousand to sixty thousand per month. Out of the 5 KII respondents, all except one were Hijra activists and Hijra gurus. One of the respondents was the program manager of an NGO focusing on Hijra rights.

Table: Socio-demographic characteristics of the respondents:

Interviewees	Topic	Parameter	Number
KII	Education	Secondary and above	4
		Below Secondary	1
	Occupation	Activist	4
		NGO Project Manager	1
IDI	Education	Primary and above	5
		Below Primary	21
	Occupation	*Hijragiri*	14
		Sex worker	4
		NGO worker/volunteer	4
		Other	4
	Income	6,000-60,000 taka	
	Expenditure	20,00-30,000 taka	

Knowledge and perception of Hijra persons about health and well-being:

When asked about their understanding of health, most of the hijra respondents could not give any decisive answer, and some of them could not comprehend the question. On further explaining the question, some of the participants mentioned "physical" well-being to be the ultimate parameter of good health. By "physical" well-being, they mentioned, to be physically well, *"shoril bhalo thaka"*, meaning to be free of any disease, such as not having headaches, body aches, fever or any physical problem. They think if someone can do his/her daily activity, that person is healthy.

> *"Good health is when it feels good to do daily activity, work, going out, walking around. People may not feel healthy, when they feel weak and dizzy. Or may get headaches." IDI 15, AGE 28. KURIL*

4 out of 26, expressed the importance of emotional well-being for attaining good health. They have mentioned how a stress free or "tension free" life is important for optimum health.

One respondent stated the importance of mental health,

> *"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. "IDI 23, AGE 18, BADDA

Few participants mentioned that health also includes eating healthy and maintaining a healthy daily routine. According to them, the fact that they could not maintain a proper healthy daily routine and get enough nutritious food affects their health.

Data shows that for a few participants, their faith plays a key role in their understanding of well-being. They mentioned that one might fall sick if God punishes them through bad health or diseases.

One respondent said;

"I am healthy by the blessing of Allah. One can get sick at any time. Humans can't say "I won't get sick". Only Allah knows this. If Allah says, "I will not make them sick. Then will anyone be able to make them sick? So, if Allah keeps me healthy, then no one can make me sick. " IDI 21, AGE 25, BADDA

General health problems and perceived reasons of their ill-health:

When asked about the general health problems they talked about some common diseases they regularly suffer, such as colds, coughs, fevers, headaches, acidity, etc. Some of them also mentioned having non-communicable diseases like diabetes, hypertension, etc.

Among the 26 IDI respondents we interviewed, 13 said to suffer from cold, cough and fever repeatedly. 9 of them complained about repeated headaches and body aches, 4 of them complained about having acidity problems and 4 of them also mentioned diabetes and many complications related to diabetes.

Some of them also complained of having other diseases like allergies, skin rash, gallstone, diarrhea, jaundice, loss of appetite, and urinary tract infections.

"I commonly catch colds, fever, and coughs. Recently I found out that I also have high pressure and diabetes that really concerns me. " IDI 9, AGE 28, KURIL

Respondents thought that most of the common health problem suffered by them comes from their daily lifestyle. Since they live in a crowded place all gathered together, proper cleanliness and hygiene cannot be maintained.

One respondent said,

> *"I can't maintain proper hygiene. Suppose if my Shissho meye (disciple) has a disease and I am staying with her, then I can also get the disease. If I could live in a cleaner environment, wear clean clothes, use soap and oil as needed, I would have better health.*
>
> *IDI 14, AGE 35, KURIL*

One respondent mentioned that lack of proper food plays an important role in their weight loss and health,

> *"We do not get nutritious food. The Hijra people are under one Guruma in one specific community. So what about the guru cooks, they have to eat by sharing the food. When it comes to sharing, each individual does not get enough food. For this reason, they lose weight, become thinner and weaker. They used to have fever frequently" IDI 5, AGE 25, RAYERBAZAR*

Also since they have to walk around the streets to collect money from different places, they spend most of their days in unhygienic environment and the lack of cleanliness causes different skin diseases. Moreover, this practice of collecting money all day under the hot sun and dusty environment also increases their Headaches, whereas walking all day gives them body and feet ache.

> *"I get a headache if I walk around in the blazing sun, there is dust-rain-mud-crowded people, also we face physical and mental pressure collecting money from other." IDI 15, AGE 28. KURIL*

Other than these general health problems, they mostly suffer from STDs, like syphilis, gonorrhea and HIV along with the disease that occur due to repeated anal sex, such as anal irritation or ulceration, anal tear, anal abscess, anal fissures and anal fistula. 12 out of 26 participants either suffered from any of these disease or knows someone who did.

A KII that we interviewed said,

> *"Many of them suffer from sexually transmitted disease, which is called Syphilis. They get an infection around their anal opening and lips. These are also sexually transmitted. Pus comes out of these infections. Pus is a symptom of gonorrhea." KII2*

Knowledge about available healthcare facilities

Formal healthcare facilities are legitimate, accredited and registered healthcare facilities whereas informal healthcare facilities included services provided by unregistered and untrained healthcare providers (Li & Song, 2019). During the interviews, respondents mentioned about the availability of different health care facilities in their area where they or their peers from the Hijra community seek healthcare services. The formal facilities included government hospitals, private hospitals, private clinics, NGO clinics and health centers. For informal healthcare facilities, they mentioned pharmacies, *kobiraji, hujurs* or religious healers and homeopathy. Most of the respondents had knowledge of both formal and informal services in their area, but some of the respondents only knew about informal healthcare service providers.

One participant expressed in this regard.

"There are many pharmacies and kobiraj in our area in North Badda. They provide tablets and medicines for Hijras. There is Dhaka medical college hospital, but far from here. . .I never visited there" IDI 21, AGE 25, BADDA

Health service seeking practice and experiences from informal sector

Data shows that when it comes to seeking healthcare, pharmacies are the most popular option for the people from Hijra community. 18 out of 26 respondents mentioned availing healthcare service from pharmacy and they opt for it as their first line of choice. 10 out of 26 participants confirmed about going to a *Kobiraj* in their area. *Hujur* or religious healers are the next most reported informal health services for the Hijra community.

Pharmacy:

According to the IDI and KII participants, majority of the Hijra persons seek unprescribed medication from pharmacies in their area. The pharmacies are easily accessible and close to their residence, with no requirement for a prescription, and affordable with no additional fee for consultation.

> *"Usually I visit the pharmacy nearby for common problems of fever, cold that I have, and they give me the right medicines and I do not have to go to a doctor and spend money which works well for me" IDI 8, AGE 21, MANDA*

Those who collect money through *Hijragiri* from all the pharmacies in their designated areas mentioned to have a good rapport with the pharmacy owners. Respondents said that the pharmacy vendors' behaviors towards their community are good, with little discrimination, compared to other formal healthcare facilities. Some pharmacy drug sellers are also involved in romantic relationships with the hijra people.

> *"Many pharmacy dispensers are boyfriends of the Hijras in our community, they are more accepting of us Hijras and help us anytime with any health issues." IDI 7, AGE 20, MANDA*

Most respondents reported experiences of seeking healthcare from the pharmacy for non-severe health problems, or they refer to 'common or ordinary health problems.' The pharmacy vendors/ unqualified healthcare consultants are referred to as 'Quack Doctors' or '*Hature* Doctors' by the respondents. They are mentioned to provide '*Totka*' medicine, often symptomatic medicines prescribed to the Hijra community for common symptoms.

An activist working for the rights of Hijra community supplemented,

> *"For regular symptoms of fever, cold, cough, stomach ache, diarrhea and other primary healthcare problems, they seek medication from the pharmacy, buy oral contraceptive pill, either self-prescribing them or asking the pharmacy vendor for the right medicine" KII 1, Age 38, Mohammadpur, Activist*

Kobiraji:

Kobiraji is a traditional informal health service, with a basis of indigenous knowledge on the informal use of medicinal plants, with healing based on spiritual beliefs.

10 out of 26 respondents reported having visited a *Kobiraj* for various reasons, which included general health issues such as jaundice, ankle sprain, conjunctivitis, toothache etc., spiritual support for saving from evil-eye or '*Nazar Tarano'*, and cause harm to others through black magic. Jaundice is a disease widely known for being cured through '*Jhar fuk'* / charm as a mode of treatment.

> *"I go to an experienced old man in my area, he knows kobiraji, he has good knowledge on herbal medicines. Many people go to him for cure, I also went for my health problems, and it helped me" IDI 10, AGE 25, MANDA*

However, when clients paid *Kobiraj* a good amount of money for treatment, *Kobiraj* behaved well to them, otherwise *Kobiraj* did not care that much. A KII working in the Hijra community says,

> *"Many Hijras go to kobiraj, for their health problems, when they are paid, they behave well, which is why the Hijra persons prefer to go them more often"*
> *KII 1, Age 38, Mohammadpur, Activist*

Two respondents mentioned they had never sought treatment from a *Kobiraj* because of their lack of belief and trust in their methods. Although they were advised to go to *Kobiraj* to seek health services by their peers. A respondent mentioned,

> *"No I have never been to a Kobiraj or Hujur, because I don't believe in them. I feel if I go there I will become a sinner." IDI 11, AGE 26, KURIL*

Hujur/ Religious healer:

Hujurs are the religious or spiritual persons who also provided health related healing support to people. Some members of the Hijra community turn to religious healers or '*Hujurs'* for their spiritual healing practices for insomnia, parasomnia, stomach ache/upset and conjunctivitis. The

mode of treatment entails '*Pani Pora'* or Holy Water which reduces incidences of nightmares and parasomnia, reciting holy verses and blowing air on eyes for conjunctivitis, and '*Gaa bondho kora*,' or 'protect body from illnesses,' which is believed to protect health and body from evil entities. The influence of seeking healthcare services from *Hujur* is based on religious beliefs and preferences. 6 respondents out of 26 mentioned seeking treatment at least once from a *Hujur* or religious healer.

> *"My friend was having a disorder of constant nightmares, for which her peers referred her to a Hujur from her area, where she was treated with Pani Pora / Holy Water" IDI 2, AGE 32, MANDA,*

> *"I took blessed water from Hujur for stomach ache. Then once I had conjunctivitis, then he blew air on my eyes, reading some holy verses. " IDI 10, AGE 25, MANDA*

A key informant of the community, who is also an activist also resonated with this health seeking pattern,

> *"Sometimes the Hijras go to Kobiraj and Hujurs to get Jhar Fuk, Pani pora and herbal medicines for their medical and health conditions. They believe in supernatural powers, they do not get properly checked up by a doctor, rather these serve as an easier solution to their problems"*
>
> *KII 1, Age 38, Mohammadpur, Activist*

5 out of 26 respondents shared that the *hujurs*/ religious healers practice Islam which does not recognize the existence of Hijra culture. Therefore, they are sometimes reluctance from their side to provide hijra people with service and sometime they even misbehave with them.

> *"I went to a Hujur and he actually did not want to talk to me at all. He indirectly said that by asking me to come later. When I went there later, I could not find him. He sent someone else in his place to tell me that he was not available, although he was treating other secretly. I went back 2 days later, and he did not want to talk to me" IDI 17, AGE 18, RAYERBAZAR*

Homeopathy:

Homeopathy derives from the Greek terminology '*Homios*', which translates to 'similar'. The idea that "like cures like" is one of the major tenets of homeopathy. Homeopathic medicine is thus predicated on the notion of treating diseases using agents that mimic the signs and symptoms of the patient (Wadley & McNamara, 2015).

This practice of health seeking is influenced by their belief in the medicines, and the influence of their leaders and peers.

Two respondents mentioned using homeopathic healthcare services to treat general health problems like allergic conditions, and headaches.

> *"I have been going to the homeopathy doctor. I had a headache for several years along with allergy problems, and for these reasons I am seeking homeopathy treatment, I will even be going there today. My Gurumaa first took me to this doctor and ever since I have only been going there" IDI 11, AGE 26, KURIL*

Self-Medication:

A number of the study participants (6 out of 26) mentioned that they don't seek any external health care and practice self-medication for common symptoms such as fever, cough, cold, runny nose, body ache, skin rashes, headaches, without any prescription, often through perceived knowledge or influenced/informed by support network in their communities.

A KII mentions,

> *"For fever, cough, cold they would purchase paracetamol by themselves, or ask for anti-histamine such as histacin for primary treatment of their symptoms. For stomach ache and diarrhea, they will take Amodis or Famodil by themselves."*
>
> *KII 1, Age 38, Mohammadpur, Activist*

Health Seeking Pattern for physical/ gender transformation:

Data shows that physical feminine attributes are an essential aspect of many members of the Hijra community. Many Hijra persons are born male and prefer to go through physical transformation. With no legalized or approved facilities present in Bangladesh, they seek different treatment methods in the informal sector for physical transformation.

The cheapest, non-invasive, most popular and widely practiced by the Hijra community is the use of oral contraceptive pills or '*Mayabori'*, perceived to enhance feminine features. 11 out of 26 respondents reported either using oral contraceptive pills themselves or someone they know in their community collecting from the local pharmacy.

A respondent describes her peer's experience,

> *"I took a lot of 'Mayabori' contraceptive pill to enhance her breast size and reduce body hair, as suggested by others. I regularly buy pills from the pharmacy without any prescription" IDI 2, AGE 32, MANDA3*

Few of the respondents (2 out of 26) mentioned going through castration and reported going to unauthorized clinics or pharmacies to avail these services.

As one respondent describes her experience in this regard,

> *"I had my penis removed through an operation. I had it done from the district of Faridpur. I arrived at the city, from where I was blindfolded and taken to the location of operation. It was not a health center, rather a pharmacy, and the clinic for these surgeries was in a secret room behind the pharmacy." IDI 8, AGE 21, MANDA*

Health service seeking practices during Covid-19

During the of Covid-19 pandemic in 2020, some of the respondents reported to be affected by the Covid symptoms but they avoided going to formal healthcare facilities due to the fear of discrimination and stigma of being identified as a Covid patient.

Some of the respondents relied on home remedies such as using menthol infused water vapor for relief of blocked nose, few of them acquired medicines from pharmacies, and others used ayurvedic or herbal treatment for Covid-19 symptoms.

One of the respondents said,

> *"I couldn't go to the hospital. Firstly took vapor of menthol water, then I went to a pharmacy, brought medicines from them. They said " You have an infection in your chest, take the medicine, it'll get healed. Don't worry. And don't go outside." That time I didn't go out for 3 months." IDI 16, AGE 50, BADDA*

Factors associated with decision-making to access informal health services:

When asked why they prefer informal health care facilities over formal ones, most respondents mentioned that they believe they have less access to formal care. In some cases, they do prefer informal health care because they have easy access to it. However, they mentioned that if there is easy access, better service quality, and acceptance from the healthcare providers, they would go to formal health care services. In this section, we describe the findings about the decision-making factors for choosing informal health care facilities instead of formal care.

Attitude of formal healthcare providers:

Negative (discriminating, negligent and sometimes derogatory) attitude by the health care providers of government and private healthcare facilities towards Hijra people was the most significant reason of avoiding formal healthcare facilities and choosing informal care, as mentioned by the respondents. 18 out of 26 respondents reported the incidence of receiving unpleasant and inhospitable, even hostile behavior from either the Doctors, or other members of the hospital workforce, including receptionists, nurses, ward boy, and other staff.

A respondent reflected,

> *"The doctors don't want to give proper checkup. They don't want to touch the hijra people. They show a disgusting attitude. This makes us feel like we are impure, as if we have dirt on our body. They don't want to come close to us. They don't want to talk to us*

properly. They make us wait and sometimes even denies giving treatment." IDI 1, AGE 23, MANDA

8 out of 26 respondents shared that the doctors and physicians do not want to attend to them, and even if they do, they misbehave or are negligent about their issues. They are said to be given many excuses to not attend them, such as unavailability of a doctor, or blatantly mention how the facility is not for them.

A respondent shared,

"No, he (referring to doctor) did not provide me any counselling. He just told me that I should never come back to him either alone or with anyone from my community. He directly told me this. He asked me to never visit. Since then, the fear of discrimination has been inside me, I still could not come out of it and I never visited there again." IDI 5, AGE 25, RAYERBAZAR

In some instances, doctors or service providers do not want to examine them physically and maintain a distance from them providing minimal care. Sometimes they just write a prescription without proper counselling. They are said to allocate very limited time to consult members of the Hijra community. The refusal of health services from private institutions discourages Hijra patients to go and seek services from the formal sector.

An activist and Hijra leader also shared regarding one of her disciples,

"One of my girls went to a doctor in a government hospital for treatment. The doctor asked 'What's your problem? she replies 'I had an operation many years ago, now it's aching there'. There the doctor said, 'okay wait' and he just wrote a prescription and gave it in 2 minutes. She was not satisfied. He did not even touch her, examine her or observe properly to try to understand what actually was the problem"

KII 4, Age 28, Rayerbazar, Activist and Hijra Gurumaa

The Hijra persons are also subject to harassment and abuse by the healthcare workers, as mentioned by the respondents. They are bombarded with irrelevant and inappropriate questions about their identity, personal life and sexual life. They also mentioned, sometimes they are

placed in the male ward, and they remain in constant fear of being sexually harassed. The healthcare providers are also said to make jokes and laugh at their identity, which impacts these patients with emotional trauma.

1 respondent also shared the incidences of sexual harassment and abuse in the hands of the healthcare provider staff, namely the assistant of the doctor,

> *"Actually, I'll say it is a matter of shame, that someone went to a consult a doctor the ward boy or assistant or whoever that was, touched the Hijra's penis and was playing with that. He said, 'You came with this and you call yourself a women? This is complete harassment"*
>
> *KII 4, Age 28, Rayerbazar, Activist and Hijra Gurumaa*

Availability:

Respondents (8 out of 26) mentioned the lack of availability of formal healthcare services like government facilities or NGO clinics in their areas of residence. Four out of them denoted the comparatively increased presence of informal providers for health services. This highlights the penetration of the informal sector dispersed in the smallest communities in different areas of Dhaka city, while the mainstream healthcare facilities by the government and the NGOs are present in major areas. The different NGO clinics that are available are said to only provide primary level treatment for common symptoms like fever, cough etc.

A respondent mentioned,

> *"Only general level treatments are given there (referring to NGO clinics). For example, sneezing, coughing and itchy anal treatment are given there with basic and primary medications. They don't even have an Xray machine, or Ultrasound machine. There are many Hijras who become ill and still cannot go to the hospital because of their shyness. They only go to the NGOs. At some point, we have to force them to go to the hospital, usually at the last stage when the disease is severe."*
>
> *KII 4, Age 28, Rayerbazar, Activist and Hijra Gurumaa*

The NGO services are project centric, and often focus on specific categories of health services, such as sexual health and rights services of the Hijra community. However for sexual health, they have HIV testing services and mainly distribution of condoms, with no provision for diagnostics or other consultations.

Accessibility

Respondents mention facing difficulties to access the existing formal healthcare facilities due to the stigma attached to their identities. As described by the respondents, the essence of an uncomfortable experience initiates from the reception line where they stand in a queue to receive a ticket for consultation. The formal healthcare system has provisions only for male and female lines.

Moreover, the receptionists question their reason for visiting the healthcare facility with the predetermined perception that they might be visiting for cash collection, as a part of their *'Hijragiri'* profession. Then they are often kept waiting for long hours, compared to other patients in queue. 3 respondents shared that they were refused treatment from the reception line, providing vague excuses like the unavailability of doctors or unavailability of services for the Hijra community.

A respondent shared,

> *"The people at the ticket counter say, 'Why are the Hijras here? Do you people even have some health problems?' So we are not given any importance from the beginning. We got very tense at that time." IDI 3, AGE 32, MANDA*
>
> *KII 4, Age 28, Rayerbazar, Activist and Hijra Gurumaa*

3 out of 26 respondents mentioned that due to their previous experiences of being ignored and unattended in formal health service centers they did not go to those health facilities next time.

> *"They show negligence. They make us wait. They see patients who are after us in the serial and make us wait. We don't get the same checkup as other (male/ female) patients.*

They check us from far and send us away. We feel dishonored, how will we go there next time?" IDI 10, AGE 25, MANDA

To seek any government service, a National ID card is primarily required to be registered in the system. For a Hijra person, their gender addressed in the ID card remains that of a man, which does not align with their true identity or their appearance. This arises problems and setbacks in the process of seeking healthcare services for the Hijra community. Two of the respondents also mentioned about hiding their Hijra identity in order to avail services from Government and other formal facilities.

One of the respondents said,

"Sometimes, we even need to change our identity to see a doctor. And in Bangladesh, many people are not yet aware of these things, in that case, the Hijras who have long hair, they tie up their hair in a bun and wear a cap over it, then wear a Punjabi and lungi with that to conceal their outlook." IDI 4, AGE 23, MANDA

Affordability:

Many of the respondents (8 out of 26) expressed that treatment costs in formal facilities, namely government or private facilities are costly, and less affordable for them.

A respondent mentioned,

"A visit to the doctors in private hospital is very costly. Cost definitely is a factor for us, as our daily income is very low. A single test for syphilis costs about 1200 to 1500 taka. If that amount of money goes for tests, how will we survive the rest of the month?" IDI 5, AGE 25, RAYERBAZAR

Two of the respondents said that they paid a broker for receiving services in private hospitals, to facilitate their treatment procedure during a health emergency, as they could not get fast consultation if they went through the normal channels.

One respondent mentioned that they prefer going the pharmacies because its affordable and they do not have to pay for expert consultation from doctors to get a prescription. The pharmacy vendor prescribes them medicine according to their symptoms. She said,

"I buy medicines worth 5-10 taka, according to what the shopkeeper in the pharmacy suggests me. Then if that medicine works, I don't go anywhere else. Till now, I have not been to any hospital to see a doctor for any problem." IDI 8, AGE 21, MANDA

Respondents also mentioned another informal provider, the *Kobiraj*, who uses a different approach to collect the cost of their services. They charge them with 'Hadiya' (fee for a certain charm), which denotes a religious contribution, and is perceived as more affordable and acceptable than healthcare costs among hijra community members.

"When we suffer from fever or cold, we buy medicines for 200 taka, but for Kobiraj, they charge for 'Hadiya' for the treatment of jaundice, which is a religious donation, priced at 501 taka or 301 taka. This is not a fixed rate, they try to charge money according to the clien's economic condition." IDI 1, AGE 19, Rayerbazar

However, respondents also mentioned that their preference for formal healthcare in terms of affordability is NGO clinics, which provide them services free of cost, with an allowance for transport fare every time they visit their facility.

Attitude of other patients and attendants in formal healthcare facilities:

Some (6 out of 26) respondents shared their embarrassing experiences regarding the negative encounters with other patients and attendants and their unwelcoming attitude towards them on the hospital premises, especially in the waiting areas. They are met with unpleasant behavior and shunned and rejected from the waiting lines of both men and women, saying they do not belong in their lines. The respondents described that they receive glaring stares of disgust and whispers about how they are a cursed abomination before they move away from them.

Regarding these incidences, a respondent shared,

"When we stand in the women's line, they feel uncomfortable, and then we stand in the men's line and they shoo us away saying we are not like them. Many also move away from us, take their kids further away from us, thinking we will ask money from them" IDI 9, AGE 28, KURIL

Influence of *Gurumaa* (leader)/ peers:

Hijra disciples are immensely respectful and devoted to their Hijra leaders or '*Gurumaa*' / 'Nani'. They mainly seek *Gurumaa*'s advice to serve as the first line of support for any health problems. Majority out of 26) respondents reported having approached their guruma/ leaders initially for any health issues.

A respondent says,

> *"I go to my Gurumaa and tell her first whenever I feel sick. Like the last time I lost my appetite, she gave me medicines. She also gave me vitamins, iron for muscle cramps, calcium tablets for bones." IDI 23, AGE 18, BADDA*

The power-relations between the *Gurumaa*/ leader of the community and their disciples play a significant role in decision making for their health-seeking behavior. The disciples tend to listen to their leaders and abide by their advice meticulously in every aspect even for health issues, regardless of their expertise.

A *Gurumaa* (leader) supplemented this,

> *"Amongst my followers, five of them stay together, I live separately. If any one of them becomes ill, they will immediately call me, even in an emergency without taking them to a hospital first; they will always call me for guidance."*
>
> *KII 4, Age 28, Rayerbazar, Activist and Hijra Gurumaa*

As mentioned by their disciples, a number of the *Gurumaa*/leaders direct their followers towards the informal healthcare services or selfcare for health issues.

Regarding this a KII respondent reflects,

> *"Many of the Hijras suffer from anal infection and Syphilis. This causes the place to swell up. When they suffer from this, they sit in warm water. They take warm water in a big round pot and sit in it as treatment and reduce the pain. They get to know this from their Guruma/ community leaders."*
>
> *KII 1, Age 38, Mohammadpur, Activist*

Hijra people also seek advice from their peers. Previous health-seeking experiences of their peer network are shared around the community, which influence their decision-making process.

> *"I heard about this pharmacy from one of my Girlfriends. She told me that the seller in the pharmacy gives good medicines according to illnesses. She took me to the pharmacy and introduced me to the shopkeeper." IDI 18, AGE 37, MANDA*

Cultural and Religious Influence:

The cultural values and religious beliefs persist in the Hijra persons from an early age acquired from their families and surroundings, which later influence their health-seeking behavior and availing of informal services. As mentioned by some respondents (10 out of 26), they have heard about certain supernatural practices and their effects from their mothers or friends, which inspired them to seek services from places such as *Kobiraj*. A few respondents (6 out of 26) also talked about how their faith and religious belief in Islam influence their health-seeking from religious healers or *Hujurs*.

> *"My mother always told me that Hujur's pani pora (blessed water) will cure all my health and life problems, so I still go there." IDI 10, AGE 25, MANDA*

Discussion:

The findings of this study suggest that the majority of the Hijra persons had minimal understanding and did not fully apprehend the idea of health and well-being in all its dimensions of physical, mental, emotional, and social aspects. The general health problems in their community were determined by their lifestyle choices, the perils of their occupation, economic conditions and the hazards of the environment they reside. The health problem most prevalent in their community are sexually transmitted diseases such as HIV, syphilis due to unsafe sexual practices and multiple partners. As stated by UNAIDS, internationally transgender and male sex workers are a priority and vulnerable population for sexually transmitted infection response, due to their higher prevalence (UNAIDS, 2012). Other common health problems include common

cold, headaches and migraines, body aches from constant walking in the sun, gastrointestinal disorders and other illnesses.

Data shows that for common health symptoms such as fever, cough, body ache, the Hijra community primarily opts to self-medicate, acquiring treatment from pharmacies in their locality without a prescription. This is resonated in another study looking at the medicine dispensing pattern of pharmacies, where they can acquire most of the drugs, such as antibiotics, steroids nervous system depressants, without a prescription, leading to receiving wrong medications and causing adverse side effects and drug resistance (Saha and Hossain, 2017). Other informal healthcare services availed by the community include spiritual healing based '*Kobiraji*' treatment for Jaundice, ankle sprains, conjunctivitis and insomnia. They also went to religious healers or '*Hujurs*' for protection from evil-eye and entities, supernatural possession of men, and Homeopathy treatment for headaches and allergies. Other studies shows that In the context of Bangladesh, seeking healthcare from the informal health sector like *Kobiraj* or *Hujur* is common for the poor and disadvantaged communities (Haque et al, 2018). Despite the wide acceptance and practice of health-seeking in the informal sector, there has been no study specifically looking at the informal health-seeking pattern of Hijra community in Bangladesh.

Our study shows hijra people seeking services from different informal providers such as *Kobiraj, Hujur* (religious healers) or homeopathy is linked to different social, cultural and religious factors such as *Gurumaa* and peer influence, cultural believes inherited from the family, faith in a specific religion etc. Besides an instinctive and inherited belief system, other factors such as wide availability, minimal service cost, positive attitude of the informal healthcare providers, and almost negligible discrimination drives the Hijra persons towards the informal healthcare sector, are also similar and resonated in other studies ((Haque et al, 2014; Uddin et al, 2010). This decision-making is further amplified by the previous negative and discriminatory experiences makes the Hijra community reluctant to seek services from the other formal health service providers, namely the government and private facilities. Our study finds members of the Hijra community are hesitant to seek healthcare at formal facilities due to the antagonistic and negligent attitude of the healthcare providers, inept and unwelcoming engagement with the reception staff, derogatory and sometimes hostile behavior of the other patients and attendants, solely dichotomous gender category and a lack of privacy and confidentiality. The interviews established that the few times they opt for going to a formal healthcare provider is when their

perceived severity of illness is beyond a certain seriousness and requires hospitalization, and the nominal healthcare cost of the government facilities. On the contrary, another study conducted by Khan et al. (2020), stated the primary reason for being the affordability and the secondary reasons to be distance from residence and availability of reliable doctors.

Our study findings also highlight the implicit prejudice by the healthcare providers towards the Hijra persons. They are rather disregarded and mistreated. The notion stems from the mainstream culture of disparity of this marginalized community, which barely comprehends the gender identity, lifestyle and their cultural norms. The Hijra persons are subject to verbal abuse by the healthcare providers, with incompetent and negligent treatment, and sometimes even sexual harassment and emotional abuse, also resonated in other literatures (Mal, 2015; Chakrapani, Babu & Ebenezer,2004). The sexual practices of Hijra patients are questioned and frowned upon. These findings are resonated in many previous literatures where the healthcare providers attitude is described as a major barrier for this community to seek healthcare in the formal settings (Bowling et al., 2016, 2018; Gupta & Sivakami, 2016; Ortiz, 2016; Sarker, 2019). The healthcare providers also belong to the majority of the population with a preconceived notion and norms of neglect and fear of the Hijra persons, with no adequate knowledge of their identity. With no further sensitization training or formal education of Hijra identity and health in the medical curricula, and they remain to treat them with neglect and discrimination.

The need for inducing physical transformative changes towards more feminine characteristics is commonly present in the Hijra community. The legalized gender-affirming surgeries of neighboring India remains the preference of choice amongst these community for those who can afford. A study conducted by Singh et al. (2014) in sever major cities of India shows the absence of gender transition services in public hospitals, even though they are present in some private hospitals with an extravagant cost for the services. From our study, we found that due to the lack of availability and the illegal status of these kind of services in Dhaka, a large proportion who doesn’t have the ability to go to India opts towards unlicensed and recluse medical centers providing cheaper alternative solutions and monetizing on their desires. This incurs an economic burden upon the Hijra community with incidences of major complications such as genital infections, shock and even death in some cases. Our study also finds, in the quest for being able to afford good quality and safe physical transformative measures, some of them also save money for a medical trip to India, to avail better quality of treatment.

In essence, health disparities for vulnerable Hijra communities in healthcare settings are influenced by social prejudice. Our study findings along with past literatures displays a lack of willingness to acquire healthcare services from formal facilities, and a inclination towards informal healthcare facilities.
Their selection of health service also depends on their understanding about the severity of the disease and the services provided by those facilities. For their common health issues like fever, cold, headache or gastric problems they opt for treatment from informal facilities that are most accessible, available and reasonable for them. For serious health issues that need experienced consultation and acute management they tend to seek service from formal health care facilities like government or private hospitals or NGO clinics.

Bangladesh still has a wide practice of superstitious indigenous health care activities that are very popular amongst the people of poor socio-economic status. The presence of many informal healthcare providers in the areas of residence of the Hijra community makes it easier for them to seek primary healthcare from these providers. Beliefs towards their unorthodox methods, previous experiences, social influence from peers and leaders, makes these informal health services more popular in their community. The accessibility, affordability and acceptance and the positive attitude of the informal providers towards the Hijra community also makes them more trusted and popular and encourages them to continue the practice within these communities.

Conclusion:

This study has documented the health-seeking practices of the Hijra people regarding informal healthcare services and their decision-making factors on why they choose the informal over formal healthcare. The negative attitude of the formal healthcare providers proves to be a deciding factor for the Hijra population to avoid formal facilities. Ingrained stigma along with lack of knowledge, education and sensitization about Hijra identity and lifestyle leads to poor acceptance of this population

Our findings suggest the health systems to be more inclusive based on gender binary, with policies to implement the recognized gender status of Hijra people for better provision for healthcare. The integration of gender studies in medical and nursing college education

curriculum is essential for the health workforce to better understand the identity, practices and needs of the Hijra population. There is also a need for capacity building on gender diversity of existing healthcare providers with rigorous trainings and workshops.

The Hijra population has special healthcare needs that requires special attention. In order to address these gaps in the NGO programs and service delivery of other formal health service providers, it is important to implement focused interventions, and equip the formal facilities with gender inclusive services and departments, with sensitized health workforce to provide treatment to the Hijra community effectively.

Future research priorities can focus on the satisfaction of the Hijra community in availing these services and compare methodically with the actual quality of services. Policy oriented research is required to understand the smooth incorporation of gender inclusive Hijra healthcare services into the mainstream health services.

Even if the formal services are more preferable, some people will always seek services from the informal sector, due their cultural, social and religious beliefs, thus informal health systems should also be improved. Some practices of the informal sectors are unscientific and has certain bad practices that do more harm than good. Awareness building programs can address these in disseminating proper messages to the Hijra community to make informed decisions. A process of referral from the informal to the formal sector for health issues that require medical supervision should be initiated. This can be achieved through policies by the government on training practitioners from the informal sector. The process can further be monitored and improved with the involvement of community-based organizations working with the Hijra communities, along with recognized government institutes of Homeopathy, Ayurvedic and Unani medicine. Pharmacies should also be regulated for dispensing appropriate prescribed medications and awareness building of both pharmacies and the hijra community on the implications of self-medications.

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Annex-1

Codebook

CODE	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	• Perception about health and wellbeing • Source of such beliefs
Knowledge about available informal healthcare facilities	Can be defined as a place used to describe any informal providers who provide services addressing health issues of any kind.	Knowledge about informal healthcare facilities where any general health issues of Hijra communities are addressed	Knowledge about other services for Hijra community other than healthcare	• Available informal healthcare facilities • Available formal healthcare facilities

General health problems / What affects the health of the Hijra people	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 ● Perceived reasons behind common diseases ● Sources of such believes (Social/ cultural/ religious etc.)
Informal Health seeking behavior	Description of the use of informal 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	Include all the informal healthcare services utilized after being identified as a Hijra person	Do not include any formal or informal healthcare facilities visited before they identified themselves as Hijra person	● Reason (illnesses) to seek health care including severity (including frequency of illness and visit) ● Health seeking pattern from informal faciltiies ● Preferences towards informal healthcare facility (decision making) ✔ Availability ✔ Accessibility ✔ Affordability ✔ Previous experience(*belief*) ✔ Support network *(Decision maker-Gurumaa, Accompany-friends*)
Experience in seeking healthcare in the informal health sector	Refers to the overall experience including incidences, events, encounters, circumstances and conduct from surrounding people, faced by the respondents when visiting the informal healthcare facility for their ailments	Include all the experiences in informal healthcare facility after being identified as a Hijra person 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	● Informal healthcare Service Provider's Attitude - Good/ bad/ neutral attitude - Comparison to formal healthcare providers attitude ● Any Harassment or discrimination -Include formal harassment in comparison to informal ● Waiting Time -In comparison to formal healthcare facility

				● Service Availability - In comparison to formal ● Attitude of other patients and attendants ● Quality of service ● Result after seeking informal healthcare
Covid-19 Experience	Refers to the lockdown in Bangladesh during the year 2020 and their overall experiences of healthcare service uptake	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 illness Covid Treatment - Compare formal Refusal to admit - Other forms of informal treatment /beliefs ● Covid Test ● Covid Vaccine (for comparison)
Sexual Health service utilization in the informal sector	Description of the use of services and experiences by respondent and her community members for preventing, diagnosing and curing sexual health problems and STI, promoting healthy sexual behaviour and well-being			● Knowledge, perception and beliefs on sexual health ● Sexual illness experiences ● Informal healthcare service utilization ● Reason/decision making factor for preferring informal healthcare services