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'The benefits do not reach us': analyzing the discrepancies between the state recognition of hijra and their reality in Dhaka, Bangladesh

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ABSTRACT

Hijra, a transgender group in Bangladesh, despite being acknowledged by the government in 2013 as a separate gender category, cannot adequately exercise their gender and sexual rights. This study aimed to explore discrepancies between the gender declaration and their lived realities of their gender and sexual rights. This study adopted the policy analysis framework, whilst linking it to SRHR frameworks by the Guttmacher-Lancet Commission. This study adopted desk review and mixed methods research to explore their ability to exercise their sexual and reproductive health rights as hijra. A total of 298 hijra participated in the study and completed quantitative surveys. Among them, 20 mutually exclusive groups of participants also completed 20 in-depth interviews and five focus groups (of 4-5 participants, totaling 20-25 participants). Data were analyzed through descriptive statistics and thematic analysis. The findings indicated that 79.2% obfuscated their hijra identity, 89.8% of whom hid from their family. Of the participants, 80.9% hid their partners due to fear of stigma and 82.2% reported societal discrimination. Almost all participants (98.7%) reported gender-based discrimination. The qualitative findings revealed motifs of exclusion and forced duplicity emerged where hijra disguised their identities, denied services, and faced gender-based discrimination in various settings including healthcare, education and employment. Legal recognition is a crucial step in improving health and quality of life for hijra, however, much work remains to advance their SRHR such as advocacy, cultural competency training of institutional service providers, and community mobilization.

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SRHR; hijra; rights; Bangladesh

Background

Politico-legally acknowledging gender identity, though an integral facet of sexual and reproductive health and rights (SRHR), does not guarantee health, rights, and social justice. A 2021 publication noted that nearly two dozen countries operationalized laws enabling people to self-determine their gender identity without medical or legal approval, and several countries have recognized transgender groups as separate gender identities (UCLA, 2021), these populations continue to experience socio-structural barriers, thus highlighting a global paradox.

The incongruence between legal stipulations and grounded practices also resonates in Bangladesh among hijra. Hijra are a unique sub-culture in South Asia that falls under the broader transgender umbrella (Khan et al., 2009). Though born male, they embody typically feminine characteristics and dressing style, both often move between masculine and feminine presentations (Khan et al. 2009). While most of them inflict feminine characteristics (e.g. augmented breasts and higher pitched voice) through ingesting hormonal pills, some are eunuchs (castrated), and a rare subset are born intersex. Historically, hijra were revered in the Bengal and wider Indian regions during the Mughal regime throughout the 15th-19th centuries, to the extent of rising to positions of power. Their voluntary emasculation entitled them the power to bless births and weddings. However, British colonization displaced hijra towards

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systemic criminalization, as the Criminal Tribes Act of 1871 characterized hijra as a 'criminal tribe' (Hinchy, 2022). This compelled police forces to instantaneously arrest hijra, thus disrupting their long-standing community support structures. These hostile attitudes carried forward even beyond the Partition of India in 1947 and the liberalization of Bangladesh in 1971, lasting well into the 20th-21st centuries (Hossain, 2019). These circumstances led them to rely on informal occupations such as ceremonial performances, sex work, and begging.

The legal landscape for hijra changed in 2013 when the Government of Bangladesh (GoB) declared them as a third gender (Al-Mamun et al., 2022). This declaration demonstrated a remarkably progressive step, despite a socio-culturally conservative society. Nevertheless, hijra remain within a legally precarious situation. Even though the legal recognition could serve as a precursor to a suite of changes necessary for ensuring the integration of hijra, legal challenges persist. The GoB merely issued a gazette notification, but did not pass an inheritance law, anti-discrimination law, or other legal protections from gender-based violence or harassment in various settings. Consequently, they still struggle to exercise basic rights, such as education, health, property rights, etc. (Al-Mamun et al., 2022). Notably, they lack the freedom to exercise their gender identity in any given setting, lead a satisfying and safe life free of stigma and discrimination, and pursue relationships with partners of their choice (Al-Mamun et al., 2022; Aziz & Azhar, 2019; Adnan Hossain, 2017; Jebin & Farhana, 2015; Khan et al., 2009). This constitutes infringements of their SRHR according to the Guttmacher-Lancet Commission (Ann M. Starrs et al., 2018).

These socio-structural disparities are rooted in sociocultural values that normalize the gender dichotomy along with the criminalization of any sex act that deviates from conventional male-to-female sex as per Bangladesh Penal Code 377 (GoB, 1976). While the Penal Code does not define the term 'carnal intercourse against the order of nature', courts in South Asia have interpreted the term as acts which go beyond penile-vaginal intercourse, and those which are not for procreating purposes. As hijra often engage with male sex partners or clients, their sexual activities also fall outside the carnal intercourse category (Goel, 2018). This criminalization, along with the religious restrictions imposed on homosexuality in a predominantly Muslim country, exacerbates their marginalized status and predisposes them to various economic, social, and health-related adversities (Jebin & Farhana, 2015). Thus, hijra remain marginalized populations deprived of basic healthcare access, exacerbating their vulnerability to diseases including sexually transmitted infections (STIs) and HIV. According national HIV surveillance data, the overall HIV prevalence in Bangladesh was 1.0%, which increased compared to 0.9% in the previous round. Whereas, active syphilis rates were found high at 11.9% (ASP, 2020).

However, limited evidence suggests that these health problems remain unaddressed often because of stigma, discrimination and other healthcare access barriers (Gourab et al., 2019; Gourab et al., 2023; Adnan Hossain, 2017; Khan et al., 2009; Manzur, 2023), thus exacerbating poor health. For instance, health systems research and peer-reviewed commentaries indicated mistreatment and refusal of care in public healthcare facilities and low readiness levels of STI/HIV services for hijra (Barua & Khan, 2022; Gourab et al., 2023). Hijra, according to local research were also found to have poor nutritional knowledge (48%), 50% of them smoked tobacco, and 56% had inadequate access to NCD healthcare (Faria et al., 2025). Recent research, particularly after the COVID-19 pandemic, alluded to isolation, stigma, loss of income and mental ill-health (Sifat, 2020). Recent scholarship also highlighted the motifs of violence, harassment, and the discordance between the third gender declaration and everyday stigma (Amanullah, Abir, Husain, Lim, Osuagwu, Ahmed, Ahmed, Nur, et al., 2022; A. Hossain, 2017). This situation is corollary with the global evidence which suggests that transgender people's grounded realities often predispose them to disproportionate ill-health and health disparities (Drabish & Theeke, 2022; Sari L Reisner et al., 2016). This is exemplified by global health prevalence data, where transgender identities may assume a relatively small worldwide presence (estimates reveal around 0.1-0.5% of the global population) (UNAIDS, 2024). Yet, their problems present a disproportionate burden to adverse physical and mental health outcomes (Baral et al., 2013; Rich et al., 2020; Scheim et al., 2024). Specifically, research has alluded to alarming rates of mental health concerns, namely depression, suicidal ideation, and illicit drug use (Luvuno et al., 2019). Additionally, because of the unmet healthcare needs of transgender populations, obesity, high blood pressure, hyperlipidemia, and self-reported diabetes have become pervasive (Rich et al., 2020). Within the immediate region, a cross-sectional study (N=145) in Chennai, India revealed a prevalence of 26.7% type 2 diabetes, 15.1% had a history of

hypertension, and 13.9% were overweight/obese (Prasanth et al., 2023). Another cross-sectional survey in Nepal documented prevalence rates of 28.5% and 28.6% for overweight/obesity and hypertension, respectively (Poudel et al., 2024). There is no such chronic disease data available in Bangladesh, despite the importance of prioritization of preventing chronic conditions in all parts of society given available health resources in the country. These findings indirectly reflect unfulfilled SRHR-related needs for transgender populations, where equitable access to chronic disease care, mental health support remain neglected components of their complete realization of SRHR-related rights.

According to global scholarship, these problems are entwined within multifactorial health inequities rooted in systemic social and economic marginalization, stigma, and discrimination (S. L. Reisner et al., 2016; Thomas et al., 2017). Transgender populations suffer from overarching socio-structural challenges based on their gender identity, limiting their scope to exercising gender-based rights (Jarrett et al., 2020; Torres et al., 2021), regardless of whether their gender is legally acknowledged. Gender-based rights, considering local hijra and reviews of the local literature and global documents, are defined as a set of socio-legal entitlements that protect hijra and other gender marginalized groups from discrimination, stigma and exclusion from essential entitlements based on their gender identity and expression (Akter & Saha, 2024; Adnan Hossain, 2017; UN, 2024).

In this context, this study adopted an SRHR framework to understand the experiences of hijra in healthcare and other contexts where they have the opportunity to exercise their legally inscribed gender identity. The SRHR framework, as described by the Guttmacher-Lancet Commission, includes four interconnected domains: (a) sexual health, including safer sex and bodily autonomy; (b) reproductive health and appropriate service access; (c) sexual rights, including freedom from violence and discrimination; and (d) reproductive rights, which include the ability to make informed reproductive decisions (Ann M Starrs et al., 2018). However, legal recognition alone does not suffice in ensuring these rights as structural exclusion undermine the realization of their rights. In neighboring countries, such as Nepal, which legally recognized transgender people in 2007, similar complexities exist. A large-scale study by Blue Diamond Society and Williams Institute revealed health and rights gaps despite the legal reform, especially with regards to sexual health services, protection from violence and employment (UCLA, 2014). This shows that legislative changes cannot guarantee fulfillment of rights, without institutional and structural paradigm shifts. This parallel reinforces the need to investigate how the legal reform in 2013 in Bangladesh has translated into hijra's ability to exercise their SRHR-related rights.

Building on this evidence, this study embedded a modified version of the SRHR framework (Table 1) to examine the discordances between policy and practice amongst hijra in Bangladesh. While existing research explored and intervened in the health outcomes of hijra and other transgender groups, global evidence presents a glaring gap: their broader rights, including their SRHR. As mentioned above, these rights include their ability to seek healthcare, exist within a stigma and discrimination-free environment, pursue an intimate partnership or sexual relationship of their choice, have their bodily integrity respected, choose whom to marry, and make informed decisions on their gender identity and expression in any given setting (Ann M. Starrs et al., 2018). This gap warrants research that transcends the

Table 1. The application of the policy analysis framework in relation to SRHR indicators.

SL	SRHR-related rights indicator	Application of policy analysis framework	Key findings
1	Achieve the highest attainable standard of sexual health, including access to sexual and reproductive health services	Given their constitutional health rights, how well are they able to complete their treatment without any discrimination or stigma?	<ul style="list-style-type: none"> • 55.7% of participants faced barriers in accessing healthcare services • Most common barriers included negligence (85.3%) and misbehaviors (50.0%) by healthcare providers, followed by denial of admission (26.5%)
2	Choose their sexual partner	Are they able to exercise their rights as a third gender, including pursuing the relationship of their choice and exercising sexual decisions as per their free will?	• Among those who ever had a male sex partner, 86.4% had to hide their relationship
3	Enter into marriage with free and full consent and with equality with spouses		• 54.8% had to cut off relationship with male sex partner due to fear of stigma
4	Pursue a satisfying, safe and pleasurable sexual life, free from stigma and discrimination	Are they able to freely express their gender identities in various public spaces?	• 55.6% of these cases were due to societal disapproval whereas the remaining were due to familial disapproval
5	Make free, informed and voluntary decisions on their sexuality, orientation and gender identity		<ul style="list-style-type: none"> • Among all participants, 79.2% reported having to hide their gender identity • 98.7% of all participants reported experiencing discrimination due to their gender identity

predominant HIV and STI framework, and systematically examines the limitations of policy-level gender recognition to translate to tangible health- and rights-related improvements for hijra in Bangladesh. Our analysis extended this by examining how legal recognition is interconnected to broader bodily, relational and structural rights in various settings, namely making autonomous decisions about their gender expression and relationships. This research carries the ultimate goal of formulating recommendations for improving the capacity of hijra to exercise their SRHR and achieve health.

In response to the research question, 'What are the challenges that hijra experience in terms of their SRHR and broader human rights conditions?' This study aimed to explore the gaps between the policy and reality of hijra in Dhaka, Bangladesh.

Materials and methods

This study was designed as per the policy analysis framework (Table 1), with the aim of illuminating the differences between policy and grounded realities by synthesizing desk review and mixed-methods findings.

Research design: applying the policy analysis framework in relation to the SRHR framework

The policy analysis framework serves as a 'social pillar of sustainable development' (Murphy, 2012) owing to its potential to inform structural-level policies. The Center for Disease Control and theoretical scholars underscored the use of this framework to provide a critical foundation for analyzing policies; encapsulating history, politics, lived experiences, and subject matter knowledge; and generating transformative knowledge, policy solutions, and actions (Hankivsky et al., 2014). Therefore, the policy analysis framework would not only consolidate our understanding of the existing gender declaration but also help us identify areas where their rights are not being exercised properly. Our framework will apply a unique adaptation of linking some of the key SRHR-related indicators of the Guttmacher-Lancet Commission document (Ann M Starrs et al., 2018) with the policy analysis framework. The key steps in this framework, and their relationship with the SRHR framework, are listed in Table 1 in the results section.

Study populations, sites and sampling

The study population included hijra between 18-60 years old identified as part of the hijra sub-culture, based in Dhaka city. Data were collected across four different catchment areas of Dhaka City with high concentrations of hijra communities (BBS, 2023). These study sites were chosen as the research team was well acquainted with these communities after operating donor-funded, NGO-operated hijra-friendly service centers known as Drop-in Centers (DICs), for over two decades. These DICs provide facility-based services (e.g., STI and HIV testing and management, a limited range of general health services, and basic counselling and group education sessions); and outreach-based services (e.g., promotion and distribution of health prevention products such as condoms and lubricants, and referrals to DICs and other appropriate health facilities),

Hijra was accessed primarily through DICs and hijra leaders' (guru) residences (dera). For the quantitative component, non-probabilistic sampling and first-come-first-serve sampling were used to recruit 298 hijra. This approach was deemed the most convenient and feasible considering the everyday movement patterns and sporadic availability of hijra based on previous research experiences with this population. For the qualitative interviews with hijra, maximum variation sampling was used to identify commonalities and differences between different sociodemographic groups (Patton, 2015).

Desk review

To gain a deeper understanding of the history, context, and applications of the policy declaration, a desk review was conducted by the research team. Social science scholars have emphasized that this step is crucial for understanding the nature of existing research and exploring research gaps warranting further

examination (Czarniawska, 2014). To attain knowledge about separate gender declarations, the research team used relevant policy documents and other historical discourses. To understand the grounded realities, the team read media reports about the challenges faced by hijra, existing local and global literature, and other relevant reports. To facilitate the desk review, search engines such as Google, Google Scholar, PubMed, and Scopus to locate both published and grey literature. The time period was set from 2009 to 2024 (to account for hijra experiences before the gender declaration). Key terminologies included 'hijra', 'transgender', 'Bangladesh', 'rights', 'barriers', 'challenges', and 'declaration'. A literature matrix was created, containing the details of the article and key findings. The desk review findings were also thematically analyzed in the same manner as the empirical data (described below). A desk review summary was prepared and converged with quantitative and qualitative findings.

Data collection

Quantitative data collection entailed face-to-face technique to collect data on sociodemographic characteristics, rights issues, sexual history/risk behaviors, healthcare-seeking patterns, experiences of stigma, rights violations, and negative experiences in various settings ranging from employment to education. Specialized rights indicators were designed by consulting globally accredited indicators from the literature (UNAIDS, 2009).

Interviewers were selected based on extensive experiences working in quantitative surveys with these populations. Two of the field researchers originated from the hijra community, which provided not only cultural acceptability for participants, but also lived experiences and emic understanding of hijra complexities.

As soon as the training was completed, the survey was field-tested before data collection in two locations (Gazipur, which is about 15km away and Dhamrai, which is about 30km away from Dhaka) among hijra participants. Field-testing was conducted not only to assess the construction of the questionnaire but also the ability of interviewers to fill out the questionnaire. After completion of the field testing, team meeting was held with investigators, data collectors and quantitative data management personnel to discuss the experiences of pilot testing. Thereafter, some fine tuning in the questionnaire was done and feedback was provided to the interviewers to improve performance as per the recommendations from the team members.

During the quantitative survey, researchers identified vocal participants who seemed willing to share their experiences beyond the quantitative survey questions. Therefore, the researchers noted down their participant IDs and they were followed up for qualitative interviews, given that they consented to a qualitative interview. In line with the principles of phenomenology (Moran, 2002), 20 in-depth interviews (IDI) and five focus group discussions (FGDs) (consisting of 4-5 individuals, totaling 20-25 participants) were conducted with mutually exclusive groups of hijra from September 2023-July 2024. The FGDs and IDIs were conducted by a team of anthropologists and sociologists who received comprehensive training from experts in hijra research at the time of onboarding. Interviews took place in a private room in the hijra's residences or guru's homes (dera), or in another private location of the participants' preference. The interviews were recorded after having received written informed and understood consents.

IDIs posed specific questions and probes about experiences of SRHR-related rights infringements in the hospital (e.g. where they usually seek healthcare, what services they took from the hospital, their feelings towards public hospitals, whether they faced problems in expressing their gender identity, their ability to pursue relationships of their choice, interactions with healthcare providers, etc.); and experiences of gender-based rights infringements in other settings (e.g. whether they were able to express their gender identity in educational settings, whether they were denied of job opportunities or discriminated in their job based on their gender identity, experiences with banking and voting, interactions with family members, and their everyday activities in public spaces). The FGDs asked these in questions, in addition to societal views regarding stigma and discrimination against hijra.

All interviews were transcribed by field researchers who were familiar with hijra community language. The interviews were transcribed, checked and verified by senior members of the research team, and coded in NVivo after creating a thematic matrix of the findings on Microsoft.

Data analysis

SPSS version 25 and Epi Info version 7.2.5 were used during quantitative data analysis. After checking for consistency, the data files were cleaned using Excel. Descriptive statistics were used, where categorical variables were expressed as percentages, and numerical variables were depicted as means with standard deviations or medians with interquartile ranges (IQR).

Qualitative analysis was thematically analyzed (Braun & Clarke, 2006) using manual approaches, where team members read interview transcripts multiple times, drawing upon themes and sub-themes. This data analysis was aimed to capture the various scenarios of gender-based discrimination and rights infringements faced by these populations. These themes formed the thematic matrix used for the remaining data. The meanings and contexts of these themes were further analyzed, and emerging issues were identified, which warranted further data collection. A codebook was used for the data analysis where a set of codes were consistently applied by four researchers (including three of the co-authors). Decision trails were maintained for these coding decisions, and resolutions to any discrepancies which were often solved by the senior author. Several measures have been adopted to ensure qualitative rigor, such as triangulation, peer debriefing, and member-checking (Ezzy, 2013).

Ethical considerations

This study received the ethical approval from the Ethical Review Committee of the Institutional Review Board of the International Centre for Diarrhoeal Diseases Research, Bangladesh (icddr,b) (approval number: PR-22121). As this study involved human participants, this study adhered to the principles of the Declaration of Helsinki. While obtaining consent from hijra, study objectives, methodologies, risks, and benefits of the research were read out from the participant information materials. Written consent (signature or thumb impression) was obtained after the participants provided consent. Participants were compensated through a gratuity payment equivalent to a conveyance allowance and costs for refreshments as per the ethical stipulations of icddr,b.

Results

These findings have demonstrated the discordances between the legal gender declaration and their lived realities in relation to the policy analysis framework. The findings amalgamate secondary data review alongside mixed-methods empirical data. In line with the SRHR framework, the findings also describe the implications on their SRHR-related health and wellbeing. The findings are summarized in the Table 1.

Socio-demographic characteristics of participants

Table 2 shows the sociodemographic characteristics of 298 participants, based in Dhaka city. Most of them (32.9%) lived alone, 25.2% lived with their intimate male partner (partner), and 17.4% lived with their guru. Most participants (43.3%) were 25-35 years old, 36.6% were 18-24 years old, 15.8% were 36-49 years and 4.4% were < 50 years old. The participants manifested various degrees of education: 19.5% had no formal schooling, 24.5% had 1-5 years of schooling, 44.4% had 6-10 years of schooling, and 11.7% had at least 11 years of schooling.

Tales of discrimination, stigma and harassment in various settings

The gazette indicates that hijra are a separate gender category in Bangladesh. This has also been reflected in several documents, such as passports and national identification document forms, paperwork for taxes, and opening bank accounts. However, the findings, along with local literature from the desk review, revealed that they were often unable to exercise their gender identities in various spheres of grounded reality, ranging from their own families to schools and employment sectors. In terms of the

Table 2. Socio-demographic characteristics of the survey respondents.

Variable	N = 298 Unless otherwise stated n, Col% (95% CI)
Age (in years)	
18-24	109, 36.6 (29.4-44.4)
25-35	129, 43.3 (35.3-51.6)
36-49	47, 15.8 (11.4-21.4)
≥50	13, 4.4 (2.3-8.0)
Mean (95% CI)	29.5 (28.1-31.0)
Median (IQR)	27 (23-35)
Years of schooling	
No education	58, 19.5 (15.0-24.8)
1-5	73, 24.5 (19.3-30.6)
6-10	132, 44.3 (39.5-49.2)
≥11	35, 11.7 (8.3-16.3)
Mean (95% CI)	6.1 (5.6-6.6)
Median (IQR)	7 (3-9)
Currently, live with most of the time	
Alone	98, 32.9 (28.2-38.0)
With friends (community)	36, 12.1 (9.1-15.8)
With parik (male lover of hijra)	75, 25.2 (21.5-29.2)
With hijra guru	52, 17.4 (13.1-22.8)
With family	37, 12.4 (9.2-16.5)
Preferred identity while self-introducing within the community	
Only badhai	124, 41.6 (33.7-50.0)
Only sex work	35, 11.7 (7.3-18.5)
Badhai + sex worker	119, 39.9 (33.5-46.8)
Randhuni hijra (cook)	6, 2.0 (0.7-5.6)
Randhuni (cook) + sex worker	10, 3.4 (1.7-6.5)
Others	4, 1.3 (0.5-3.4)
What others	N = 4
Dancer/dance performer	1
Kormokkhom hijra (working hijra)	1
Businessman hijra	2
Average income in the last 3 months[§]	
≤ 10,000	79, 26.5 (19.6-34.8)
10,001-20,000	179, 60.1 (54.3-65.5)
> 20,000	40, 13.4 (9.9-18.0)
Mean (95% CI)	13,908.2 (13,020.3-14,796.3)
Median (IQR)	13,667 (10,000-17,333)

[§]109.50 BDT = \$1 USD (Bangladesh Bank rate 20-08-23, <https://www.bb.org.bd/en/index.php>).

Mean (95% CI) in USD: 127.0 (118.9-135.1).

Median (IQR) in USD: 124.8 (91.3-158.3).

former, a few hijra claimed that their relatives labelled them as 'half-ladies' or 'maigga' (girly boy), etc. This was substantiated by numerical expressions, which revealed that 98.0% (95% CI: 95.1-99.2) of the participants were or had been excluded from their families, societies, or relatives, and 98.7% (95% CI: 96.5-99.5) were discriminated in any setting on the basis of their gender identity (Table 3).

Experiences of seeking healthcare in public healthcare facilities

One of the key SRHR-related rights is the ability to seek healthcare for any ailment, including their sexual health, in an environment free of stigma and discrimination. Quantitative findings (see Table 4) indicated that more than half of the hijra participants reported facing barriers based on their gender identity in public healthcare facilities despite their constitutional right to seek healthcare inscribed in the reviewed policy documents. The most commonly reported barrier was negligence from healthcare providers (85.3%; 95% CI: 70.7-93.3), followed by misbehavior from healthcare providers (50.0%; 95% CI: 36.6-63.4) and denial of hospitalization (26.5%; 95% CI: 16.5-39.6). In this paper, misbehavior has been defined as intended or inadvertent deviation from ethical standards that constitute respectful, equitable care, particularly manifesting as abuse, discrimination or hostility from healthcare providers (Beauchamp & Childress, 1994). This could include discriminatory attitudes or language, withholding information or care, or verbal/physical abuse (Freedman et al., 2014). Whereas, negligence is defined as the failure to exercise the degree of care, diligence and skill of a competent healthcare provider, resulting in increased risk of

Table 3. Discrimination, stigma and harassment in various settings.

Q SL.	Variable	N=298 Unless otherwise stated n, Col% (95% CI)
q218	Ever been/ had to be excluded from one's family/ relatives/ society for the hijra identity	
	Yes	292, 98.0 (95.1-99.2)
	No	6, 2.0 (0.8-4.9)
q602	Ever been subjected to discriminated because of gender and sexual identity in any settings	
	Yes	294, 98.7 (96.5-99.5)
	No	4, 1.3 (0.5-3.5)
q203	Ever tried for a job	
	Yes (tried as a hijra)	63, 21.1 (16.3-27.0)
	Never	103, 34.6 (28.0-41.8)
	Yes (but I did not try as a hijra)	132, 44.3 (38.7-50.1)
q207	Ever been denied from a job opportunity for being a hijra (Denominator is who ever tried for a job)*	N=195
	Yes	122, 62.6 (51.7-72.3)
	No	73, 37.4 (27.7-48.3)
q225	Ever faced any barriers or discrimination for the hijra identity while renting house to live	
	Yes	233, 78.2 (71.6-83.6)
	No	18, 6.0 (4.0-9.1)
	Never needed	27, 9.1 (5.8-14.0)
	Never rented house as a hijra	20, 6.7 (3.7-11.9)
	If Yes, types of barriers or discrimination faced while renting house to live (Denominator is who faced obstacles or discrimination for the hijra identity while renting house to live)	N=233
	Demanded high rent	63, 27.0 (21.5-33.5)
	Refused to give house for rent	170, 73.0 (66.5-78.5)
q201	Have bank account	
	Yes (opened bank account as a hijra)	10, 3.4 (1.6-6.8)
	No	240, 80.5 (75.5-84.8)
	I had an account before becoming a hijra/ I did not go bank as a hijra	48, 16.1 (12.9-20.0)
q202	Customer experience in the bank (In last 6 months) (Denominator is who opened bank account as a hijra)	N=10
	Normal	7, 70.0 (40.0-89.1)
	Discriminatory	3, 30.0 (10.9-60.0)
q209	Gender identity on the NID card	N=222
	Male	193, 86.9 (77.9-92.6)
	Female	1, 0.5 (0.1-3.1)
	Others (Hijra)	28, 12.6 (6.9-21.9)
q220	Can participate in any religious event as a hijra	
	Yes	4, 1.3 (0.4-4.7)
	No	271, 90.9 (82.8-95.4)
	I don't go intentionally	15, 5.0 (2.7-9.0)
	Yes (but as a man)	7, 2.3 (0.9-6.2)
	Yes (but as a woman)	1, 0.3 (0.0-2.3)

harm to patients (Reader & Gillespie, 2013). These scenarios were also corroborated by the qualitative findings, which revealed scenarios of misbehavior and neglect from the healthcare providers. Specifically, one participant described an incident of unsolicited questioning and harassment in the following way:

I was bitten by a dog a few days, so I went to the hospital to get the vaccine. After going the doctor, instead of injecting in my body, he was coming to inject in my chest. I asked him why he injected in my chest, and requested him to inject in another part of my body. But he insisted he will inject in my chest and asked me "what are you inserting in your breasts?" (Pia, 31 years old, IDI).

Another participant anecdote reflected the glaring lack of specialized knowledge and training about hijra's bodies, genital compositions, psychological dispositions, and gender identities. As Iris mentioned:

Once I went to a hospital. While they initially agreed to treat me after me telling them I was transgender, the situation changed when I went inside the room. After taking off my clothes at the body part where I felt pain, he said "you're okay but why do you call yourself transgender? You are not an intersex person. Why are you acting like a girl?" This is the type of discrimination I faced in the hospitals. (Iris, 34 years old, IDI).

Table 4. Experiences in mainstream healthcare settings.

Variable	N=298 Unless otherwise stated n, Col% (95% CI)
Ever faced barriers in assessing healthcare services at public/ private hospitals (except NGO) due to sexual orientation or gender identity	
Yes	68, 22.8 (18.9-27.3)
No	49, 16.4 (11.2-23.5)
No one identified the respondent as a hijra	5, 1.7 (0.7-3.7)
Never went to a hospital	176, 59.1 (50.9-66.7)
Ever faced barriers in assessing healthcare services at public/ private hospitals (except NGO) due to sexual orientation or gender identity (Denominator is who went to hospital ever in lifetime)	N=122
Yes	68, 55.7 (46.8-64.3)
No	49, 40.2 (31.6-49.4)
No one identified the respondent as a hijra	5, 4.1 (1.8-9.3)
If yes, types of barriers faced in accessing healthcare services at public/ private hospitals (except NGO) due to sexual orientation or gender identity (Denominator is who ever faced barriers in accessing healthcare services at public/ private hospitals (except NGO) due to sexual orientation or gender identity)*	N=68
Did not allow to enter	4, 5.9 (2.1-15.7)
Denied to admit in the hospital	18, 26.5 (16.5-39.6)
Misbehave from healthcare provider	34, 50.0 (36.6-63.4)
Negligence from healthcare provider	58, 85.3 (70.7-93.3)
Lack of privacy and confidentiality	3, 4.4 (1.6-11.5)
Others	3, 4.4 (1.6-11.5)
What others	N=3
Difficulty to stand in line	1
Bad behavior from other healthcare seekers	1
Sexual harassment by checking genitals by the healthcare providers	1
If no, description of experience or reasons for not facing barriers in assessing healthcare services at public/ private hospitals (except NGO) due to sexual orientation or gender identity (Denominator is who never faced barriers in assessing healthcare services at public/ private hospitals (except NGO) due to sexual orientation or gender identity)	N=49
Forcefully acquired early medical service	20, 40.8 (22.4-62.2)
Received good/ normal/ regular service	29, 59.2 (37.8-77.6)

Table 5. Experiences regarding education for hijra.

Variable	N=298 Unless otherwise stated n, Col% (95% CI)
Years of schooling	
No education	58, 19.5 (15.0-24.8)
1-5	73, 24.5 (19.3-30.6)
6-10	132, 44.3 (39.5-49.2)
≥11	35, 11.7 (8.3-16.3)
Mean (95% CI)	6.1 (5.6-6.6)
Median (IQR)	7 (3-9)
Was able to complete desired level of education	
Yes	7, 2.3 (1.5-7.0)
No	291, 97.7 (94.3-99.0)
Reasons for not being able to complete the desired level of education (Denominator is who could not complete desired level of education)*	N=291
Lack of interest	79, 27.1 (21.6-33.4)
Discriminatory behavior by faculty/ staff	10, 3.4 (1.7-6.9)
Discriminatory behavior by classmates	63, 21.6 (17.3-26.8)
Economic reasons	167, 57.4 (49.2-65.2)
Family reasons	151, 51.9 (44.7-59.0)
Social reasons	52, 17.9 (13.2-23.7)
Others	3, 1.0 (0.3-3.1)
What others	N=3
Due to fear of perceived lack of opportunity for hijra	1
Due to fear of physical harassment in school	1
As the grades were poor	1

Qualitative findings also alluded to the reluctance of hijra to visit public and private healthcare facilities because of the behavior they previously received from healthcare providers and hospital staff. As one of the hijra mentioned:

These experiences were a stark contrast from their experiences at the donor-funded, NGO-operated DICs (described in methods section). As the DIC services are specialized for hijra and other gender and sexually marginalized populations, healthcare providers are already culturally competent. As DICs

primarily adopt a peer outreach-based approach as hijra's first line of care, many of the service providers are from the community, thus providing culturally-grounded services. As one of the participants mentioned:

Let's say I go to a government hospital, and talk about condoms and gels (lubricants). Then they will laugh at me. But if I go to the DIC, there are hijra service providers like me. They do not laugh at me there. Better yet, after sitting I in the DIC, I will be given any services I want. (Maya, 22 years old, IDI).

Similarly, another participant described her situation in the following way:

Everyone in the DIC is expert (*pakki*). As the saying goes, nothing can be hidden from the doctor, no matter who the doctor is. I noticed that, even if we do get treatment from the government hospital, we feel embarrassed to share our health problems, plus he may not know our hijra health issues very well. But when I went to the DIC, the service providers clearly knew about the anus (*batly*), genitals (*ligam*), and how we have anal and oral sex (Hawa, 19 years old, FGD).

While some believed that special considerations should be made to accommodate hijra, their lived experiences indicated otherwise. They even noted that they faced unprecedented marginalization and heightened vulnerability towards sexual health diseases, such as HIV and STIs, which warrant further prioritization. For example, one participant (all participant names are pseudonyms) explained her experience as follows:

I visited the hospital immediately after falling sick. Even though I got the first ticket for the queue, I still had to wait in line. Then, I went to a doctor, and after he barely saw me, he sent me to the third floor where I had to get another ticket and wait for a long time. However, they have never attended me properly. Being a sick hijra, what they should do for us is at least relax some of their rules or make special considerations because of the unique problems we face. (Meena, 30 years old, IDI)

In addition, participants cited that they did not feel comfortable seeking support in an atmosphere where healthcare providers were not attuned or responsive to their complexities. One participant described this as follows:

We (hijra) do not feel like visiting other hospitals (besides the DIC) because the doctor would either be a man or woman, and they are used to handling issues relating to men or women. But as you know, we as hijra face unique problems (sexual health problems such as HIV and STIs) but when we share with them, even though they know about us, they give us a dirty look when we share our problems with them. This made me feel upset and uncomfortable. (Shumi, 27 years old, FGD)

Nevertheless, qualitative evidence has illuminated a few positive experiences where they were not discriminated or neglected due to their gender identity. One participant described, 'I did not need to take the long queue. The hospital authorities helped me get treatment first, and it was a fast process' (Raina, 25 years old, FGD). Quantitative evidence also supported this, revealing that among those who did not face barriers in health facilities, 59.2% (95% CI: 37.8-77.6) reported satisfactory services, without the need to forcibly expedite their healthcare services.

A few of the participants also recommended solutions for fostering an enabling healthcare-seeking environment for hijra. Hijra justified their need for specialized treatment in separate corners because of poor treatment from other patients and healthcare providers. For example, one of the hijra gurus advocated for a separate ward and dedicated service providers for hijra in the following way:

If we talk about medical treatment, there are separate wards for men, women, and children. If there was a separate ward for hijra, third gender, or transgender, whatever I say, and if there was a dedicated doctor for them, in that case, it would be very easy for them to get medical services (Mina, 28 years old, IDI).

Moreover, participants expressed the importance of having gender-neutral lines to absolve hijra from the dilemma of standing in sex-specific queues. As one of the hijra mentioned:

I am not sure which line to stand in, in hospitals. If I stand in the men's line, people say "oh my god it is a hijra!". If I stand in the women's line, women get scared and complain to the guards to kick me out. So where do I go? (Reina, 25 years old, FGD).

Complexities of education and employment

In line with the hijra's fundamental SRHR-related right to freely express their gender identity in any given setting, our findings revealed that many hijra lacked the space to exercise their identity as a separate gender. The findings revealed that many hijra encountered difficulties completing their education. 44.3% of the participants had six to ten years of schooling, whereas only 11.7% were found to have more than 11 years of schooling (see [Table 2](#)). Qualitative findings indicate that due to their hijra identity, their lack of interest in continuing their education is influenced by bullying, teasing, and abusive incidents by their peers at school ('Due to my feminine characteristics, I was bullied for my walking style, and they intentionally touched my body parts (private parts such as buttocks and breasts). Because of this, I left the school!') (Selina, 33 years old, IDI).

Moreover, several hijra participants felt despondent about their job prospects, including their government jobs, as they could not avail of any benefits or opportunities within their existing gender identity, i.e., they could not find jobs while presenting as hijra. Specifically, they believed that because they were hijra, there were no provisions for them to work in a mainstream job; therefore, seeking necessary education felt futile. This shows the relationship between their inability to exercise employment rights and their ability to complete their education. As one of the participants mentioned:

"For hijra like us, there are no arrangements for our job, we do not have any opportunities or benefits. Therefore, what is the focus of this study? Keeping this in mind, I just gave up studying." (Shubroti, 38 years old, FGD)

Because of this complexity, a few hijra claimed that they could not find formal occupation, compelling them to resort to sex work, and depending on abusive partners. These circumstances latently diminish a participant's ability to exercise their SRHR, thus culminating in poor SRH outcomes. As one of the sex worker participants mentioned:

"I could not complete my education because of all the bullying and trouble it caused me. I was not qualified for any proper job either. So now I have to rely on sex work to support my stomach. My clients do not like to use condoms. And I have to live at the mercy of my parikh (male intimate partner) who beats me sometimes. I do not feel good, in fact I have been tested positive for a sexual disease" (Ira, 28 years old, IDI).

Some hijra participants reported applying for jobs, although 62.6% (95% CI: 51.7-72.3) reported that they were denied employment on the basis of being hijra. Although a smaller proportion of hijra were able to secure jobs, some of them reported discriminatory experiences (i.e., unfair treatment attributed to their gender status) that reduced their willingness to continue and compelled them to resign in many cases. One hijra who ultimately quit her job relayed the following experience:

I used to work in a garment factory. Even though I was working there as a man, my feminine characteristics were quite noticeable, so everyone else caught on quickly. Sometimes, when the buyer came to visit the factory, they kept me locked in the bathroom and let me out when the visitors left. (Shumi, 27 years old, IDI)

However, not all the experiences were negative. Rather, the review of newspaper articles revealed that a few hijra were employed as political figures, office assistants, journalists, or in other mainstream occupations (Star, 2023). For instance, one of the notable hijra in her community was deployed as a union chairperson in her sub-district, thus demonstrating her voice on a political platform. However, even if she was deployed a mainstream job despite her job, this does not necessarily indicate her experiences in the job itself were positive. This was exemplified by several of our participants' anecdotes which indicated that they were onboarded in their respective jobs as hijra but did not always receive favorable treatment from employers and colleagues. Hijra participants have claimed that an enabling environment could be created for seeking employment by convening sensitization sessions with employers. One of the hijra participants relayed her sentiments in the following way:

I think we need to have a sitting with the job providers. You (the research team), us (the hijra) and the job providers. We need to explain to them about the problems we face. Hopefully they will become more understanding that way (Mina, 32 years old, FGD).

Exercising the basic right to shelter

Housing is a basic human right for all populations, irrespective of socio-demographic circumstances, based on Constitution 28 of the Government. However, hijra reported struggles while renting out accommodations as a result of their gender identity, thus signaling another breach of their SRHR-related rights. Quantitative findings revealed that 78.2% (95% CI: 71.6-83.6) of the participants faced challenges while renting a house, and 73.0% (95% CI: 66.5-78.5) said that the homeowner refused to rent out housing due to their hijra identity (Table 3). This adversity is also highlighted by qualitative evidence, as described below.

"Upon seeking vacant residences in more desirable surroundings, we were met with a common response from house owners upon revealing their identity. The owners claimed that the house was already occupied, despite the advertisement being up. The owners were unwilling to rent to the hijras, using the excuse of the house being rented to justify their reluctance. (Soni, 35 years old, IDI)

These incidents are rooted in the fear of landlords towards these populations, who misconstrue them as a public nuisance who could drive other tenants away from the building.

Consequently, these unstable housing situations have diminished hijra to seek shelter in unhygienic slums or depend on abusive intimate partners, heightening their vulnerability towards violence and compromising their SRHR.

Enacting their civil and political rights as a hijra as citizens

As per the documents read during the desk review, hijra have the inscribed privilege to enact their rights on both political and civil society forums, such as casting votes, registering for national identification, opening a bank account, etc. Our review indicated that most of these administrative forms included provisions for indicating gender other than male and female, thus allowing the provision to express their gender on the paperwork. Quantitative evidence mostly indicates that these rights were reflected in grounded realities. In particular, 70.0% (95% CI: 40.0-89.1) of the hijra reported that they had faced normal, non-discriminatory experiences while going to the bank. This is supported by qualitative anecdotes. Specifically, one of the participants stated that their experiences are contingent on their etiquette, regardless of whether they are hijra; therefore, being hijra does not pose any additional disadvantage.

You know what? Regardless of whether you are a minority or a majority, people will judge you anyway. It depends on how you act and carry yourself. For example, I tried to act smartly and did not face any problems. Even if they initially looked at me differently, they tried not to do so. Therefore, it really boils down to whether you behave decently. (Protiti, 25 years old, FGD)

However, despite provisions to indicate their gender on the national identification (NID) card, only 12.6% (95% CI: 6.9-21.9) reported that they applied for an NID as a hijra, whereas the remainder, barring one, indicated that they were male in their NID. Qualitative experiences also reflect the barriers faced during the uptake of these services. For example, one participant described her experiences as follows:

Once I went to the commission office to change my identification from male to hijra, but they laughed at me and asked me to show my private parts to prove my gender. It felt embarrassing. (Kaya, 26 years old, IDI)

Stories of disguise as a result of compromised gender identity

Secondary data from the desk review of previously published research (Gourab et al., 2019; Manzur, 2023; Sarker, 2019), newspaper articles and reports (BLAST, 2019; Star, 2022; Watch, 2016), and firsthand study findings show that disguise and concealment of gender identity is a pervasive phenomenon. Disguise and concealment entailed hijra wearing either masculine (wearing shirts and pants) or feminine attire (wearing a burqa). Specifically, the quantitative findings revealed the diversity of settings in which considerable proportions of hijra participants felt compelled to hide their identities, such as public toilets, shopping malls, election offices, and religious events. The detailed percentages by setting are shown in Figure 1.

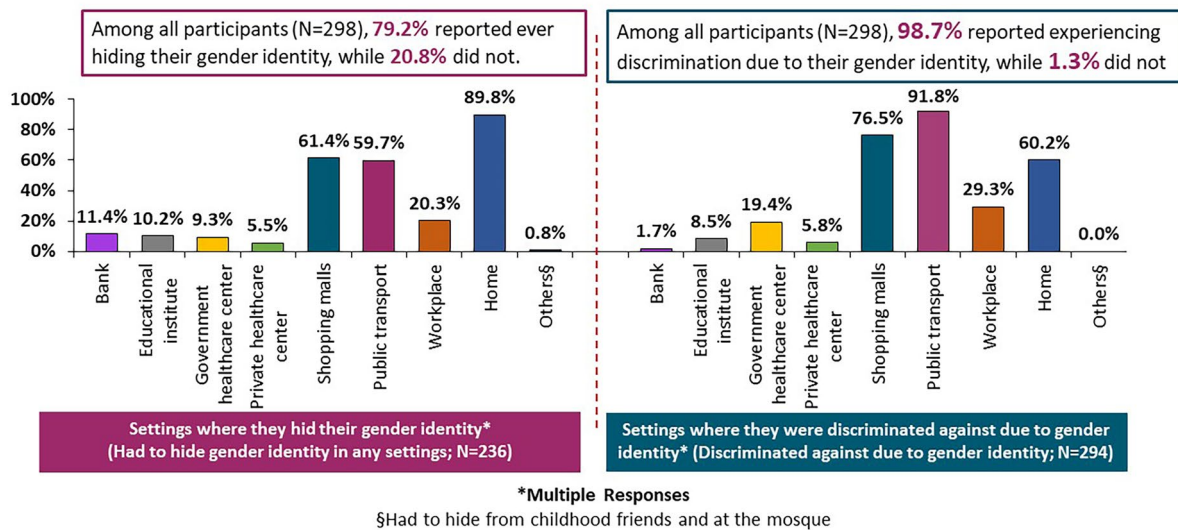


Figure 1. Settings where hijra felt compelled to conceal and were discriminated based on gender identities (N=298).

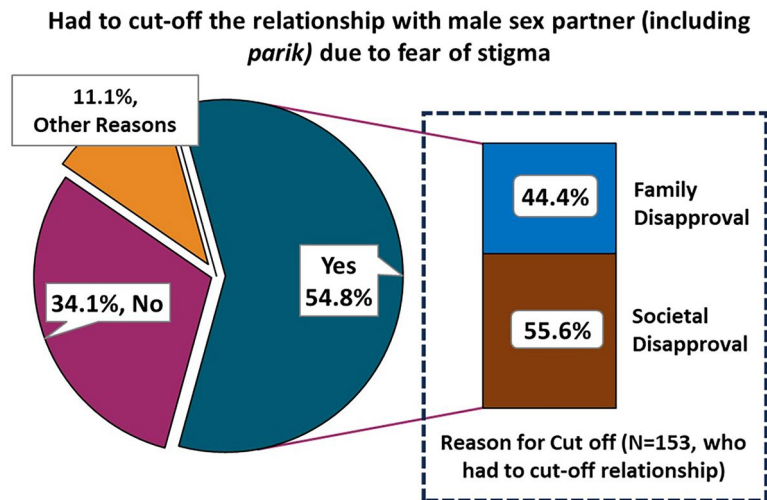


Figure 2. Hijra who had to cut off relationships.

This was also corroborated by qualitative findings that uncovered stories of participants disguising their gender identities because of anticipatory fear and previous experiences of gender-based discrimination. These experiences often started in the family setting, where societal stigma and perspectives about the gender binary led their families to distance themselves from the participant. Therefore, the participants felt compelled to disguise and covertly visit their families; otherwise, they would be subjected to mockery and discrimination by other family members and neighbors. As one of the participants mentioned:

I could not go home. If I visit, I will ensure that I keep it secret by wearing borka (burqa). The neighbors and my in-laws of mine come to see me whenever I go to my house. It seems festive in our house, because everybody comes to see me. They touched me and made very bad comments about why I had done so. (Reena, 23 years old, IDI)

Similar experiences resonate in larger settings. For instance, a majority of hijra participants were unable to participate in religious congregations due to their gender identity (90.9%; 95% CI: 82.8-95.4). This participant narrated her experiences as follows:

I cannot attend prayers being hijra. I had to go to the mosque wearing lungi (long skirts worn by males) and panjabi (long tops worn by males). The religious leader in the mosque was happy upon seeing me, and encouraged me to perform my prayers in the first row. (Josna, 28 years old, IDI)

However, not all experiences in public settings have been reported to be negative. Rather, they gratefully acknowledge the separate gender declaration, citing it as an avenue to freely express their gender identities. As one of the participants expressed, 'Wherever I go, I freely dress up and act like a hijra... I think I am a part of the society so I can freely express my identity' (Dina, 35 years old, FGD). Another participant revealed a bright spot in her freedom to exercise her gender where she was able to freely use the toilet. She described her experience in the following way:

When using the toilet, if I say, "Apa, can I go to the bathroom?" The people (both other patrons and cleaners) at the toilet say, "Yes, go. No problem." No one restricts me. Everyone lets us use it. I use the women's toilet. No one has ever restricted me before and I am able to use it without any trouble (Amani, 25 years old, IDI).

Lacking the scope to pursue relationships of their choice

One of the key SRHR-related rights indicated in the literature is the participants' ability to pursue a relationship of their choice. However, our findings revealed that many hijra could not sustain same-sex relationships due to overarching structural challenges. Specifically, 51.3% of the participants (N=298) reported having to cut off a relationship with a male sex partner (parik) due to fear of societal stigma associated with being hijra. Among those who had a parik (N=279), 54.8% had to cut off the relationship to avoid stigmatization. For those who ended the relationships due to stigma, the main reasons included societal disapproval (55.6%, 95% CI: 48.6-62.3) and family disapproval (44.4%, 95% CI: 37.7-51.4). Specifically, a participant shared her recent breakup experience, revealing that her parik's colleagues could not accept their relationship. Despite living together and providing financial support, her partner left and then cut off contact. She described her experiences in the following way:

I had a breakup a few days ago. Because many of those working in my parik's team could not accept me. I lived with him. He used to take money from me at various times. All my money was gone at once. Then he would say "I need to go home." He went home and cut off contact with me. (Hena, 27 years old, FGD)

Quantitative survey findings revealed that 80.9% (95% CI: 73.5-86.6) of participants reported having to hide their male sex partner due to fear of stigma regarding their sexual orientation. Specifically, among those participants who had a parik (male sex partner) (N=279), 86.4% (95% CI: 79.3-91.3) felt the need to hide their partner. In a qualitative interview, Raina explained that she had to conceal her relationship with her Parik, from her family and community, under the guise of a male friend. She hid her true relationship due to societal stigma, as relationships with hijra were viewed as sinful and unacceptable. She described it in the following way:

My family does not know about my Parik. They know about my 'brotherly' relationship with my Parik. I cannot introduce him as my Parik. People in my area know me as a boy. That is why I hide my relationship with the Parik. And this matter is not good in society, they believe that this type of relationship with hijra is a sin. (Raina, 22 years old, IDI)

Discussion

This study was the first of its kind to comprehensively explore the SRHR and other rights of hijra, adopting policy analysis lenses. Although other studies have implicated that hijra have been struggling to authentically express their gender identities, our study findings revealed additional complexities. Specifically, despite their legally inscribed right to express their hijra identity in any setting, our findings revealed that they were often compelled to obfuscate their identities, disguising as men. Even though a key component of SRHR is their ability to freely exercise their gender and sexual rights, this often remained compromised in various settings, e.g. employment, education, housing and civil spaces. This often drove them towards informal occupations, precarious housing situations, and sex work, thus potentially exacerbating their SRH outcomes. Their SRH-related welfare was notably at risk due to healthcare access barriers, often attributable to misbehavior, neglect, discrimination from healthcare providers, and other infrastructural limitations such as sex-specific queues and lack of specialized treatment options.

One of the most crucial facets of SRHR is the ability to exercise their healthcare rights by taking up affordable and available healthcare services for their health concerns. This study revealed insights into the institutionalized and systemic barriers that have contributed to discriminatory and hostile healthcare-seeking environments for hijra. This has been corroborated by several other qualitative studies based in Bangladesh that have cited culturally incompetent services (Gourab et al., 2019; 2023; Kabir, 2023; Manzur, 2023). Similar healthcare access barriers have been reflected in India, such as discrimination at healthcare facilities, lack of treatment protocols, low health literacy, and poor healthcare-seeking behaviors (Pandya & Redcay, 2021). A study based in the US revealed that 29% of transgender people avoided seeking healthcare due to fear of discrimination, whereas 23% of them were denied healthcare (Equity, 2020). A systematic review in Africa revealed that 38-55% of transgender people reported discrimination while seeking healthcare (Jessani et al., 2024). A multi-country study in South Asia (Bangladesh, India, Nepal, and Pakistan) revealed that 48% of transgender individuals were denied healthcare, and 67% encountered verbal abuse (Tanner et al., 2022). In the global context, the quantitative aspect in other literature was merely limited to measuring healthcare access barriers (i.e., whether or not they received healthcare), without accounting for other associated, complex issues such as the ability to assert their gender positionality (Amanullah, Abir, Husain, Lim, Osuagwu, Ahmed, Ahmed, Nur -A Yazdani, et al., 2022). Another complexity highlighted in our findings was the hijra's frustration about not receiving any special accommodations because they were hijra. Rather, they were forced to conform to the gender binary and were subjected to discrimination, an insight yet to be reflected in other global discourse. However, in rarer cases, our participants reported positive healthcare-seeking experiences in the form of expedited treatment, and humane approaches. This practice could ultimately serve as a blueprint for medical curricula when teaching medical students about humanizing approaches towards patients suffering with marginality, such as hijra. This would provide hijra and other marginalized populations with a conducive space to exercise their healthcare-seeking rights, an integral facet of SRHR.

Our study findings also revealed considerable magnitudes of discrimination, stigma, and harassment in various private and public spaces beyond healthcare such as education, employment, housing prospects, and political/civil rights, which were triangulated with their lived experiences. In contrast, a study by Amanullah et al. (2022) reported that a comparatively lower proportion of hijra participants reported breaches in health, civil, and political rights compared to economic and other human rights (Amanullah, Abir, Husain, Lim, Osuagwu, Ahmed, Ahmed, Nur -A Yazdani, et al., 2022). In terms of education, many hijra reported their inability to complete schooling because of bullying and lack of disciplinary actions against perpetrators by educators. A study in India revealed that 50% of transgender students dropped out of school due to bullying, harassment, and lack of a gender-affirming infrastructure (Cambridge, 2023). However, scholarship on education remains limited despite its importance in a marginalized individual's ability to exercise their SRHR-related rights, e.g. freely exercising their gender identity without negative ramifications.

Specifically, other quantitative and qualitative studies in Bangladesh indicated the inability of hijra to secure employment in the mainstream job sector due to structural barriers and a lack of educational qualifications (Abedin & Sarker, 2022; Jebin, 2018). Similar scenarios of exclusion were experienced in Pakistan where 70% of participants experienced workplace harassment or refusal of formal employment (Arslan et al., 2023). Qualitative studies in Nepal revealed at one least one human rights violation among transgender populations, including economic violence, refusal of jobs, and educational barriers (Women, 2023). Moreover, a systematic review revealed that trans-inclusive organizational cultures lack uniformity across the US, thus demonstrating ambiguities and discrepancies in employment rights throughout a single setting (Davis & Yeung, 2022).

Our study also revealed that hijra's gender identities considerably reduced their prospects of securing viable housing. They mostly noted facing resistance from landlords, which was substantiated by a study in Malaysia which indicated landlords' refusal to rent out housing to transgender persons (ARROW, 2022). Similarly, a study in India revealed denials of housing, harassment by landlords, and forcible segregation into poorer neighborhoods (ICJ, 2019). However, our study linked this complexity to their ability to situate viable housing and their dependency on sex work and abusive partners, thus compromising overall SRHR.

Our findings also revealed various scenarios where hijra were forced to conceal their gender identities, citing that they often disguised as cisgender men. Although research on concealment in

workplaces and other settings remains limited in this region, a report based in the USA revealed that transgender people often felt forced to conceal their identities (Sears, 2024). Moreover, a study based in Los Angeles alluded to the concealment and avoidance of public goods for LGBTQ+ people in Los Angeles (UCLA, 2024), which was also corroborated by our research. However, the rights infringements in these studies, especially in our region, were merely illustrated through statistics, without explaining the underlying determinants and contexts, thus providing an incomplete picture of the data. However, this analysis is crucial as gender-based discrimination and concealment remain central to SRHR.

Our socio-demographic findings showed that the median age was 27 years old, which aligns with the general adult Bangladeshi population, which documents a median age of 28 years old (BDHS, 2022). While the mean years of schooling was 6.1 for our hijra participants, the general population average was slightly higher at 7.6 years (BDHS, 2022). Additionally, while the average monthly income was BDT 32,422 for all households in Bangladesh, the mean income was 13,908 BDT for hijra, which is considerably lower. The disproportionately lower education and income rates allude to the role of gender identity in compromising their ability to pursue financial solvency.

Implications of findings and recommendations

The findings revealed diverse contexts of stigma, discrimination, and other rights infringements among hijra in healthcare, education, employment, sociopolitical, and other settings. As reflected in the findings, these complexities had nuanced implications on their SRHR, such as their ability to practice and negotiate safer sex, and circumvent sexual violence. This could potentially affect not only their vulnerability towards HIV, STI and other sexual health problems, but also imbue other mental and physical health implications. This could disproportionately displace them towards health disparities, especially amidst existing healthcare access barriers.

Based on the existing healthcare disparities revealed in our findings, such as misbehavior and neglect from healthcare providers, public and private healthcare settings in Bangladesh and other culturally similar contexts would benefit from the cultural competency training of healthcare providers. For example, the Asia Pacific Transgender Network initiated workshops in which it developed a training module for promoting the cultural competency of healthcare providers in collaboration with local transgender advocacy groups (APTN, 2024). Additionally, as per participants' anecdotes, healthcare facilities could benefit from gender-neutral lines and specialized wards and treatment for hijra and other marginalized groups.

To address the violence, discrimination and structural exclusion faced by hijra in various settings, advocacy could be initiated to enforce additional legal protections for hijra in healthcare, education, employment and housing sectors. Legal protections could include anti-discrimination laws, inheritance laws, or other legal protections from gender-based harassment or violence. Moreover, since the existing NGO interventions are the first line of care and support for hijra, free legal services can be rendered through DICs through community-based paralegals from the hijra community.

Moreover, since this study revealed that hijra suffered from various rights infringements such as discrimination, stigma and the need to conceal their identities, the scope of services in the existing NGO intervention modality could be expanded to include sociolegal support for violence and psychosocial counselling. Further, since public attitudes towards hijra are significantly associated with their degree of legal inclusion (UCLA, 2018), advocacy efforts and mass media campaigning efforts need to be sustained to cultivate a positive attitude towards LGBT people, potentially advocating for the relaxing of colonial laws on homosexuality. As recommended by one of the participants, training programs for providers is crucial, a practice already being adopted by TransCanWork in the US (TransCanWork, 2025).

This study also planned to have a second part of initiating roundtable discussions with a diverse body of hijra community members and stakeholders, with the ultimate aim to propose policy recommendations. However, due to overarching socio-structural challenges, such the recent emergence of anti-transgenderism groups, prejudice has escalated against hijra. These circumstances have collectively posed steep barriers to advocacy sessions with policy-planning and decision-making stakeholders. Nevertheless, it is crucial to conduct roundtable meetings with stakeholders to co-design a set of policy recommendations to ensure that they are capable of exercising their rights. This initiative can be started through convening at least

one safe, private meeting to move this agenda along, in order to attenuate prejudice towards these populations.

Key findings reported mistreatment from educators, job providers, healthcare providers and other civilians assuming authoritative positions. In this context, multifaceted structural interventions need to be co-designed by hijra community members and wider ally stakeholders, to ultimately impart them with the space to exercise their healthcare-seeking and other rights as a separate gender category. For example, interdepartmental linkages need to be created between the police, Ministry of Social Welfare, and Ministry of Legal Affairs to circumvent violence, discrimination and harassment (CAP, 2012). This particularly applies for law enforcement officials (CAP, 2012). Efforts need to be revitalized to reintroduce hijra complexities within educational materials in schools and medical curricula for aspiring doctors. Additionally, the nationwide influence of national media could be leveraged for positive messaging of hijra (Hughto et al., 2021). There is currently a community empowerment intervention ongoing in Bangladesh for marginalized populations, including hijra. This intervention consists of social (e.g. life skills training, counselling and advocacy with local influential people), economic (e.g. vocational training, capital support for starting small businesses and advocacy with job providers) and health empowerment (e.g. health education and healthcare provider advocacy) interventions. This needs to be continued and expanded.

Directions for future research

Future implementation research could be conducted to co-design and test multilayered stigma reduction interventions for hijra and other marginalized populations. This could ultimately be supported by longitudinal studies which would assess the long-term effects of these stigma reduction interventions on their health and wellbeing. Furthermore, community-based participatory research could explore and examine the feasibility and acceptability of viable job training and employment opportunities for hijra. Moreover, gaps could be filled in chronic disease surveillance by instituting standardized epidemiological cohorts of hijra to quantify burdens of non-communicable diseases and mental health problems.

Strengths and limitations

This study is the first of its kind to conduct a structured analysis of the differences between policy and reality using an acclaimed framework. This guided the use of a literature review to understand the history of the policy, while also drawing on insider perspectives from mixed methods research to explore the problems faced by this community. The use of multiple data collection techniques also enabled triangulation. This analysis is also crucial because of its ability to analyze how various structural inequalities shape the well-being and freedom of marginalized populations to freely exercise their rights as a separate gender. Such insights could also be applied in other settings where equivalent types of transgender populations with similar characteristics struggle with the expression of their gender identities in the public setting, including healthcare. Existing scholarship on hijra in Bangladesh and LMICs primarily focuses on healthcare access barriers and is mostly limited to review articles and one-shot qualitative studies that have explored single aspects of hijra or other transgender populations' SRHR-related rights.

However, since this study was conducted in Dhaka, this sample was not representative of all the hijra in Bangladesh, as Dhaka is a relatively urban area that may have different cultural characteristics than rural districts. According to the national census data of 2022, 677 hijra live in Dhaka district (BBS, 2023). The sample size achieved in this study constitute 44.01% (298/677) of the hijra in Dhaka. Therefore, data from this study can be generalized to hijra who live in Dhaka district. Another limitation is the temporal ordering, where some of these experiences may have occurred prior to the legal recognition in 2013.

Conclusion

In essence, this study shows that hijra are in a vulnerable position, even more so in the context of discrimination, negative propaganda, and misconceptions surrounding these populations. This has further exacerbated their ability to exercise SRHR-related and other crucial rights. This could potentially

undermine the long-standing efforts of the Government of Bangladesh to place hijra on the politico-legal map of integration. Thus, this study could potentially open the dialogue with stakeholders to identify priority actions in the employment, education, healthcare, housing and civil sectors to safely allow hijra to express their gender identities and, thus, their SRHR.

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Author contributions

Samira Dishti Irfan: Conceptualization; Data curation; Formal analysis; Funding acquisition; Investigation; Methodology; Project administration; Resources; Supervision; Validation; Visualization; Writing- original draft; Writing- review and editing. Masud Reza: Conceptualization; Data curation; Formal analysis; Investigation; Methodology; Project administration; Software; Supervision; Validation; Writing- review and editing. Mohammad Niaz Morshed Khan: Data curation; Formal analysis; Investigation; Methodology; Project administration; Resources; Software; Supervision; Validation; Writing- review and editing. Rakibul Hassan: Data curation; Formal analysis; Investigation; Software; Visualization; Writing- original draft. Sharful Islam Khan: Conceptualization; Data curation; Formal analysis; Investigation; Methodology; Project administration; Resources; Software; Supervision; Validation; Writing- review and editing. All authors approved the final version to be published.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Ethical approval

This study received the ethical approval from the Ethical Review Committee of the Institutional Review Board of the International Centre for Diarrhoeal Diseases Research, Bangladesh (icddr,b) (approval number: PR-22121). As this study involved human participants, this study adhered to the principles of the Declaration of Helsinki.

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Data availability statement

Due to the sensitive nature of the data and the safety concerns faced by this highly vulnerable, marginalized population, we have not deposited this data in an online repository. However, upon reasonable request from the Research Administration of icddr,b, the data can be made available.

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