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Locating Hijra and Transgender in Bangladeshi Health Discourse : A Critical analysis

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Abstract: Bangladesh has acknowledged hijra as a separate gender other than men and women since 2013. Nevertheless, they do not have access to sexual reassignment surgery, body modification or hormonal therapy within a legal health framework, whereas being a hijra or transgender person is a significant health concern. Still, it has never been considered in health policy. The body of a transgender or hijra person is always a subject of discrimination. This is not only about prejudice; it is a systematic process that colonial discourses have hegemonised. To turn hijra from a social category to a medical category, mainly covering them within the disabled framework, is an influence of medical discourse that must be addressed from an intersectional lens. This chapter also critically analyses Hijra's body transformation process from a sociological perspective to articulate how hijra and transgender health in Bangladesh discusses physiology and a part of the socio-cultural construction of the body image of a male-female gender binary. It also analyses the state policy and its implementation by conducting ethnographic research among hijra in Dhaka, Bangladesh.

1. Introduction

In Bangladesh, India and Pakistan, gender nonbinary people are popularly known as *hijra*. In Thailand, transgender people are known as *kathoey*; in Indonesia, *waria, and* Mexico *muxe.* In Bangladesh, they are historically adopted the appellation “hijra", often translated to transgender (Akhtar, 2021,p.3). Hijra and transgender health is a critical identity in Bangladesh, where the transgender community faces significant challenges in accessing healthcare services. Discrimination and stigma are widespread, and healthcare professionals often lack the knowledge and skills necessary to provide appropriate care to transgender individuals. Though much scholarly paper locates hijra as transgender, there is in-depth tension between these two groups. As hijra is an umbrella term like transgender (Snigdha, 2021), many of them are transwomen as well. Still, the communal identity, and livelihood practices, particularly the Western hegemonised discourse of transgender embedded in transwomen in Bangladesh, want to draw a border between hijra and transgender. And therefore, to prioritise their identity discourse, in this paper, they locate hijra and transwomen separately. Hijra and transgender people in Bangladesh often face discrimination and exclusion in all areas of life, including primary healthcare, hospital care and surgeries. Many healthcare professionals lack the knowledge and understanding to provide appropriate care to transgender individuals, leading to poorer

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health outcomes and increased risk of preventable illnesses. One of the most significant barriers to accessing healthcare for transgender individuals in Bangladesh is discrimination and stigma.

Transgender people are often ostracised and excluded from mainstream society, leading to a lack of access to healthcare services. This, coupled with the lack of knowledge and understanding among healthcare professionals, means that transgender individuals are often reluctant to seek medical care when needed. Hijra and transgender individuals in Bangladesh are also located at an increased risk of contracting sexually transmitted infections (STIs) and HIV. This is partly due to a lack of healthcare services and discrimination and stigma preventing transgender individuals from accessing safer sex information and resources. In addition, the global health discourses locate them as a target group for HIV projects which socio-culturally identify them as a more vulnerable and stigmatised community, which has been vividly discussed in this chapter. Though there are many health issues that transgender people face other than HIV infection, there is minimal research on other health issues (Snigdha, 2021). The majority of the health data, transgender people were located on HIV infection in previous yet, in recent days, mental health, sexual and reproductive health, substance use disorders, violence and victimisation, and the effects of stigma and discrimination such as mental health issues have been a great concern last couple of years. Hence, Some efforts are being made to address these issues; in recent years, there has been an increase in awareness and understanding of transgender health issues in Bangladesh, and in particular, some healthcare professionals have undergone training to understand the needs of intersex patients better. Some community-based organisations provide support and information to transgender individuals, including information on healthcare services and safe sex practices. Nevertheless, these organisations often operate with limited resources and face significant challenges in accessing funding and support.

Bangladesh has acknowledged hijra as a separate gender other than men and women since 2013 (Snigdha, 2019). However, they do not have access to sexual reassignment surgery, body modification or hormonal therapy within a legal health framework, whereas being a hijra or transgender person is a significant health concern. Still, it has never been considered in health policy. The body of a transgender or hijra person is always a subject of discrimination. This is not only about prejudice; it is a systematic process that colonial discourses have hegemonised. To turn hijra from a social category to a medical category, particularly covering them within the disabled framework, is an influence of medical discourse that must be addressed from an intersectional lens. This chapter also critically analyses Hijra's body transformation process from a sociological perspective to articulate how hijra and transgender health in Bangladesh discusses physiology and a part of the socio-cultural construction of the body image of a male-female gender binary. It also analyses the state policy and its implementation by conducting ethnographic research among hijra in Dhaka, Bangladesh.

2. Methods

The ethnographic research methodology used participation observation, case studies, in-depth interviews, and focus group methods blended with qualitative data collection to obtain a detailed and reliable picture of hijra and the transgender community. I use my five-year rapport build-up science in my PhD journey to explore and analyse their

experiences regarding health service access and the perception of health. Through ethnography, 'tales from the field' were explored to acquire multiple perspectives and interpretations of bodies and health. Ten hijra gurus, five chela and five transgender women's in-depth interviews were taken. In addition, one focus group discussion among the *chibry* (hijra who went to sexual reassignment surgery called *chibry* in their local term) has been conducted. Both hijra and transgender have been selected purposively. The data has been thematically analysed, and all the research participants' consent has been taken. For ethical considerations, all the interlocutors' identity is disclosed, and I have been using pseudonyms for confidentiality.

3. Locating transgender and hijra people in Health discourse

According to WHO's Guidelines on HIV Prevention, diagnosis, treatment and Care for key populations released in 2013, transgender people are among five groups disproportionately affected by HIV globally; the others are men who have sex with men, sex workers, prisoners and people who inject drugs. These groups are usually documented as critical populations for the HIV response because of their increased risk of HIV infection, and they are often stigmatised, criminalised, and marginalised, which affects their ability to access health services, including HIV prevention, testing and treatment (Aaron, 2016). Verster (2013) states, "It is estimated that in low- and middle-income countries, transgender women are around 49 times more likely to be living with HIV than other adults of reproductive age". In 2014, WHO released key populations guideline and published a technical brief with its partners in 2015 entitled HIV and young transgender people on how best to provide health services, programmes and support for young transgender people.

The same year, a WHO Policy Brief on Transgender people and HIV was published, summarising relevant WHO recommendations. In addition, WHO and its partners developed a guide on using the technical guidance entitled Implementing Comprehensive HIV and STI Programmes with transgender people, published this year by the United Nations Development Programme. Verster (2015) qualitatively surveyed transgender people worldwide for WHO guidance and mentioned, "We found that transgender people tend to have health priorities other than HIV". Also, Verster (2016) states that unless health services are designed according to the needs of transgender people and in consultation with them, it may be challenging to reach them with HIV prevention and care. These post-colonial health discourses regarding hijra and transgender people were translated into the Orient differently, and non-government organisations and community-based organisations targeted them as HIV risk groups who need to be trained for protected sex science last decades. Targeting these community people as STD and HIV significantly made them more marginalised and vulnerable, eventually not improving their sexual reproductive health.

According to Khan et al. (2009), social deprivation, stigma, and harassment have never received attention in Bangladeshi development sectors. Both hijra and transgender people state in various research that the mainstream society never tried to understand their culture, gender, and sexuality (Snigdha, 2019, 2021; Hossain, 2020). Their human and sexual violations have been overlooked in the traditional HIV intervention frameworks (Khan, 2007). According to Khan et .al (2009), the sole promotion of condoms and

lubricants ignores multidimensional ruptures and alienation within any targeted population. Moreover, understanding the sociocultural and human rights aspects of discrimination against the hijra and transgender community and deprivation can help reduce STD/HIV transmission and safeguard this marginalised community.

4. Health Access to Transgender and Hijra in Bangladesh

Bangladesh is a homonormative society, so accessing health services for non-binary gender identity is not a bed of roses. They are often overlooked within healthcare settings, and their lived experiences have been largely ignored in mainstream health policy (Alam & Marston, 2023). So therefore, both the transgender and hijra populations are also victimised as gender non-binary. Both the community members claim that they have never been seriously taken as a patient; instead, they have been judged for their gender identity. Two of my transgender interlocutors' cases might be relevant here.

> *Mira, a student, age 24, is a transwoman who identifies herself as transgender. In her 20s, she attended a close group community party and wore a party dress. While walking on the street, she could not handle her gown and was hit by a private car.; she immediately visited a physician with her friend because she could not walk properly. When she went to the physician, at first, he was not very comfortable to treat her. Instead of treating her immediately, the physician was curious about what sex identity he should write in the prescription. He asked- " tell me first, are you a male or female". Mira said, I could not even stand because of pain, and in his chamber, he did not ask me to sit first; he was asking about my sexual identity. Then my friend told him I was a biologically born male but a transgender woman. The doctor started to check me with a very annoying look and diagnosed that my feet were broken. Then he said – "Do not worry; this foot injury can be curable, but the problem in your brain is incurable". I was in much pain, but how he treated me was more painful and hurt my heart. I am not a hijra; I am a transgender woman; I never left my hand begging; I paid him for his service, so why did he react so?*

In the above case, it has been stated that though Mira got the private health service, she has been treated differently. The physician's statement, "The problem in your brain is incurable", clearly echoes the most popular Western medical discourse that 'transgendersim is madness' or being transgender is a mental health disorder where they have been located clinically experience a degree of gender incongruence; a discordance between their sense of their gender (Winter et al., 2016; Meyer-Bahlburg, 2010; McHugh, 2014) which has been highly criticised in recent days and had been argued that being transgender is not a mental health disorder (Canady, 2019). However, it reflected that Bangladeshi physicians had hegemonised the Western medical discourse regarding transgender. Also, their discomfort ability to treat a non-binary person vividly shows the dominance of colonial hetronormtive discourses. The following case might reflect how prejudice has been embedded in healthcare practitioners-

> *Nasima, a hijra guru, age 45, got typhoid at the age of 25, and she went to the government hospital but has been refused health care service from the government hospital as she is a hijra. Even she could not meet the medical practitioner. The nurse told her the doctor refused to provide her with any*

> *service as he was not interested in providing any service to such a person as her. Nasima said-*
> *After giving recognition, things have changed a lot nowadays, but still, we hijra are deprived. We get medical care from private hospitals only if we have enough money to pay them. We were admitted to the hospital when we could pay cabin rent. If we wanted to admit to the ward, the hospital authority denied us admission as they did not have any separate section for us. Even when we went to the diagnostic centre to identify the disease, we could not use their toilet if we needed a urine check-up. As they only have male and female toilets. No one. Neither the state nor the system thinks about us.*

The above case is significant in locating the difference between inequalities and changing environments. It vividly shows that the situation has changed since the recognition, but it represents their inaccessibility to government health services. The case also shows that they can only access health care services if they have enough money to afford private health care or can admit to the cabin because they have been systematically ignored. Ironically, while many Western countries argue for separate transgender toilets in public spaces (Patel, 2017; Slater & Jones, 2018; McGuire et al., 2022), in Bangladesh, hijras still struggle for minimal health care services. They do not have any access to the diagnostic centres' toilets because of their gender identity, which reflects the social hetronormitivety in Bangladesh(Alam & Marston,2023).

Moreover, research data also shows that the access to health services for Hijra and transgender is not equal in Bangladesh. In some cases, it shows that those who claim as transgender are getting little better opportunities compared to hijra. One of my hijra participants, Mita, said that "We are not as *chissha* (beautiful) as the transgender; we cannot perform like them, cannot able to express ourselves like them because we are not that much educated, that why they said they are trans and we are hijra". During my fieldwork, I felt a distinctive line between transgender and hijra when I spoke with them. If we get back to Mira's case, we can identify the statement, "I am not a hijra; I am a transgender woman; I never left my hand begging" This significantly creates a borderline between hijra and transgender, reflecting into their surgery and hormone therapy. Not all hijra people seek gender-affirming treatment. Aruna (chibry, age 35) said, "Not everyone who wants gender-reassignment surgery in Bangladesh can access it; few hijras remove their genitals by self-mutilation, many of them went to *katial* (quack) before, and most hijras go to '*karkhana'* (secret temporary medical centre for the surgery)".
On the contrary, all of my self-declared transwomen interlocutors underwent hormonal therapy or sexual reassignment surgery. Interestingly, they all take their transformation health services from the neighbour country India. It should be mentioned that in Bangladesh, though the government acknowledge the hijra as a separate gender, they legally did not permit to do gender-confirming surgery. Therefore, this type of surgery has been conducted secretly, which caused high risk for them. Ans hijra people generally underwent this surgery there, whereas the high-rank rich hijra went to India for hormonal therapy and sexual reassignment surgery.

COVID-19 Situation of Hijra and transgender health

Based on the UN High Commission statement, during the COVID-19 pandemic, Lesbian, gay, bisexual, trans, queer and intersex (LGBTQI) people even appear more severely vulnerable when the people have comorbidity or compromised immunity, particularly people who live with HIV/AIDS, tuberculosis or any other transmittable, communicable and non-communicable illness like diabetes, Blood Pressure or cardiac disease (Akhtar, 2021). In many cases, homeless persons, including LGTBI people, are less able to protect themselves through physical distancing and safe hygiene practices, increasing their exposure to contagion, access to health services, de-prioritization of essential health services, Stigmatization, discrimination, hate speech and attacks on the LGBTQI community, domestic violence and abuse, access to work and livelihood, are the significant issues to look into in this COVID-19 realities since many transgender communities are of an extraordinary disadvantageous situation with COVID-19 (Akhtar, 2021). The newly imported concept of social distance and lockdown significantly affect their everyday lives, particularly hijras, because their traditional profession demands to get closer to the person, entertain them, seduce them for sex work, ask for money as *cholla* or go for *badhai* as a newborn child blessing all sort of income source was interrupted. Therefore, many struggles to live, food, shelter and essential primary health care (Ahmed & Sifat,2021; Sifat et al., 2022).

5. Conclusion

To improve hijra and transgender health in Bangladesh, it is essential to increase awareness and understanding of transgender issues among healthcare professionals and the wider community. This can be achieved through targeted education and training programs and by providing support and resources to community-based organisations that work with transgender individuals. It is also important to address discrimination and stigma against transgender individuals in all areas of life, including healthcare. This may require changes to legislation and policies, as well as increased advocacy and awareness-raising campaigns. Also, the government and other stakeholders must take the initiative to train the physicians, nurses, word boy and other medical paramedics to learn how to handle hijra and transgender patients. We must take further steps to minimise the discrimination, stigma and prejudice against hijra and the trans community to ensure their basic health service. Moreover, we must fix our hospital, diagnostic centre and community care infra structure and build unisex toilets and cabins to ensure that all gender binary people, including transgender and hijra people, can get proper medical access.

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